GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Employment Services
Labor Standards Bureau

Office of Hearings and Adjudication
COMPENSATION REVIEW BOARD

(202) 671-1394-Voice
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CRB No. 07-005

SANTOS A. GONZALEZ,

Claimant–Petitioner,

v.

UNICCO SERVICE COMPANY AND TRAVELERS INSURANCE COMPANY,

Employer/Carrier–Respondent.

Appeal from a Compensation Order of
Administrative Law Judge Amelia G. Govan
AHD No. 06-155, OWC No. 604331

Jessica G. Bhagan, Esquire, for the Petitioner

Douglas A. Seymour, Esquire, for the Respondent

Before E. COOPER BROWN, *Chief Administrative Appeals Judges*, JEFFREY P. RUSSELL, and SHARMAN J. MONROE, *Administrative Appeals Judges*.

JEFFREY P. RUSSELL, *Administrative Appeals Judge*, for the majority of the Compensation Review Panel; E. COOPER BROWN, *Chief Administrative Appeals Judges*, concurring in part and dissenting in part:

DECISION AND REMAND ORDER

JURISDICTION

Jurisdiction is conferred upon the Compensation Review Board pursuant to D.C. Official Code §§ 32-1521.01 and 32-1522 (2004), 7 DCMR § 230, and the Department of Employment Services Director's Directive, Administrative Policy Issuance 05-01 (February 5, 2005). [1]

[1]Pursuant to Administrative Policy Issuance No. 05-01, dated February 5, 2005, the Director of the Department of Employment Services realigned the Office of Hearings and Adjudication to include, *inter alia*, establishment of the Compensation Review Board (CRB) in implementation of the District of Columbia Fiscal Year 2005 Budget Support Act of 2004, Title J, the District of Columbia Workers' Compensation Administrative Reform and Anti-Fraud Amendment Act of 2004, *codified at* D.C. Official Code § 32-1521.01. In accordance with the Director's Directive, the CRB replaces the Office of the Director in providing administrative appellate review and disposition of workers' and

BACKGROUND

This appeal follows the issuance of a Compensation Order from the Administrative Hearings Division (AHD) of the Office of Hearings and Adjudication (OHA) in the District of Columbia Department of Employment Services (DOES). In that Compensation Order, which was filed on September 19, 2006, the Administrative Law Judge (ALJ) found that certain neurological testing was reasonable and necessary and medically causally related to a stipulated work injury. However, the ALJ declined to authorize Petitioner to change physicians to Dr. Batipps in conjunction with obtaining that care, and stated that she could not authorize such treatment to be provided by Dr. Batipps due to a prior and unappealed order from the Office of Workers' Compensation (OWC) denying Petitioner's request to change attending physicians. Petitioner now seeks review of that Compensation Order.

As grounds for this appeal, Petitioner alleges as error that the decision of the ALJ is not in accordance with the law, given that the medical care requested was found to be reasonable and necessary and causally related to the work injury. Respondent opposed the appeal, asserting that the failure to order Respondent to provide the requested medical care was in accordance with the law. Respondent did not file an Application for Review contesting the findings made by the ALJ concerning the reasonableness and necessity of the medical care, or its relationship to the work injury.

Upon assignment to this Review Panel, and preliminary review of the issues presented, this panel issued an Order which read in part:

> Upon review of this matter, the review panel has determined that there are issues presented upon which the panel would benefit from additional briefing and oral argument. Specifically, the panel requests that the parties brief the issue of the applicability and effect of the Utilization Review procedures contained in the District of Columbia Workers' Compensation Act at D.C. Code § 32-1507 (b)(6), (A) through (E) and -1507 (b)(7). Among the issues to be briefed are: (1) whether such provisions permit or preclude review of this case by the CRB, in light of the appeal provision therein found at subsection (D) thereof; (2) whether such provisions are mandatory, permissive, or some combination of both; (3) the scope of the provisions, including whether they are applicable to the request for authorization for the medical care sought by Petitioner in these proceedings; and (4) whether the request for authorization for the medical care in this case is a request for medical care by Dr. Batipps specifically, or is a request for provision of specific medical procedures regardless of the provider thereof.

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disability compensation claims arising under the District of Columbia Workers' Compensation Act of 1979, as amended, D.C. Code Ann. §§ 32-1501 to 32-1545 (2005), and the District of Columbia Government Comprehensive Merit Personnel Act of 1978, as amended, D.C. Code Ann. §§ 1-623.1 to 1-643.7 (2005), including responsibility for administrative appeals filed prior to October 1, 2004, the effective date of the District of Columbia Workers' Compensation Administrative Reform and Anti-Fraud Amendment Act of 2004.

Order Scheduling Oral Argument and Briefing, December 20, 2006. Said oral argument was heard January 31, 2007.

ANALYSIS

As an initial matter, the scope of review by the Compensation Review Board (CRB) and this Review Panel, as established by the Act and as contained in the governing regulations, is limited to making a determination as to whether the factual findings of the Compensation Order are based upon substantial evidence in the record, and whether the legal conclusions drawn from those facts are in accordance with applicable law. *See* D.C. Workers' Compensation Act of 1979, as amended, D.C. Code Ann. §32-1501 to 32-1545 (2005), at §32-1521.01(d)(2)(A). "Substantial evidence," as defined by the District of Columbia Court of Appeals, is such evidence as a reasonable person might accept to support a particular conclusion. *Marriott International v. District of Columbia Department of Employment Services*, 834 A.2d 882 (D.C. 2003). Consistent with this standard of review, the CRB and this Review Panel are constrained to uphold a Compensation Order that is supported by substantial evidence, even if there is also contained within the record under review substantial evidence to support a contrary conclusion, and even where the reviewing authority might have reached a contrary conclusion. *Marriott*, 834 A.2d, at 885.

