Government of the District of Columbia
Department of Insurance, Securities and Banking

Stephen C. Taylor
Commissioner

Peter Lewis

Claimant

v.

Department of Insurance, Securities and Banking

HEARING OFFICER'S PROPSOSED FINDINGS OF FACTS AND CONCLUSIONS OF LAW

Appearances: Adam Levi, Assistant General Counsel, Department of Insurance, Securities and Banking; Claimant, Peter Lewis appeared in person and by counsel, Brandi S. Nave, Esq., Nave & Associates.

LEGAL BACKGROUND

The Compulsory/No-Fault Motor Vehicle Insurance Act of 1982 Amendment Act of 1985," D.C. Law 4-55, took effect September 18, 1982. The purpose of the Act was to provide adequate protection for victims who are injured in the District of Columbia or who are injured while riding in motor vehicles registered or operated in the District of Columbia. The Uninsured Motorist Fund ("Fund") was created under the Act for awarding compensation to a victim for medical and rehabilitation expense, work loss or funeral expenses where the victim would not otherwise be compensated. To be eligible, there must be no applicable insurance coverage, nor any other means available to compensate the victim for his or her loss. In furtherance of this objective, the law provides that while and award shall be equal to the amount of the victim's loss, any payment of benefits shall be decreased by all amounts received by or available to the victim from collateral sources." *See D.C. Code 2404.01(4)(e); See also Doris M. Daniel v. District of Columbia Insurance Administration, 639 A.2d 590 (1994).* The Department of Insurance, Securities and Banking ("Department") is the administrator of the fund.

PROCEDURAL HISTORY

On Peter Lewis ("Claimant") requested a hearing for reconsideration of a decision issued by the Department in which Claimant's request for compensation from the Uninsured Motorist Fund ("the Fund") was denied. *See Department's decision attached hereto as Exhibit "A."*

On June 4, 2014, in the District of Columbia, while Claimant was working as a transportation assistant on a District of Columbia school bus, the bus was struck by a vehicle driven by FA, an

uninsured motorist. Claimant sustained injuries to his neck, back and leg. On June 4, 2014, Claimant [1]was evaluated and treated at the United Medical Center Emergency Room. Subsequently, on June 5, 2014, claimant sought treatment from his primary care physician at Kaiser Permanente. Also on June 5, 2014, Claimant was evaluated by Dr. Jagdev Dhillon at Metro Medical Clinic, Inc. Dr. Dhillon diagnosed Claimant with a thoracic sprain/strain; lumbosacral sprain strain; and a right leg sprain/strain. On June 5, 2014, Claimant began four (4) weeks of chiropractic therapy at Metro Medical Clinic, Inc. The cost of treatments received at Metro Medical Clinic, Inc. is $4,090.

On June 10, 2014, claimant filed a claim for worker's compensation benefits with the District of Columbia's Office of Risk Management ("ORM") in which he sought payment for out-of-network chiropractic treatments received at Metro Medical Clinic, Inc. On September 23, 2014, ORM notified Claimant's attorney that his worker's compensation claim was denied. On January 5, 2016, ORM sent Claimant's attorney a second letter stating that the ORM had previously notified the Claimant that his request for worker's compensation was denied.

On January 25, 2016, Claimant by and through counsel, filed an application to the Fund seeking payment for medical bills incurred for the medical treatment Claimant received at Metro Medical Clinic, Inc.[2] On May 18, 2016, in a written decision, the Department found that the Claimant was not eligible to receive compensation from the Fund for his medical bills. In its decision, the Department stated that: (1) Claimant failed to report the accident to not more than 45 days after the accident; (2) Claimant failed to file his claim against the fund within 180 days after the accident; (3) Claimant had health insurance with Kaiser Permanente at the time of the accident; and (4) that the police report taken at the scene stated that the Claimant was not injured in the accident.

On May 17, 2016, Claimant through his attorney requested a hearing contesting the Department's decision. The hearing in this matter was held on June 21, 2016. Claimant testified on behalf of himself. No witnesses were called by the Department. After the hearing, this Hearing Officer held the record open for two (2) weeks, to July 5, 2016. The purpose for holding the record open was to allow the parties to submit additional evidence they would like this Hearing Officer to consider. On June 221, 2017, the Department filed a 2014 Kaiser Permanente Summary Plan and Member Handbook ("Handbook"). The document was provided to Claimant's counsel and there was no objection to it being admitted into evidence[3], therefore, the Handbook was admitted into evidence. Based on the findings of facts and conclusions of law contained herein, this Hearing Officer recommends that the Commissioner adopt this Hearing Officer's Proposed Finding of Facts and Conclusions of Law.

FINDINGS OF FACTS

1. Claimant is employed by the District of Columbia Office of the Superintendent of Education as

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[1] To be eligible for compensation the victim of an accident in the District of Columbia must have been injured in the accident.

