

OFFICE OF RISK MANAGEMENT

NOTICE OF FINAL RULEMAKING

The Chief Risk Officer of the Office of Risk Management (ORM), Executive Office of the Mayor, pursuant to the authority set forth in section 2344 of the District of Columbia Government Merit Personnel Act of 1978 (CMPA), effective March 3, 1979 (D.C. Law 2-139; D.C. Official Code § 1-623.44 (2012 Supp.)); 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, effective December 14, 2004, hereby gives notice of the enactment of a new chapter 1 to title 7 of the District of Columbia Municipal Regulations (DCMR), and the repeal of chapter 31 to title 7 of the DCMR. A Notice of Proposed Rulemaking was published in the *D.C. Register* on December 16, 2011, at 58 DCR 10676. The final version of the rules is effective upon publication in the July 27, 2012 District of Columbia Register.

The amendments support ORM's efforts to reform the Public Sector Workers' Compensation Program (PSWCP), protect the due process rights of employees who receive PSWCP benefits, enhance the transparency of PSWCP policies and procedures, create new policies in areas where policies are authorized by statute but do not exist, achieve budgetary savings, make the PSWCP regulations consistent with the current statute, organize all PSWCP regulations into one chapter, and eliminate inconsistencies, redundancies, and technical errors in existing regulations.

The existing chapter 1 (Public Sector Workers' Compensation Benefits) of title 7 (Employment Benefits) of the DCMR is repealed and replaced with a new chapter 1 to read as follows:

Chapter 1 PUBLIC SECTOR WORKERS' COMPENSATION BENEFITS

100 GENERAL PROVISIONS

- 100.1 The provisions of this chapter are promulgated to implement title 23 of the District of Columbia Government Comprehensive Merit Personnel Act of 1978 (Act) (D.C. Law 2-139; D.C. Official Code §§ 1-623.01, *et seq.* (2006 Repl. & 2012 Supp.)), which governs the Public Sector Workers' Compensation Program (Program).
- 100.2 The Office of Risk Management (ORM) has oversight and administrative responsibility for the Program, including all Initial Determinations (IDs) and Eligibility Determinations (EDs) rendered by the Program.
- 100.3 All employees, contractors, sub-contractors, and agents, acting for or on behalf of the District to implement the Program pursuant to the Act, including third-party administrators, shall comply with these rules.

100.4 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 §§ 2-501, *et seq.* (2011 Repl. & 2012 Supp.)), binding case law, government contract provisions and modifications, and applicable judgments or settlements.

101 FORMS

101.1 Any notices, claims, requests, applications, or certificates that the Act or this chapter requires to be made shall be on approved forms.

101.2 All approved forms shall be obtained from the Program, including forms for requesting a hearing to appeal a decision of the Program regarding a claim for compensation. If a form pertains to requests for hearings or attorney representation pursuant to §§ 129-132 of this chapter, forms shall be obtained from the Office of Hearings and Adjudication (OHA) of the Department of Employment Services.

102 INVESTIGATIONS

102.1 The Program shall conduct any investigation that is necessary to make an ID of eligibility for benefits under this chapter.

102.2 The Program shall investigate the claim throughout the life of the claim to confirm that a claimant or employee is still entitled to benefits under the Act, including, when necessary, to make an eligibility determination (ED).

102.3 Claimants and employees are required to cooperate with all aspects of the Program's investigation, including participating in "alive and well checks," attending physical examinations, and providing documentation of all medical services, earnings information, and dependent and marital status.