Petitioner seeks review of the Compensation Order on the grounds that the recommendation for the requested medical care was from a physician to whom, Petitioner asserts, she was referred by Dr. Gregory, a chiropractor from whom Petitioner had obtained care and who, in Petitioner's view as articulated in this appeal, held the status of "treating physician", and that the ALJ was therefore in error to deny authorization for such care which the ALJ also found to be reasonable and necessary as a result of the work injury. Petitioner asserts that in such a circumstance, the care should have been ordered to be provided, pursuant to *Roberta West v. Washington Hospital Center*, Dir. Dkt. No. 99-97, H&AS No. 276A, OWC No. 281076 (Decision of the Director on Remand, May 14, 2003).[2]

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[2] The cited *West* case is one of several cases arising from Ms. West's claim before this agency, and deals only with the question of an employer's liability for medical care obtained from a physician at the direction or upon referral by a "treating physician". In that decision, the Director answered a question posed by the Court of Appeals in an earlier case, *Sibley Memorial Hospital v. District of Columbia Dep't. of Employment Serv's. and Anne Garrett, Intervenor*, 711 A.2d 105 (1998), and repeated in *Washington Hospital Center v. District of Columbia Dep't. of Employment Serv's. and Roberta West, Intervenor,* 789 A.2d 1261 (2002). The question posed was whether the abolition of the Panel system for selecting attending physicians and the contemporaneous creation of a utilization review mechanism, in the 1991 amendments to the Workers' Compensation Act, should be interpreted by the Agency as modifying or eliminating the rule established in *Medical Associates v. Dep't. of Employment Serv's.*, 565 A.2d 86 (1989), in which the Court of Appeals upheld as reasonable the Agency's determination that an attending physician could make referrals to other physicians without the need for approval to "change physicians" from the OWC or the employer. The Director in *West* held that even given the amendments, the Act still permitted an attending physician to refer a claimant to another physician for treatment, without the need for OWC or employer approval. We do caution the parties and others, however, that the use in that case and by Petitioner herein of the terms "series" or "chain" of referrals raises the possibility that the meaning of these cases could be misunderstood. As the Court noted in *Medical Associates*, "Moreover, this case does not involve even a single referral by a non-Panel member, nor an initial referral by a Panel member followed by a succession of referrals, which could raise the same quality and cost concerns that the Panel system is designed to avoid." *Medical Associates, supra*, at 88. Thus, while the Director uses the term "series of successive referrals", and Petitioner's counsel cites the case as standing for the proposition that an employer "is liable for the medical care, which resulted from a series of referrals that were reasonable due to the consequences" of a compensable work injury, care should be taken to remember that the "series" is a series of referrals *each from the*

Employer responds to the appeal by asserting that the failure to order provision of the medical care was in accordance with the law, in light of the ALJ's having held that the request to change "treating physicians" to Dr. Batipps, the neurologist recommending the additional medical testing and care, was outside the jurisdiction of AHD pursuant to *Renard v. District of Columbia Dep't. of Employment Serv's.*, 731 A.2d 413 (1999), and had previously been denied by OWC in an order that was not appealed and hence became final. Employer also asserts that the finding that the neurological testing was reasonable and necessary was in error and ought to be reversed. However, that assertion was contained in a single sentence within the body of "Employer's Memorandum in Opposition to Claimant's Application for Review", filed November 3, 2006. Respondent did not file an Application for Review, and this Memorandum was filed beyond the time for such an application. Accordingly, we do not consider the matter to be before us.

The primary analytical problem with this case is the fact that, while AHD was assumed at the time of the formal hearing by all parties to this action to have authority and jurisdiction to determine whether certain medical procedures sought by a claimant are reasonable and necessary as a result of a compensable work injury, and hence are the responsibility of the employer, under *Renard*, requests for authorization to change an attending or treating physician are within the sole province of OWC. Given that OWC was requested to authorize such a change but that that request was denied in January, 2006, and given further that said order from OWC was not appealed and became final, it may appear that the decision of the ALJ finding that the additional neurological testing and any needed treatment that such testing may indicate is reasonable, necessary and causally related to the work injury, is irreconcilably contradictory with the OWC ruling. However, that is not necessarily so.

The terms "treating physician" and "attending physician" are both used in decisions of this Agency and the Court of Appeals in connection with requests for medical care and an employer's responsibility for it. These terms are frequently used interchangeably. While such usages are not necessarily inaccurate, care should be taken to consider what we are really talking about when we discuss "authorization to change physicians".

7 DCMR 299.1, "Definitions", *Attending Physician*, states that an attending physician is "the treating physician selected by claimant to treat the injury or disability", which definition obviously does not address the fact that many injuries or disabilities require the involvement of multiple physicians of differing specialties who give "treatment". 7 DCMR 212.12 and 212.13 purport to govern requests to "change" medical care providers, but what constitutes a "change" is not discussed.

On one level, any treatment by anyone other than the "attending physician" could constitute a "change", even if the second provider does so at the direction and referral by the "attending" physician. However, this agency, including not only the Director but also this Board, as well as the Court of Appeals, have viewed referrals from a properly selected "attending physician" to other physicians not to represent a "change" in physicians requiring OWC or employer authorization. See, *Roberta West v. Washington Hospital Center*, Dir. Dkt. No. 99-97, H&AS No. 276A, OWC

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attending or treating physician, and in none of these cases was an employer found liable for referrals to additional physicians who saw and treated an employee without the referral coming from the treating or attending physician.

No. 281076 (Decision of the Director on Remand, May 14, 2003); *Medical Associates v. Dep't. of Employment Serv's.*, 565 A.2d 86 (1989). These cases recognize that, given the realities of modern medical practice, the Act and the regulations necessarily anticipate that there is a difference between an "attending" physician, on the one hand, and a physician who provides treatment on the other, for the purposes of the "change of physician" process.[3] This determination is compelled by merely recognizing that there can be many "treating physicians" in a case, if that term means nothing more than a physician who renders medical care, but at any given time, the terms of the regulations permit only a single "attending" physician, and it is that physician with whom the regulations deal.

For the purposes of obtaining medical care from someone other than the "attending physician" selected by a claimant, we believe that the established rules that govern the authority of a "treating physician" to make such referrals without OWC or employer authorization are what is meant by "attending physician".

Regarding authorization to change such "attending physician", and thereby shift from one physician to another the overall independent "management" of the medical case from one "attending" physician to another, we take it as established by *Renard* that such decisions rest solely with OWC, subject to appeal to this Board.

However, we also note that questions concerning the reasonableness and necessity for and medical causal relationship of a course of recommended treatment are generally accepted by the workers' compensation community to be within the jurisdiction of both OWC and AHD, in the same manner as are other issues of compensability. However, the Compensation Order in this case presents a significant question relating to the process by which such (that is, reasonableness and necessity of a course of requested or contemplated medical care) issues can be resolved.