[2] The Uninsured Motorist Fund awards compensation to a victim for medical and rehabilitation expenses, work loss or funeral expenses where the victim would not otherwise be compensated.

[3] During the hearing the Department sought to introduce into evidence a 2013 Kaiser Permanente Summary Plan and Member Handbook. Counsel for the Claimant objected. The basis for the objection was that the Claimant was injured on June 4, 2014 and that he received medical treatment from June 4, 2014 through July 2, 2014, therefore a 2013 Summary Plan and Handbook was not relevant. This Hearing Officer ruled that the 2013 Kaiser Permanente Summary Plan and Handbook was not relevant to these proceedings.

a transportation aide. On June 4, 2014, Claimant was injured in an automobile accident when the school bus he was working on was struck by another vehicle driven by FA, an uninsured motorist. Claimant sustained injury to his back, neck and right arm.

2. The District of Columbia Metropolitan Police Department were called in response. One of the respondent policers completed a "Traffic Crash Report" which stated that FA, the uninsured motorist was at fault.

3. The accident was promptly reported to Claimant's supervisor. Claimant was instructed to complete a worker's compensation form and submit the form to the District of Columbia Office of Risk Management ("ORM").

4. On June 4, 2014, Claimant was treated for his injuries in the emergency room at United Medical Center. Claimant was examined by Dr. Nsubuga who diagnosed claimant with a lumbar strain. Claimant was prescribed medication and was discharge with instructions to seek follow up care from his primary care physician if needed for his injuries.

5. At all relevant times, Claimant had employer sponsored health insurance with Kaiser Permanente, a health maintenance organization (HMO), under which entitled him to benefits only if his treatment was provided by Kaiser-affiliated health care providers. Clamant also health insurance benefits under a Medicaid program administered by the District of Columbia.

6. On June 5, 2014, Claimant sought follow up treatment from his primary care physician at Kaiser Permanente. Dr. Van Der Linde examined the Claimant and diagnosed him with a lumbar muscle strain, neck muscle strain, and a right shoulder muscle strain. He was prescribed medications for his injuries along with home care therapy and was given a note excusing him from work for June 4, 2014 and June 5, 2014. Claimant did not return to be examined by Dr. Van Der Linde nor was he treated by another Kaiser Permanente physician. In addition, there is no record evidence that Claimant was referred to a Kaiser Permanente facility for physical therapy.

7. On June 5, 2014, Claimant retained the services of attorney Brandi Nave, Esq. from Nave & Associates, PLLC.

8. Claimant testified that on June 5, 2014, on the advice of Claimant's Counsel, Claimant was examined at Metro Medical Clinic by Dr. Jagdev Dhillon. Dr. Dhillon stated in his medical evaluation report that Claimant's injuries were consistent with a cervical sprain/strain; thoracic sprain/strain; lumbosacral sprain/strain; and a right leg sprain/strain. Dr. Dhillon provided Claimant with a disability slip indicating that Claimant could not work June 5, 2014 through July 2, 2014.

9. On July 3, 2014, Claimant was re-examined at Metro Medical by chiropractor, Maya Bazley, who released Claimant to return to work. Claimant returned to work on July 3, 204.

10. By letter July 7, 2014, Claimant was notified that the at fault driver was uninsured at the time of the accident. (*See letter from National General Insurance*).

11. Claimant testified that his medical bills from Metro Medical Clinic were submitted to Kaiser Permanente for payment. Claimant further testified that because Metro Medical Clinic is not a Kaiser affiliated healthcare provider, his claim was denied. Claimant further testified that the total amount

due to Metro Medical Clinic, Inc. for accident related medical services was $4,090. Claimant's counsel represented that chiropractic care was not a Medicaid covered medical expense in 2014.

12. On or about June 6, 2014, claimant filed a worker's compensation claim seeking payment for medical services provided to him by Metro Medical Clinics, Inc.

13. On September 25, 2015, the worker's compensation administrator, Corvel, acknowledged receipt of Claimant's claim.

14. On July 10, 2014, Claimant's attorney filed a notice of representation with ORM. Subsequently, Claimant's Counsel wrote ORM on the following dates requesting an explanation of Claimant's worker's compensation benefits: (1) on October 23, Claimant wrote ORM requesting an explanation of medical benefits; (2) on September 23, 2014, Claimant's attorney provided ORM with a list of Claimant's medical bills and lost wages; (3) On October 30, 2014, Claimant wrote ORM requesting an explanation of benefits; on March 14, 2015 and April 25, 2015, Claimant's attorney wrote to ORM requesting an explanation of medical benefits; (4) on December 2, 2015, Claimant's attorney sent a letter to Rick Ross, Esq. Chief Risk Officer for the Office of Risk Management, in which stated that ORM never provider Claimant with an explanation of benefits.