103 SUBPOENAS

- 103.1 The Program may issue subpoenas as part of its authority to conduct investigations pursuant to § 102 of this chapter.
- 103.2 The Program may issue a subpoena for the following purposes:
- (a) To compel the attendance of employees, claimants, or witnesses within a radius of one hundred miles (100 mi.) of the District of Columbia at interviews, alive and well checks, depositions, settlement conferences, or any other inquiry being held for the purposes of obtaining information about a claim;
 - (b) To administer an oath or affirmation and to examine employees, claimants, or witnesses; and
 - (c) To require the production of books, papers, documents, and other evidence.
- 103.3 A subpoena issued under this section shall provide notice to the recipient of the legal authorization for the subpoena, the testimony or evidence being sought by the Program, the deadline for providing the testimony or evidence, and the telephone number and mailing address of the authorizing official issuing the subpoena.
- 103.4 Subpoenas may be issued pursuant to this section only upon written authorization of the Chief Risk Officer, as attested to by the signature of the Chief Risk Officer.
- 103.5 Subpoenas issued pursuant to this section shall be enforced by the Superior Court of the District of Columbia.

104 REPORT OF EARNINGS

- 104.1 Reports of earnings may be required of a claimant whenever the Program, in its discretion, determines that a report is needed. The report may require the claimant to provide copies of tax documents to the Program or require the claimant to authorize the Program to obtain copies of tax documents from local and federal tax authorities.
- 104.2 When the Program determines that a report is needed, pursuant to § 104.1, the Program shall notify the claimant in writing that he or she is required to file a report, and that failure to file the report may subject the claimant to termination of benefits.
- 104.3 Reports shall be filed with the Program within thirty (30) days of the date of notification of the request.

105 PROGRAM NOTICES OF INITIAL DETERMINATIONS AND ELIGIBILITY DETERMINATIONS

105.1 The Program shall issue a notice of determination (NOD) regarding each ID and ED pursuant to this section. An NOD 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 or a hearing before the OHA, whichever is applicable. Sample NODs shall be published on ORM’s website.

105.2 An NOD shall be issued:

- (a) When accepting a claim for benefits or when modifying, suspending, or terminating benefits;
- (b) When changing the type of benefits a claimant receives;
- (c) When amending an NOD pursuant to § 111 of this chapter;
- (d) When accepting or denying a claim for recurrence of injury pursuant to § 120 of this chapter; or
- (e) When issuing a schedule award pursuant to section 2307 of the Act.

105.3 An NOD shall contain a narrative description of the rationale for the decision, cite relevant portions of the supporting documentation or claim file, and attach supporting documentation.

105.4 An NOD shall be sent to the claimant's last known address by first-class mail, postage prepaid. A certificate of service shall be executed by the Program at the time of mailing. If the claimant is represented by an attorney, a copy of the NOD shall be sent to the claimant’s attorney. Failure to send a copy of the NOD to the claimant’s attorney shall not constitute a failure to provide notice to the claimant, nor shall it toll any deadlines under this chapter, unless failure to do so unduly prejudices the claimant.

106 COMPUTATION OF TIME

106.1 Any days required to be counted shall be counted commencing with the day after the date referenced in the rule, or, if an NOD is issued, the date after the certificate of service attached to the NOD issued by the Program.

106.2 If the deadline for any activity falls on a Sunday, Saturday, legal 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, the deadline will be continued to the next business day.

106.3 Whenever it is not specified by the plain language of the rule, the term “day” or “days” shall mean “calendar day” or “calendar days.”

107 SUPERVISOR REPORT OF INJURY

107.1 In accordance with section 2320 of the Act, the official superior of an employee, or an employee, shall report by telephone to the Program any injury which results in that employee's death or probable disability. Claims shall be reported to the Program by calling the phone number for this purpose that is published on ORM's website.

107.2 The official superior shall report the claim to ORM by telephone within twenty-four (24) hours of the incident, injury, or death. No later than three (3) days after the initial report, the official superior shall report the claim, in writing, using Form 1, the Employer and Employee First Report of Injury or Occupational Disease, and Form 2, Supervisor's Report.

107.3 The official superior of the employee shall supply all information requested by the Program.

107.4 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 official superior;
- (e) The employee's occupation at the time of the injury or death;
- (f) The employee's wage or base salary information;
- (g) The length of the employee's employment;
- (h) The location of the accident;
- (i) A description of the events which resulted in the death, injury, or disease;
- (j) The type of injury; and
- (k) The body parts affected.