In her Compensation Order, the ALJ made the following comments:

> Pursuant to the Act, when it appears that the necessity, character or sufficiency of medical care or service to an employee is improper or that medical care scheduled to be furnished must be clarified, the concerned party may initiate review by a utilization review organization or individual. D.C. Code, as amended, § 32-1507 (a)(6)(B). The parties have raised the issue without presenting any evidence to indicate such a review has been sought. In the absence of such evidence, the undersigned cannot determine that the recommended neurological testing and treatment is unreasonable or unnecessary. *See Sibley Memorial Hospital, supra; see Landesburg v. District of Columbia Department of Employment Services*, 794 A.2d 607 (D.C. 2002).

Compensation Order, page 5.

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[3] We hasten to add that this analysis should not be read to affect other areas of the law as they relate to "treating physicians", particularly to the treating physician preference in evaluating competing medical evidence, as set out in numerous cases, including *Short v. District of Columbia Department of Employment Services*, 723 A.2d 845 (D.C. 1998), and *Stewart v. District of Columbia Department of Employment Services*, 606 A.2d 1350 (D.C. 1992). That set of rules and considerations are based not upon statutory or regulatory assignments of such status, but rather are premised upon factors revolving around the relationship of the physicians to the patient and to the litigation, and are matters of credibility and reliability, not medical case management.

While both cases cited by the ALJ did in fact involve "utilization review" evidence, neither stands for the proposition that, in the absence of a utilization review report produced pursuant to the Act's utilization review procedures, an ALJ is precluded from determining whether a particular course of medical care is unreasonable or unnecessary. Despite so ruling, we note that the ALJ nonetheless then proceeded to consider the reasonableness and necessity of the requested medical care. Further, in *Landesberg* it is not at all clear that the "utilization review" was performed pursuant to the Act's provisions therefor. Nonetheless, the ALJ appears to proceed to evaluate the record medical evidence before her, and concluded that "there is no record evidence to contradict [the opinions] of Dr. Gregory and Dr. Batipps regarding claimant's need for additional neurological testing and treatment". Compensation Order, page 5 – 6.

Although the ALJ appears to have recognized the existence and potential impact of the utilization review provisions, because it is not clear how the ALJ viewed those provisions in the context of this case, we cannot escape a discussion of the meaning and effect of the utilization review procedures described in the Act. Although we recognize that these procedures appear to be little used in practice, the failure to employ the utilization review procedures in this instance may have consequences beyond limiting the ALJ's options in considering the evidence, which limitations (if any there were) the ALJ apparently perceived yet failed to honor.

The provision in question, D.C. Code § 32-1507 (b)(6), reads as follows:

> Any medical care or service furnished or scheduled to be furnished under this chapter shall be subject to utilization review. Utilization review may be accomplished prospectively, concurrently, or retrospectively.
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> (A) In order to determine the necessity, character, or sufficiency of any medical care or service furnished or scheduled to be furnished under this chapter and to allow for the performance of competent utilization review, a utilization review organization or individual pursuant to this chapter shall be certified by the Utilization Review Accreditation Commission.
> (B) When it appears that the necessity, character, or sufficiency of medical care or service to an employee is improper or that medical care or service scheduled to be furnished must be clarified, the Mayor, employee, or employer may initiate review by a utilization review organization or individual.
> (C) If the medical care provider disagrees with the opinion of the utilization review organization or individual, the medical care provider shall have the right to request reconsideration of the opinion by the utilization review organization or individual 60 calendar days from receipt of the utilization review report. The request for reconsideration must be written and contain reasonable medical justification for the reconsideration.
> (D) Disputes between a medical care provider, employee, or employer on the issue of necessity, character, or sufficiency of the medical care or service furnished, or scheduled to be furnished, or the fees charged by the medical care provider shall be resolved by the Mayor upon application for a hearing on the dispute by the medical care provider, employee, or employer. A party who is adversely

affected or aggrieved by the decision of the Mayor may petition for review of the decision by the District of Columbia Court of Appeals.

(E) The employer shall pay the cost of a utilization review if the employee seeks the review and is the prevailing party.

The potential for this provision to affect Agency review of questions concerning the provision of medical care under the Act has been evident in the decisional law for a long time. In *Garrett v. Sibley Memorial Hospital,* Dir. Dkt. 95019, H&AS No. 92-502, OWC No. 99-847 (Decision of the Director January 22, 1997) the Director affirmed a decision by a hearing examiner (now ALJ) who found an employer responsible for provision of medical care obtained from a physician to whom a claimant was referred by his "treating" physician, citing as authority the case of *Medical Associates v. District of Columbia Dep't. of Employment Serv's.*, 565 A.2d 86 (D.C. 1989). In *Medical Associates*, the Court had approved as a reasonable interpretation of the Act the Agency's decision that a physician with "attending physician" status could make such referrals without seeking approval of OWC pursuant to the provisions of the Act requiring agency approval to change physicians. On review by the Court of Appeals, however, the Court took cognizance of the fact that the Act had been amended since *Medical Associates*, recounting the fact that in the case under review, the new utilization review procedures had been employed, and expressed concerns that the issues on appeal were intertwined with the various problems and potential inadequacies in the way the hearing examiner considered the evidence and reports that emerged from that new process. *Sibley Memorial Hospital, supra*, at 106 – 107. In its concluding section, the court questioned the Director's reliance upon *Medical Associates*, writing as follows:

> Ordinarily, this court must accord deference to an agency's reasonable interpretation of the statute that it administers. [...] This deference is only warranted, however, when the record provides some evidence that [the Agency] considered the language, structure, or purpose of the statute when selecting an interpretation. [...] There is nothing in the record to show that the Director considered any of these factors in concluding in this case that Claimant did not engage in an unauthorized change of physicians. Rather, the Director relied solely upon *Medical Associates* without explaining how that decision was dispositive of the particular facts in this case. We note that in *Medical Associates* this court specifically distinguished its fact from the facts in the instant case. *See, [Medical Associates, supra] at 88* ("This case does not involve ... an initial referral by a Panel member followed by a succession of referrals, which could raise the same quality and cost concerns that the Panel system is designed to avoid.").
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> In addition, *Medical Associates* was decided prior to the 1991 amendment to the Workers' Compensation Act, in which the Panel system was abolished. [footnote 7]. Thus, a Panel system was in place in *Medical Associates* to insure some sort of control over a series of referrals to different doctors, and a single referral to a non-Panel physician in that case was by a Panel physician who never lost contact with the patient.
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> [...]