15. By letter dated December 2, 2014, ORM notified Claimant that he was no longer eligible to receive benefits from worker's compensation. The letter further stated that the basis for their decision was that Claimant finished therapy on July 2, 2014 and that he returned to work on July 3, 2014. Claimant testified that the only benefits he received from worker's compensation was the restoration of the annual leave he used for the period he was out of work (June 5, 2014 through July 2, 2014).

16. By letter dated January 5, 2016, Kim Scott, Senior Claims Adjuster at ORM, notified Claimant's Counsel regarding payment of Claimant's outstanding medical bills. The letter stated that "in order for the Public Workers' Compensation Program ("Program") to pay for medical services provided by a treating physician, the physician must be a member of the" Program panel list of physicians." The letter further stated that "This was communicated to your office via a response email sent to V'hesspa Glenon[4] on September 23, 2014." The letter further stated that "The medical bills received by the Program for medical services provided by Metro Medical Clinic, Inc. for the period of June 5, 2014 through July 2, 2014 were previously provided to your office via email on December 11, 2015." The letter further stated that "As Metro Medical Clinic, Inc. is not a member of the Program panel, the Program has returned the medical bills to Metro Medical Clinic, Inc. with a zero-payment status. Lastly, the letter indicated that a copy of the email notifying Claimant's Counsel of the status of the claim was enclosed in the email. However, Claimant's Counsel did not produce the enclosure at the hearing. In fact, Claimant's Counsel stated that she never received the enclosed correspondence.

17. On or about January 25, 2016, Claimant's Counsel filed a claim with the Department for payment from the Fund for medical expenses. The Department denied the request citing Claimant's late filing (600 days after the accident) to the Fund. Claimant testified that he filed his claim to the Fund only after ORM denied payment.

18. This Hearing Officer finds that Claimant knew or had reason to know that Metro Medical Clinic was a non-participating provider. Regardless, of whether Claimant was advised at the on-set by Metro Medical Clinic if it was a participating provider, he subsequently submitted the medical bills to

[4] V'hesspa Glenon worked with Claimant's Counsel at the Law Office of Nave & Associates.

Kaiser for reimbursement. Claimant admitted that Kaiser denied his request to have the medical services provided by Metro Medical Clinic covered and that such information was provided to his counsel.

19. This Hearing Officer further finds that Claimant was made aware as early as September 23, 2014 by ORM that his medical bills would not be covered because of Metro Medical Clinic status as a non-participating provider. Claimant was also aware of Metro Medical Clinic's status after Kaiser denied those medical bills. Moreover, Claimant was represented by counsel throughout this period. Because the law is clear on the issue of whether the Public-Sector Worker's Compensation Program covers claims of non-participating providers, Claimant must bear the consequence of his decision to press his claim with ORM in the face of ORM's explicit guidance and the supporting legal authorities.

Analysis

The undersigned has reviewed and considered the totality of the evidence, as well as the arguments, presented by the parties on the issues presented. To the extent an argument is consistent with the findings of fact, analysis, and conclusions of law contained herein, it is accepted; to the extent an argument is inconsistent, it is specifically rejected.

A. The Claimant filed its claim with Mayor in Compliance with D.C. Code § 31-2408.01 (b)(1) and (b)(2)

The District of Columbia Official Code §31-2401.01(b)(1) states that. . . "the accident upon which the claim is based must be reported to the Mayor not more than 45 days after the accident." The Department concedes that the police report taken by MPD satisfies the 45-day notice requirement, therefore, this Hearing Officer finds that this issue is moot.

B. Claimant failed to file for Uninsured Motorist benefits within 180 days.

To be eligible to receive compensation from the Fund, "the victim must file a claim. . . and submit all required information and documents within 180 days after the accident, except that this requirement may be extended for good cause shown or if the victim still undergoing medical treatment." *See District of Columbia Official Code § 31-2408.01 (b)(2) (2001).* Good cause is defined "substantial and reasonable cause not tainted by negligence or lack of diligence on the part of the claimant. *See 26-A DCMR § 1802.5.*

The Department argues that the Claimant is time barred from receiving benefits from the Fund and that Claimant filed his claim more than a year. In support of its argument, the Department argues that claimant's claim was filed more than a year after the expiration of 180 days and that Claimant has not shown "good cause" to waive the 180-day period.

Claimant makes several arguments why the 180- day requirement should be waived for good cause. First, Claimant argues that on June 6, 2016, Claimant filed for worker's compensation benefits.