107.5 Form 2 shall contain the following information:

- (a) Whether the official superior 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 or death;
- (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 or death;
- (g) A description of the events which resulted in the death, injury, or disease; and
- (h) A copy of the employee's position description and all incident reports.

107.6 The official superior shall complete and submit supplemental reports to the ORM as requested. The supplemental reports shall contain, but not be limited to:

- (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, to the official superior's knowledge, had a similar injury prior to the alleged injury, and if so, full details of the prior injury or incident and associated medical reports; and
- (d) Statements of other injuries or accidents of a similar character and the full details.

107.7 The official superior shall complete Form CA-3, Report of Return to Duty.

108 EMPLOYEE NOTICE OF INJURY OR DEATH AND CLAIM FOR BENEFITS

108.1 An employee shall give notice of an injury, or an employee's representative shall give notice of an employee's death to the employee's official superior within thirty (30) days of the injury or death, and all information that is required by section 2319 of the Act shall be supplied to the Program within that period.

- 108.2 Once the Program is notified by the official superior or by an employee of an employee's injury or death, the Program shall forward by first-class mail or electronic mail the forms for making a claim for benefits to the employee or someone on the employee's behalf for review, revision, and execution.
- 108.3 The employee shall provide all information required by the Program to make a determination on the claim.
- 108.4 The Employee or his or her representative shall complete Form CA-7, Claim for Compensation, Part A, Employee Statement. The notice 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 and step, and number of hours scheduled to work per day;
 - (f) State the employee's benefits deductions, if any, as listed in § 113 of this chapter;
 - (g) State whether a claim has been made against a third party as a result of the injury, disease, or death;
 - (h) State the names, relationship, and birth dates of employee's dependents, and the amount of support paid for dependents not living with the employee;
 - (i) Be signed by, and contain the address of, the individual giving the notice;
 - (j) In the case of the death of an employee, the individual filing the Form CA-7 shall provide documentation establishing the relationship to the deceased. Documentation may include :
 - (1) A certified copy of a birth certificate;
 - (2) A certified copy of a marriage license;
 - (3) Documentation of the executor of the employee's estate; or

(4) Other documentation satisfactory to ORM.

(k) Have attached proof of dependency, if applicable, for example, birth certificates and court orders; and

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

108.5 The employee shall complete a Medical Authorization and Release of Confidential Information and Earnings Data Form that ORM provides.

108.6 The employee shall have his or her physician complete and return to the ORM a Form 3, Physician's Report of Employee's Injury, which shall state the nature and probable cause of the injury, including whether the injury was sustained while in the performance of the employee's duties.

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

(a) Statements and medical documentation regarding any similar injury that occurred prior to the alleged injury or any pre-existing condition that may be related to the injury;

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

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

108.8 The employee shall supply copies of the completed forms to the official superior for review and signature.

108.9 The employee shall return the completed forms to the Program within thirty (30) days of the injury or death or within fifteen (15) days of the date from which the forms were mailed to the employee, whichever is later.

108.10 The employee shall make supplemental reports when required by the Program or when any of the information that the employee provides the Program changes after it is initially submitted to the Program.

108.11 The Program may require an employee to attend an orientation program regarding the requirements and processes of the Program before the employee may receive benefits under this chapter. Failure to attend the orientation may result in controversion of the employee's claim, pursuant to § 111.4 or 112 of this chapter.