> Therefore, on remand, the agency should revisit this issue, considering how the purposes of the Act might be thwarted or furthered through permitting an employee to change physicians through a chain of referrals rather than through written authorization as required by 7 DCMR § 212.12. In addition, the agency should not only consider distinctions between this case and *Medical Associates* and how this might affect the determination of whether Claimant's change of physician was authorized, but also consider the repeal of the Panel system and how such repeal might affect the reasonableness of the agency's past interpretation of the statute that was reflected in *Medical Associates*.
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> In sum, the tasks for DOES upon remand of this case are:
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> [...]
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> (3) To reexamine the sequence and reasons for examinations and evaluation of the Claimant by different physicians in this case and set forth its reasoning and conclusion why this particular series of events does not constitute an unauthorized change of physicians within the meaning of the applicable statute [footnote omitted].

Sibley Memorial Hospital, supra, 108 – 109 (non-bracketed ellipses in original). The referenced footnote 7 is as follows:

> The Panel system was abolished at the same time the procedure for obtaining utilization review reports was created. Under the Panel system, the Mayor had a list of physicians, or "panel", from which employees could select a treating physician. Under the current system, the employee may choose any licensed doctor, dentist, or chiropractor as her treating physician. D.C. Code §§ 36-307 (b)(3), -301 (17A) [currently, D.C. Code §§ 32-1507 (b)(3) and -1501 (17A)].

The Court again discussed the possible ramifications of the abolition of the Panel system and the simultaneous enactment of the Utilization Review model in *Washington Hospital Center v. District of Columbia Dep't. of Employment Serv's. and Roberta West, Intervenor*, 789 A.2d 1261 (2002):

> We noted [in *Sibley Memorial Hospital, supra*], however, that the case differed from *Medical Associates*, which involved only a direct referral from the attending physician and not successive referrals. Furthermore, we noted that even *Medical Associates* itself was decided under the old panel system and not under the new statutory scheme. [...] To the best of our knowledge, this re-examination is still in progress.

Washington Hospital Center, supra, 1264 – 1265. In May, 2003, the Director partially addressed the specific issue presented, that relating to provision of medical care upon referral by the "attending physician" to another physician, in the decision on remand in that case. Without addressing the reasons for the new statutory scheme, the Director held that the it did not change the Agency's view of whether an "attending physician" could make such a referral, and affirmed their ability to do so.

Roberta West v. Washington Hospital Center, Dir. Dkt. No. 99-97 (Decision of the Director on Remand, May 14, 2003).

To date, however, there has never been a decision in this agency or from the Court in which the broader question, how the 1991 amendments affect the process of considering "necessity, character or sufficiency" of medical care, is to be addressed. Until the 1991 amendments, it was generally accepted that such questions, including whether and how claimants should be permitted to change "attending physicians", were to be determined either under the informal processes in OWC, contemplated and provided for in 7 DCMR 219, or the formal hearing processes contemplated and provided for in 7 DCMR 221.

Then, in 1999, the Court of Appeals ruled that, under the statutory and regulatory scheme, there is no right to a "trial type" hearing in connection with requests for a change of an attending physician, in *Renard v. District of Columbia Dep't. of Employment Serv's.*, 731 A.2d 413 (1999), thereby ruling that such questions are not appealable to that Court, under the District of Columbia Administrative Procedure Act (DCAPA), because under D.C. Code § 1-1502 (8), such agency proceedings do not constitute a "contested case". Thus, by determining that there was no right under the Act to a formal hearing on this issue, the Court has necessarily ruled that AHD does not have jurisdiction to hear such claims.

The Court in *Renard* did not address the utilization review procedures in the 1991 amendments, but we must assume that the *Renard* decision suggests a dichotomy between change of physician questions, on the one hand, and questions concerning the "necessity, character and sufficiency" of contested medical care (either that requested by a claimant but denied by the employer on a voluntary basis, or that obtained unilaterally by a claimant for which recompense by employer is sought). This is because the amendments specifically provide for a "hearing" to be conducted by the Mayor in the case of "disputes between a medical care provider, employee or employer on the issue of necessity, character or sufficiency" of the disputed medical care recommendation and request. D.C. Code § 32-1507 (b)(6)(D). Such a dichotomy is also to be implied by the fact that the 1991 amendments treated the method and manner of physician selection separately from that of "necessity, character and sufficiency of medical care", dealing with the former by abolishing the "panel of physicians", broadening the definition of "physician" to include chiropractors, and broadening further the universe of available "attending physicians" to include any such professional licensed in the District of Columbia, while dealing with the latter by enacting the utilization review procedures.

Again, we take it as established by the Court in *Renard* that, as the ALJ ruled in this case, the issue of change of physician (meaning changing from one properly selected managing or attending physician to another) is not an issue for which a claimant may seek a formal hearing, and that such decisions are strictly within the province of OWC, subject to Agency review by this Board.[4] *See also*, *Lane v. Linens of the Week*, CRB No. 05-207, OWC No. 594244 (May 6, 2005).

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[4] Our colleague in dissent asserts that the *Renard* decision does not stand for the proposition that AHD is without jurisdiction to entertain requests for authorization to change physicians. It appears that he is suggesting that the Court was issuing a decision limited to the specific procedural route employed in that case in declining to exercise appellate jurisdiction, and that had the parties in that case then sought and obtained a formal hearing in AHD, the Court could

However, we also take it as clear from the 1991 amendments that questions concerning "necessity, character or sufficiency" of medical care *are* the proper subjects of such formal hearings, because they have always been considered such, and because the amendments expressly provide for such hearings in subsection (D).

However, in so providing for such hearings, the amendments also appear to have created a mandatory process of utilization review, with the added requirement that such process be undertaken prior to the conduct of a formal hearing. That is, the statute specifically provides for such a hearing in the penultimate subsection, (D), immediately following subsection (C), dealing with requests for reconsideration of the utilization review recommendation issued initiated under the provisions of subsection (B).