The Claimant further argues that there is no record evidence that Claimant has any identifiable insurers who by its policy contract terms are obligated to compensate the Claimant and pay Claimant's medical claims or any other damages because of the accident. Second, Claimant argues that he never received a letter of acknowledgement from the District of Columbia Office of Risk Management. However, Claimant acknowledges he received the notice of termination of benefits. Third, Claimant argues that there is no evidence in the record that Claimant has any identifiable insurers who are

mandated by local or federal statute to compensate Claimant. Claimant further argues that the Office of Risk Management failed to respond to counsel's numerous request for an explanation of worker's compensation benefits. Claimant counsel also stated that the only communication she received regarding Claimant's worker's compensation benefits was on January 5, 2016. Lastly, Claimant argues that the delay by the Office of Risk Management in adjudicating Claimant's worker's compensation clause claim should constitute good cause to waive the 180-day requirement. In other words, Claimant argues had if ORM had notified Claimant sooner, Claimant would have filed his claim to the Fund before expiration of 180-days. Claimant further argues that ORM's delay satisfies the "good cause" requirement and that the 180-days should be waived.

This Hearing Officer finds that Claimant's argument is not convincing. There is no record evidence to show that Claimant had to wait for a response from ORM prior to filing his claim with the Fund. Furthermore, D.C. Official Code § 31-2408.01(e) states that the "amounts of compensation awarded shall be equal to the amount of the victim's loss, decreased by all amounts received by or available to the victim from collateral sources." The term "collateral sources" includes payments from a health benefit or group health plan or Medicare and Medicaid. See 26-A DCMR § 1803.4. Therefore, this Hearing Officer finds that Claimant is not entitled to receive compensation from the Fund.

In *Tesfamariam v. District of Columbia Dep't of Consumer & Regulatory Affairs*, 645 A.2d 1105, the D.C. Court of Appeals held that "health insurance did not disqualify her from receiving compensation." "That insurance is relevant, however, because it constitutes a potential collateral source for her medical expenses. . . and might require a reduction in her ultimate recovery.

C. Claimant's Health Insurance with Kaiser Permanente Does Not Make Him Ineligible for Benefits from the Fund

As previously stated, health insurance did not disqualify Claimant from receiving compensation from the Fund. If Kaiser Permanente paid a portion of Claimant's medical bills, any monies from the Fund would be a reduction from monies received from the Fund. Therefore, I find that this factor does not make Claimant ineligible for compensation from the Fund.

D. Claimant Sustained Injuries from the accident and incurred medical expenses which were not compensated by a collateral source.

The primary purpose of the Fund is to award compensation to a victim of an accident who sustains injury from the accident and would not otherwise compensated for his or her loss. *See D.C. Official Code § 31-2408 (a) (2001).* Additionally, the amounts of the compensation awarded shall be equal to the amount of the victim's loss, decreased by all amounts received by or available to the victim from collateral sources.

In the Department's Compliance Division's letter of determination, the Department stated that because Claimant was not injured in the accident, he was not eligible to receive compensation. The Department based its decision on information obtained from the police report. The police officer who author the report indicated on page (4), item 205 a-c that there was "no injury." However, on June 4, 2014, Claimant received emergency medical treatment. On June 5, 2014, claimant sought follow up treatment from his primary care physician. Also on June 5, 2014, Claimant was examined by a chiropractor. On June 5, 2014, Claimant began receiving chiropractic treatments. Claimant received treatment for four (4) weeks. Each medical report from the health care providers stated that Claimant's injuries was due to a motor vehicle accident. I find that the medical reports are credible. According, I find that Claimant was injured on June 4, 2014.

Claimant could have applied to the Fund long before the expiration of the 180-day requirement. If Claimant received payment for his medical expenses from worker's compensation, the amount paid would be considered a collateral source and any funds Claimant might be eligible for from the Fund would be reduced by the amount paid from worker's compensation.

PROPOSED CONCLUSIONS OF LAW

Because Claimant has not satisfied his burden of showing "good cause" why he is eligible for compensation from the UM Fund when his claim was submitted to the Department more than a year after the 180-day filing period provided, Claimant is not eligible for compensation pursuant to D.C. Official Code § 31-2408.01 *et seq.*

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FINAL ORDER

Based upon the review of the record contained herein and the Hearing Officer's Proposed Findings of Facts and Conclusions of Law, it is this 6th day of August 2018

ORDERED that the Hearing Officer's recommendations are adopted; and it is further

ORDERED that the Hearing Officer's recommendations shall constitute the final determinations & Order of the Commissioner as fully set forth herein.

Stephen C. Taylor
Commissioner
Department of Insurance, Securities
and Banking
Dated: This 6th day of August, 2018

PROPOSED ORDER

Based upon the Findings of Facts and Conclusions of Law, the Hearing Officer's recommends that the Department's determination of the eligibility benefits from the Fund be sustained.

Lisa D. Butler, Esq.
Hearing Officer

August 6, 2018
Date

cc:

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