109 TIME OF ACCRUAL OF RIGHT AND CONTINUATION OF PAY

- 109.1 When an employee makes a claim for temporary total disability (TTD) compensation, the employee shall be entitled to continuation of his or her full salary, or continuation of pay, pursuant to this section.
- 109.2 An employee is not entitled to indemnity payments or continuation of pay for the first three (3) business days of temporary disability which would otherwise have been work days for the employee, except:
- (a) When the disability exceeds fourteen (14) days; or
 - (b) When the disability is followed by permanent disability.
- 109.3 An employee shall use sick, annual, or other available leave during the first three (3) business days of temporary disability for any days which would otherwise have been work days for the employee.
- 109.4 Commencing on the first day following the three (3) days described in §§ 109.2 and 109.3, the claimant's employment agency shall furnish continuation of pay to the employee as follows:
- (a) To employees hired before January 1, 1980, for a period of forty-five (45) consecutive calendar days or until the Program has either upheld or denied the employee's claim for TTD, whichever occurs first; and
 - (b) To all other employees for twenty-one (21) consecutive calendar days or until the Program has either upheld or denied the employee's claim for TTD, whichever occurs first.
- 109.5 Claims for continuation of pay may be controverted or denied by the Program in the following situations:
- (a) When the injury or occupational disease occurred off the employing agency's premises and the employee was not in the course of employment;
 - (b) When the injury was caused by the employee's willful misconduct, when the employee intended to bring about the injury or death on himself or herself or another person, or when the employee's intoxication was the direct cause of the injury;
 - (c) When the injury does not prevent the employee from working;
 - (d) When the employee was not in active pay status at the time of injury or occupational disease (for example, in the case of leave without pay or absence without official leave);

- (e) When the stoppage of work first occurs six (6) months or more after the date of injury, if the claim has already been accepted for medical benefits only;
- (f) When the employee initially reports the injury after termination of employment; or
- (g) When the Program denies the claim.

109.6 If continuation of pay has been paid to an employee whose claim for TTD is subsequently and finally denied or whose claim for compensation has been denied or controverted pursuant to § 109.5, the Program shall forward to the employee a form for the employee to elect whether the payments made shall be charged to the employee's sick or annual leave. The employee shall be required to fill out and return the form to the Program within thirty (30) days.

109.7 If the employee returns the form to the Program, the Program shall forward it to the Office of Pay and Retirement Services in the Office of the Chief Financial Officer for processing.

109.8 If the employee does not return the form to the Program within thirty (30) days, the Program shall inform the employee's employment agency. The employment agency shall charge the continuation of pay payments to sick leave or, if the employee does not have any available sick leave, to annual leave. If the employee has no leave available, the employment agency shall inform the Program and the payments shall be deemed overpayment of pay, in accordance with section 2329 of the Act.

110 LEAVE REINSTATEMENT OR BUY BACK

110.1 Once the Program accepts a claim for TTD, a claimant shall not be required to use his or her sick or annual leave while the claimant is not working as a result of the compensable injury, except as stated in § 109 of this chapter.

110.2 A claimant whose TTD claim is accepted by the Program may have his or her leave hours reinstated or buy back his or her leave hours in the following circumstances:

- (a) The claimant's disability exceeds fourteen (14) days or is followed by permanent disability and the claimant used three (3) days of sick, annual, or other leave during the first three (3) days of the injury, pursuant to § 109 of this chapter;
- (b) The claimant used sick, annual, or other leave after the continuation of pay period and before the claimant's claim was accepted; or

- (c) Any other circumstance where the claimant used sick, annual, or other leave after a claim for TTD has been accepted, for example, for a doctor's appointment or medical procedure related to the accepted claim.

110.3 If the circumstances described in § 110.2(a) or (b) above exist, then sixty-six and two-thirds percent (66 2/3%) or, if the claimant is entitled to augmented pay pursuant to section 2310 of the Act, seventy-five percent (75%) of the claimant's leave will be reinstated upon the acceptance of the claim.

110.4 If the Program determines that a claimant is eligible to have leave reinstated pursuant to § 110.2(c), or that a claimant is eligible to buy back his or her leave for any reason, the Program shall send a form to the claimant that informs the claimant of the following:

- (a) The dates and hours of leave that the claimant is eligible to have reinstated or to buy back;
- (b) The cost of buying back the leave, which shall be the difference between sixty-six and two-thirds percent (66 2/3%) or, if the claimant is entitled to augmented pay pursuant to section 2310 of the Act, seventy-five percent (75%) and one hundred percent (100%) of the value of the leave; and
- (c) That the claimant will be required to sign the form and return it to the Program in order for his or her leave to be reinstated.