Given that there are no regulations as yet promulgated to establish specific procedures for this review to occur, we must interpret the provisions as best can, giving the statutory, regulatory, and Court illuminated scheme as integrated an approach as we are able.

The first section of the utilization review provisions, subsection (A), states that "Any medical care or service furnished or scheduled to be furnished under this chapter *shall* be subject to utilization review" (emphasis added). Thus, it appears that the procedures to be discussed in the following sections are mandatory, given the use of the term "shall".

However, subsection (B), the provision that appears to govern how such procedures are to be initiated, reads "[w]hen it appears that the necessity, character, or sufficiency of medical care or service to an employee is improper [...] or must be clarified, the Mayor, employee, or employer *may* initiate [utilization review]" (emphasis added). Here, the permissive use of "may" could

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have exercised such appellate jurisdiction. Such a suggestion either ignores or misapprehends the analysis employed by the Court, which stated unequivocally that:

> Plainly, the statute does not require a hearing before the decision whether to permit a change is made [footnote stating that there is likewise no Constitutional requirement for such a hearing omitted]. And, the regulations issued pursuant to it do not do so either. Besides prohibiting a change to another medical care provider ... without authorization of the insurer or the Office [of Workers' Compensation], they provide only that:
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> > If the employee is not satisfied with medical care, a request for change may be made to the Office. The Office may order a change where it is found to be in the best interest of the employee.
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> 7 DCMR § 212.13. This discretionary decision ("may") need not be preceded by any sort of hearing, let alone a trial-type one. *In fact, the DCWCA requires trial-type hearings only with respect to "claims for compensation"*. D.C. Code § 36-320; *see* 7 DCMR § 220 – of which a request for change of physician is self evidently not one [footnote omitted] and disputes over medical fees. *See* 7 DCMR § 212.10.

Renard, supra, at 414 -415 (emphasis added). The statute and regulations remain unchanged today from the relevant terms thereof as of the date *Renard* was issued. Unless there is authority to support the proposition that AHD may conduct hearings on issues to which no party has a right to such a hearing by statute, then AHD has no authority to conduct hearings on requests to change physicians. Neither party in this appeal has argued that such authority exists, our colleague in dissent has not identified any such authority, and we are aware of none.

suggest that, despite the mandatory nature of the applicability (or possibly, the availability) of utilization review procedures, the decision to initiate such a review remains a discretionary choice available to any of the three listed parties. In other words, the mandatory language in the first subsection could establish nothing more than the fact that all medical issues are potentially subject to the utilization review process, if one of the three parties listed in the initiating subsection elects to use them. Petitioner argues in favor of this interpretation in the Application for Review, in the supplemental brief, and at oral argument. Or, the mandatory language in subsection (A) could bring all such issues within the mandatory purview of the section, with the permissive language meaning that any of the three listed parties have the power to initiate the process, depending upon the circumstances of a particular dispute. This is Respondent's position.

The next subsection, (C), discusses the procedure to be employed where the subsection (B) review has resulted in a utilization review report that conflicts with the view of "the medical care provider". While the meaning of this is presumably clear where, for example, a course of medical care recommended by a claimant's physician has been challenged by an employer who obtains a utilization review report that challenges the reasonableness or necessity of that proposed course of treatment, the availability of the procedure to the claimant suggests that it could also be employed to challenge a denial of a request for medical care. Apparently the Council assumed that there would be instances where an "attending" physician declines to order or authorize a particular course of care that a claimant nonetheless wished to obtain, and that this procedure would provide a mechanism to challenge the reluctant attending physician. In any event, the aggrieved party is given 60 days within which to request reconsideration *by the utilization review report's author*, which request must contain "medical justification" for such reconsideration. This suggests that the reconsideration request is to be made either by a medical care provider directly, or by a party through the use of a medical report.

Before turning, however, to the merits of the instant appeal, we must first address subsection (D) because of the jurisdictional question that it raises for the CRB. That provision states:

> Disputes between a medical care provider, employee, or employer on the issue of necessity, character, or sufficiency of the [disputed medical care or services], or the fees charged by the medical care provider shall be resolved by the Mayor upon application for a hearing on the dispute by the medical care provider, employee, or employer. *A party adversely affected or aggrieved by the decision of the Mayor may petition for review of the decision by the District of Columbia Court of Appeals.*

D.C. Official Code § 32-1507(b)(6)(D) (emphasis added).

The emphasized last sentence of subsection (D), standing alone, appears on its face to remove the CRB's jurisdiction to administratively review a decision reached following a hearing before AHD concerning the necessity, character, or sufficiency of the disputed medical care or services, or the fees charged, requiring instead direct appeal from AHD to the D.C. Court of Appeals.[5] However, a

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[5] Further supporting this interpretation is the fact that subsection (D) is contained within the body of section (b)(6) and is in fact followed by an additional subsection (E) (assessing costs for section (b)(6) procedures upon an employer if the employer ultimately loses), and because subsection (D) contains no language suggesting that it is applicable to other disputes outside that section, it appears that it applies to disputes arising under section (b)(6) only.

construction of this provision within the context of the Act as a whole leads, instead, to the conclusion that use of the term "Mayor" in the subsection (D) should be read no differently than its use as found in other provisions of the Act. To begin with, the term "Mayor" is defined under the Act to include "the Mayor of the District of Columbia, or his designated agent." D.C. Official Code § 32-1501(14). Thus, whereas throughout the Act reference to "Mayor" is made, inevitably "Mayor" is found under the Act to contemplate not only the Director of the Department of Employment Services, to whom the Mayor's authority under the Act has been delegated, but in turn, at times, the Office of Workers' Compensation, the Administrative Hearings Division, or the Director of DOES, depending upon the statutory context within which the term "Mayor" appears. *See e.g.*, the pre-2004 amendment language of Sections 32-1520 and 32-1522.

Finding no legislative history specifically explaining usage of the term "Mayor" in subsection (b)(6)(D), we thus interpret the term to contemplate the full extent of internal Agency decision-making required with respect to all compensation and disability claims before an Agency decision becomes final under the Act. In light of the 2004 amendments to Sections 32-1520 and 32-1522 of the Act, this necessarily requires CRB review and determination of the claim for relief, following a hearing before AHD, before appeal to Court of Appeals can be made.

We turn, then, to the central question posed at the outset: is section (6) the mandatory and exclusive process for resolving medical necessity (and fee) disputes under the Act, or is it a voluntary process electable by any of the three parties mentioned in subsection (B)(i.e., the Mayor, employee or employer)?

The confusion or ambiguity presented by the mandatory "shall" in the opening paragraph of the section, and the permissive usage "may" in subsection (B) is reconcilable if one takes the provisions as being mandatory and exclusive, because, given the variety of potential interested parties who could be on the "wrong side" of the initial and disputed medical decision, it could be any of the three parties who would want to initiate the process. That is, despite the procedures exclusivity in the realm of medical issue disputes, it could be any of the three identified parties who would seek to initiate the process, hence, the permissive "may" aptly describes the nature of the potential different circumstances under which one or another of the disputants might be inclined to commence the process and obtain their preferred outcome.

The contrary interpretation, that the process is completely voluntary and that there are other procedures available for resolution of medical issue disputes also covered in the section is less likely and *not* obviously reconcilable with the mandatory "shall" employed in the opening subsection: the legislature could just as well have used the permissive "may" in that opening paragraph had it chosen to make its terms merely an optional procedure for this class of disputes, and it could as well have made clear the optional nature of the process by so denominating it within the section. Further, it is hard to imagine the point of a legislative enactment creating such a voluntary procedure in the first instance, given that there is nothing to prevent the parties from engaging in such a process, or any other dispute resolution process of their own devising, in the absence of the statute.

We have examined and reviewed the legislative history contained in the "Report on the 'District of Columbia Workers' Compensation Equity Act of 1990', Bill 8-74", the legislation in which the utilization review provisions were created, for guidance in our consideration of these provisions.

That review reveals some things that are instructive in interpreting the provision. On page 5 of the report, it is recited that, according to the testimony of then Director of DOES F. Alexsis Roberson, there had been a 29% increase in insurance premium, as opposed to an anticipated reduction in such costs, in the 10 years since the Council adopted the Workers' Compensation Act of 1978, replacing the Longshore and Harbor Workers Compensation Act (LHWCA), which itself had been replaced in part to reduce insurance premium costs and thereby improve the competitive advantage of the District of Columbia in seeking to attract employers in the region. On page 8 of that report, a summary of "business community" opinion (gleaned apparently from some of the testimony which included "105 witnesses over a three day period" (page 7)), includes reference to the belief that "an on-going right of an employee to change physicians at the expense of employer would encourage doctor shopping until an employee could find and retain a physician who would support the wishes of the employee who does not wish to return to work." No discussion of the physician selection process is included in the similar summary of labor community opinion on the pages following. However, on pages 13 and 14 of the report, it is noted that one change sought by that community was the change of terminology in the Act from "physicians" to "professional health care providers", a change which the committee thought broader than was advisable, preferring to amend the definition of physicians to include dentists and chiropractors, but which definition it viewed as more narrow than "professional health care provider". This section also includes a statement as to the meaning of "utilization review", without comment upon the opinions of the business or labor communities, or the committee.

On page 17, the discussion of the provision covering "Medical Services and Supplies", then section 36-307, the section where the utilization review provisions ultimately came to be, discusses the committees view that "the Committee is recommending the adoption of a cost control measure (utilization review, discussed below) which is expected to control, if not lower, workers' compensation costs in the District". Committee Report, page 15.

The referenced "discussion" of utilization review begins on page 18 of the report, and includes the following:

> The panel of physicians appointed by the Mayor is eliminated. An employee my choose any physician, defined earlier as a doctor, dentist, or chiropractor licensed to practice in the District of Columbia Health Occupation Revision Act of 1985.
>
> Further, any person who provides medical care or services for injured workers is required to use standard coding pursuant to regulations promulgated by the Mayor. [...]
>
> To stem the rising cost of medical care and services without jeopardizing appropriate medical care for injured workers the Committee provides an amendment which states that all medical care and services furnished or scheduled to be furnished are subject to utilization review [...]

> Differences of opinion between a medical care provider, employee, or employer on the necessity, character, or sufficiency of the medical care or service furnished or scheduled to be furnished or the fees charged by the medical care provider shall be resolved by the Mayor upon application by the Mayor [sic] by either the employer or employee. The cost of utilization review shall be assumed by the party requesting the review; except an employer must pay the cost of the utilization review where the employee seeks the review and wins the dispute.
>
> Medical care providers shall not hold employees liable for services rendered in connection with a compensable injury. The interest in the Committee in this regard is to discourage physicians from recommending and providing unnecessary medical services. Currently, physicians who overtreat employees sue them for medical fees which employers/insurance carriers refuse to pay. With the establishment of utilization review, it is conceivable that this practice would increase without an appropriate deterrent.

Committee on Housing and Economic Development Report, page 19 – 20. In the "Section-By-Section" analysis that follows, there is no editorial comment upon the provisions in question. There is no discussion, for example, of why the Committee decided that disputes remaining following the conclusion of the utilization review process, including the hearing thereon held by "the Mayor", are taken to the District of Columbia Court of Appeals, without reference to the Director of DOES as they are recognized to be generally under the Act in the Committee report (or, for that matter, how this change from an alternative contained later in the report, at page 56, establishing a right to appeal not to the Director or the District of Columbia Court of Appeals, but to the Superior Court of the District of Columbia, came about).

Lastly, nothing in the "Summary of Testimony" found in the report on pages 59 – 70, addresses the utilization review procedures specifically, although at least six witnesses (at pages 65, 66, and 67) expressed support for the physician choice provisions; in the "Executive's Position" portion of the report covering the views of the Director of DOES, there is no specific discussion of the utilization review procedures, except that she expressed support for inclusion of chiropractors and dentists in the class of health care providers who provide "independent primary care", presumably under the status of "attending physician".