110.5 Once the Program receives the form requested in § 110.4, the Program shall forward the form to the Office of Pay and Retirement Services in the Office of the Chief Financial Officer for processing.

111 INITIAL DETERMINATIONS

111.1 The Program shall make an ID on a newly filed claim within thirty (30) days of the date the claim was first reported to the Program.

111.2 In making its ID, the Program shall consider all relevant evidence in the claim file, including all relevant medical evidence received pursuant to §§ 123 and 124 of this chapter.

111.3 An ID may deny benefits, in whole or in part, based upon the following factors:

- (a) The employee's lack of a compensable injury pursuant to section 2302 of the Act;
- (b) The Program's controversion of the claim for two (2) years, pursuant to § 112.7;

- (c) The employee's failure to cooperate with treatment or rehabilitation recommendations or with Program requirements for providing information; or
- (d) Any other grounds, such as fraud, that reasonably demonstrate that the employee is not entitled to benefits under the Act.

111.4 A new claim shall be denied or controverted when an employee fails to cooperate by following the procedures set forth in this chapter.

111.5 The ID is effective unless the employee succeeds on a request for hearing as provided in this chapter, or unless one (1) of the following circumstances occurs:

- (a) The Program decides that the ID was issued in error; or
- (b) The Program receives additional information after issuance of the ID that requires the Program to issue an amended ID.

111.6 If one (1) of the circumstances in § 111.5 occurs, the Program shall issue an amended NOD.

111.7 The Program shall issue an amended NOD pursuant to § 111.5(b) if the Program determines that a claimant is entitled to benefits for an additional body part or injury that is related to the original injury claim. A body part or injury shall be added to an accepted claim if the Program determines after considering all relevant factual evidence, including all relevant medical evidence received pursuant to §§ 123 and 124 of this chapter, that the injury or injury to the body part is directly related to the original injury for which the claim was initially accepted.

111.8 Before the Program may issue an amended NOD pursuant to § 111.7, the claimant shall provide notice of the additional body part or injury within thirty (30) days of the new injury or within thirty (30) days of when the claimant first became aware or reasonably should have become aware that an additional body part or injury is directly related to the original claim.

111.9 A claimant seeking to amend an NOD pursuant to §§ 111.7 and 111.8 shall make a claim for the additional body part or injury by completing a supplemental Form CA-7, Claim for Compensation, Part A, Employee Statement, in accordance with § 108.4 of this chapter; a Form 3, Physician's Report of Employee's Injury, pursuant to § 108.6; and any other medical or supplemental reports required pursuant to §§ 108.7 and 108.10. The claimant shall return the forms to the Program within fifteen (15) days of the date from which the forms are mailed to the employee.

111.10 If a claimant suffers a new injury or an injury to an additional body part pursuant to § 111.8 while at work, the claimant's official superior shall fill out the forms required in §§ 107.4 through 107.7 within fifteen (15) days of the date from which the forms are mailed to the employer.

111.11 The Program shall issue an amended NOD either awarding or denying the claim for an amended NOD within thirty (30) days of the Program's receipt of all forms required pursuant to §§ 111.8 through 111.10. The Program may controvert a claim for an amended NOD pursuant to §§ 112.3 through 112.7 of this chapter.

112 CLAIMS DEEMED ACCEPTED AND CONTROVERSION

112.1 A newly filed claim for benefits shall be deemed accepted by the Program if the Program does not issue an initial notice of determination or notice of controversion within thirty (30) days of the date the claim was first reported to the Program. This subsection only applies to newly filed claims and does not apply to any other request for compensation or benefits under this chapter, including claims for amended NODs under § 111.5(b) or claims of recurrences of injuries under § 120 of this chapter.