In summary, we conclude that the legislature intended the amendments, including the abolition of the physicians panel and the creation of a utilization review paradigm in which (1) an attending provider of independent primary care could be selected from a broadened class of providers which as a result of the amendments includes not only the previously allowed physicians, but also dentists and chiropractors, and the provider was no longer required to be from a panel, but could be any provider licensed to practice in the District of Columbia, (2) the care provided would be subject to utilization review whenever there was a dispute as to whether medical care being recommended by the attending provider was reasonable or necessary, on the one hand, or adequate for the needs of the worker on the other, (3) that the employer could seek to limit provision of unreasonable and/or unnecessary care, claimant could seek to obtain additional care where it was not being provided, and the agency could obtain insight from utilization review in the context of overseeing the

compensation system, (4) claimants would be shielded from collection suits by medical care providers, and (5) fee disputes would be subject to the same review process. Nothing in the legislative history suggests that these procedures were to be employed as an adjunct to the existing procedures; rather, the report gives every indication that the institution of utilization review and the related changes were viewed as a comprehensive revision of the manner in which questions and disputes relating to the provision of medical care, as a medical matter (rather than questions that are purely related to compensability of a claim generally) under the Act would be resolved.

Accordingly, we view D.C. Code § 32-1507 (b)(6) as being the exclusive and mandatory procedure envisioned by the legislature for resolution of all disputes arising under the Act which relate to "the necessity, character, or sufficiency of any medical care or service furnished or scheduled to be furnished". This would include issues relating to the "reasonableness and necessity" of medical procedures recommended or sought, on the one hand, and disputed, on the other, but not to the issue of the selection and change of the attending physician, because those questions are the subject of other specific statutory and regulatory provisions, and not to the causal relationship of a medical condition for which care is sought to the work injury, or other issues of compensability and disability generally, as they are not included within the definition of "utilization review" found at D.C. Code § 32-1501 (18A): " 'Utilization review' means the evaluation of the necessity, character, and sufficiency of both the level and quality of medically related services provided to an injured employee based upon medically related standards."

With these determinations and considerations in mind, we turn to the case at hand.

By virtue of the un-appealed and final order of OWC, Dr. Danziger remains Petitioner's attending physician. Petitioner's contentions to the contrary, expressed in the supplemental brief, the application for review, and the oral argument, consist entirely of reasons why in his view, Dr. Danziger should not have been held to be Petitioner's "attending physician", and focus upon specific factual details as to why this is so, including an argument that the "true" attending physician is in fact Dr. Gregory. However, none of those arguments address the inarguable fact that Dr. Danziger was so declared by OWC, in specific contrast to Dr. Gregory, in an order issued following an informal conference, at which Petitoner was represented by counsel, and from which no appeal was taken. Among the facts proffered by counsel at oral argument was that Petitioner's bills from Dr. Gregory had not been paid, yet that fact is specifically addressed and rejected by OWC in its order. Repetition of that argument in these proceedings accentuates the fact that Petitioner's objections to the Compensation Order represent an attempt to relitigate the matters resolved in the un-appealed OWC order.

Pursuant to *Sibley Hospital*, Dr. Danziger may, without further action of this agency, authorize and direct that Petitioner obtain the additional neurological testing.[6] It may well be that, in this case as a practical matter, if Petitioner returns to Dr. Danziger and requests a referral to a neurologist—either Dr. Batipps or some other-- for this purpose, he will make such a referral, while retaining his management and direction of the case as it concerns future courses of treatment and referrals.

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[6] Of course, this authority is subject to the existing rules and procedures permitting employers to contest such recommended treatment on various grounds, including causal relationship or compensability generally, as well as on reasonableness and necessity grounds within the context of utilization review, as discussed in this Decision and Remand Order.

Alternatively, as we have previously pointed out, a denial by OWC of a request to change attending physicians is not a denial for all time and for all purposes. Rather such requests may be renewed, and supposing there are reasonable grounds, the request may be granted. See, *Guerrero v. Clark Construction,* CRB No. 05-213, OWC No. 592187 (June 1, 2005).

Further, and more to the point, the posture of this case as it now stands is this: OWC has denied authorization to change attending physicians from Dr. Danziger to Dr. Batipps, and that decision was not appealed and currently controls; AHD has denied any implied request from Petitioner that a change in attending physician be authorized, and that decision is in accordance with *Renard's* proscription of AHD jurisdiction in connection therewith; and AHD has found that Petitioner is in need of further neurological testing, such testing being that recommended by Dr. Batipps, and that such testing is required as a result of the compensable work injury; while the ALJ included "further treatment" within her description of the medical services required, presumably, the need for additional care beyond the anticipated testing will depend upon the outcome of those tests and the recommendations of the physicians involved. However, the ALJ also noted that there has been no utilization review conducted in this case.

In this case, the party seeking authorization for further medical care as recommended by Dr. Batipps is Petitioner. This medical care has been opposed by Respondent as being not medically necessary. There is, obviously, a "dispute" between "a medical care provider" that is, Dr. Batipps, who is joined with the "employee", Petitioner, on the one hand, and "employer", Respondent, on the other, "on the necessity, character or sufficiency" of medical care. However, neither the recommendation for nor the opposition to providing this treatment, on this record at least, is premised upon a report or opinion issued by a person or organization "certified by the Utilization Review Accreditation Commission", as required by subsection (A) of the 1991 amendments. Nor, either, is the request for or opposition to providing the treatment the result of the process contained in the Act.

Further, the medical care has not been recommended by the attending physician, Dr. Danziger.

The statute, in recognizing the existence of something called an "attending" physician would appear to place treatment decisions, at least initially, under his or her control. In this case, there is an attending physician, yet Petitioner is seeking medical care not recommended or authorized by that attending physician.

If the attending physician had recommended or authorized it, the obligation would presumably have been upon the party objecting to the provision of that care to undertake the statutory process for resolving such a dispute, or in the absence of such an undertaking, be found liable for it. On the other hand, in the absence of such a recommendation or authorization by the attending physician, it would appear that the dispute arises from the Petitioner's desire to obtain care that has not been authorized or recommended by the attending physician. Accordingly, the Act would appear to place upon Petitioner the obligation for initiating the utilization review process in order to obtain the testing and to obtain additional treatment recommendations based upon the results of that testing, or to do without same, at least at Respondent's expense.

The circumstance is, indeed, not the happiest circumstance, and perhaps not the best suited to providing Petitioner with unfettered options in obtaining treatment. But such is the nature of the Act; it is designed not to permit unfettered discretion to either a worker or an employer when it comes to medical care, but rather to give responsibility for deciding, in cases where there is a dispute, what medical care will be provided under its terms, first to an accredited "utilization review" person or organization, and then, in the instance of a continuing dispute, to this Agency through a formal hearing.

The Compensation Order did not explicitly order that Respondent provide the medical care that was found by the ALJ to be reasonable and necessary as a result of the work injury. It did, however, find that such care is reasonable and necessary, without having the benefit of the statutorily prescribed utilization review. In that regard, it is not in accordance with the law.

We recognize that, despite having been in existence for nearly 15 years, the utilization review procedures have not been widely implemented or employed as they were apparently intended. Accordingly, we believe that, in the interest of fairness to all parties, and in light of the principal that newly announced applications and interpretations of the Act ought not be determine the outcome of a case that arose before the rule becomes entrenched without the parties having a chance to present their case in light of the rule, (*see*, *Epstein, Becker and Green v. District of Columbia Dep't. of Employment Serv's.*, 850 A.2d 1140 (2004)) we will remand the matter for further proceedings consistent with the utilization review provisions of the Act as discussed herein. Those proceedings shall be designed to permit Petitioner to initiate such utilization review if he wishes to have the issue considered by AHD in the future, pursuant to subsection D.C. Code § 32-1507(b)(6)(D).

Accordingly, we shall affirm the Compensation Order to the extent that it denied Petitioner's request that Petitioner be authorized by AHD to change attending physicians, vacate that part of the Compensation Order which found that the requested medical care was reasonable and necessary as being contrary to the procedures established in the 1991 amendments to the Workers' Compensation Act, and remand the matter to AHD with instructions that either party, if there is still a dispute as to the necessity, character, or sufficiency of medical care following such utilization review, be permitted to request a formal hearing following Petitioner's undertaking to employ the utilization review procedures as contained in the Act, should such party so desire.

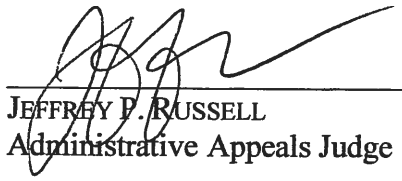
CONCLUSION

The Compensation Order of September 19, 2006 is supported by substantial evidence and is in accordance with the law insofar as it denied any implied request that Petitioner be permitted to change attending physician. The Compensation Order of September 19, 2006 is not in accordance with the law, insofar as it found the neurological testing recommended by Dr. Batipps to be reasonable and necessary and ordered that such testing be provided.

ORDER

The Compensation Order of September 19, 2006 is affirmed insofar as it denied Petitioner's request for authorization to change attending physicians. The Compensation Order of September 19, 2006 is reversed insofar as it found the neurological testing recommended by Dr. Batipps to be reasonable and necessary and ordered that such testing be provided. The matter is remanded to AHD to permit the parties to undertake consideration of Petitioner's request for provision of medical care pursuant to the utilization review procedures found at D.C. Code § 32-1507 (b)(6).

FOR THE COMPENSATION REVIEW BOARD:



JEFFREY P. RUSSELL
Administrative Appeals Judge

February 21, 2007
DATE

E. Cooper Brown, *Chief Administrative Appeals Judge*, concurring in part and dissenting in part:

This appeal presents two separate issues. The first involves a claim seeking authorization for medical treatment. With respect to the proper resolution of this issue, I concur with the majority's decision as to the mandatory nature of the utilization review process prescribed under D.C. Official Code § 32-1507(b)(6). For the reasons explained by the majority, the question of the necessity, character and sufficiency of the medical care Claimant seeks must be remanded for an initial utilization review determination. Only should a dispute thereafter arise due to the resulting utilization review report may an aggrieved party apply for a formal hearing pursuant to subsection (b)(6)(D).

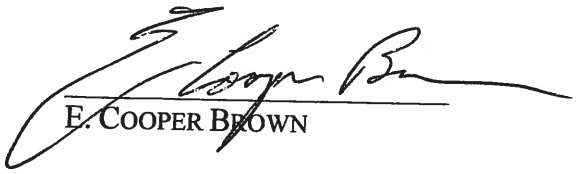
With respect to the second issue raised by this appeal, however, I must respectfully dissent from my colleagues. The second issue results from OWC's denial of Claimant's request for a change of attending physician, and AHD's subsequent refusal to entertain jurisdiction over this request in light of OWC's order. For the reasons set forth hereafter, I am of the opinion that AHD is not precluded from exercising jurisdiction over Petitioner's change of physician petition.

The ALJ below, and the majority of this Review Panel, cite *Renard v. D.C. Dept. of Employment Services*, 731 A.2d 413 (D.C. 1999), for the legal proposition that AHD does not have jurisdiction to entertain an employee's claim seeking a change of attending physicians; that such decisions are exclusively the province of OWC, subject to agency administrative review before the CRB. Even

though the majority's interpretation of *Renard*, and that of the ALJ below, is consistent with the interpretation to which the Agency has ascribed since *Renard's* issuance in 1999, I do not read the Court's holding so expansively.

I do not view the Court's decision in *Renard* as precluding AHD from conducting a "contested case" formal hearing in all cases involving a request to change attending physicians (or for that matter, hospitals, *see* §32-1507(b)(4)). *Renard* focused exclusively on the question of whether or not the Court of Appeals had jurisdiction under the Administrative Procedures Act, D.C. Code § 1-1510(a) [now D.C. Official Code § 2-510(a)] to entertain an appeal from a decision issued by DOES involving an initial determination by OWC pursuant to informal conference, followed by administrative review and final decision by the Director. Upon review of the agency procedure that was employed, assessed against the nature of the claim therein presented, the Court of Appeals concluded that the "contested case" proceeding necessary to invoke the Court's jurisdiction had not occurred, and none was required. The Court expressed no opinion on whether a party, pursuant to the Agency's regulations (commencing at 7 DCMR § 219.20 et seq.), might nevertheless reject an OWC claim examiner's informal recommendation with respect to a change of physician request, before it became final, and apply for a formal hearing, or as the procedures allow, by-pass the OWC informal claims process entirely and apply directly for a formal hearing before AHD.

While I am not prepared to say that in all cases a party may apply for a formal hearing before AHD on a claim seeking a change of an attending physician, I am of the opinion that in the instant case, where the request for the change is inextricably intertwined with the issue of the reasonableness and necessity of the medical treatment being sought, that Petitioner's application to AHD seeking a hearing on the requested change was proper, notwithstanding OWC's determination.



E. COOPER BROWN