112.2 When a claim is deemed accepted pursuant to this section, payment of compensation shall become effective on the thirty-first (31st) day.

112.3 In the event that the Program does not have sufficient information to make an initial determination regarding compensability within thirty (30) days, the Program shall issue a notice of controversion to the employee.

112.4 The Program shall issue the notice of controversion before the thirtieth (30th) day following the date the claim was reported, shall explain the reasons a determination cannot be made, and shall describe the information or actions needed to make a determination. Reasons for a controversion may include:

- (a) The employee has not submitted all the required forms or information;
- (b) The Program does not have sufficient medical evidence to make a determination; or
- (c) The employee has not attended an orientation program pursuant to § 108.11 or has failed to cooperate pursuant to § 111.4.

112.5 If the notice of controversion is issued because the employee has not submitted all the required forms or information, the notice shall inform the employee that he or she has fifteen (15) days to send the Program the required forms or information. The notice shall further state that if the Program does not receive the required forms or information, the employee's claim will be held in abeyance until the required forms or information is received.

112.6 If the employee does not send the Program the required forms or information within fifteen (15) days of the request in § 112.5, the Program shall issue a second notice of controversion. If the required forms or information is not received after the second notice, the Program shall take no further action on the claim until it receives the required forms or information.

112.7 If a claim is controverted and held in abeyance for two (2) years after the date of injury or death and the employee has not sent the Program the required forms or information, the Program shall issue a notice to the employee denying the claim pursuant to section 2322(a) of the Act.

113 BENEFITS DEDUCTIONS

113.1 Effective concurrent with the effective date of this chapter, an employee who receives the following benefits on the date that he or she is injured shall continue to receive the following benefits if his or her claim for indemnity compensation is accepted, and the premiums, if any, shall be deducted from the claimant's indemnity compensation payments:

- (a) Health care insurance;
- (b) Life insurance;
- (c) Dental insurance; and
- (d) Vision insurance.

113.2 When the Program accepts a claim for indemnity compensation, it shall notify the claimant of the benefits for which premiums will be deducted under this section.

113.3 The premiums, if any, paid by the Program under this section shall be the same as any premiums paid for the same benefits by the District for active employees. The premiums paid by claimants under this section shall be the same as any premiums paid for the same benefits by active employees.

113.4 District government contributions that are paid for any of the benefits listed in § 113.1 shall not be reported by the District government as taxable income.

113.5 A claimant who wishes to opt out of any of the benefits listed in § 113.1 after he or she begins receiving indemnity compensation may do so by following the policies, procedures, and regulations of the District of Columbia Department of Human Resources.

114 COMPUTATION OF INDEMNITY PAYMENTS

- 114.1 If a claim is accepted by the Program and the Program decides that the employee is eligible for indemnity compensation, the employee's indemnity payments shall be calculated under this section, except compensation for death benefits shall be calculated pursuant to § 122 of this chapter.
- 114.2 The employee shall provide the Program with a copy of the employee's most recent pay stub(s), as requested by the Program, in order for indemnity payments to be determined under this section.
- 114.3 To determine TTD indemnity payments, the Program shall review the pay stub and make the following calculations, in the following order:
- (a) Determine the employee's unadjusted average weekly wage by dividing the employee's gross annual salary by fifty-two (52) weeks:
 - (1) If the Program determines that the employee's annual rate of pay is not paid at a fixed rate, the Program shall determine the average annual earnings by multiplying the employee's daily wage, or the average thereof if the daily wage has fluctuated, by:
 - (A) Three hundred (300), if the employee is employed on the basis of a six (6) day work week;
 - (B) Two hundred eighty (280), if the employee is employed on the basis of a five and one half (5 ½) day work week; or
 - (C) Two hundred sixty (260), if the employee is employed on the basis of a five (5) day work week;
 - (2) If the Program determines that the employee regularly receives overtime pay, premium pay for hazardous service, or additional pay because of working at night or in any other special circumstance, and failure to include any of these payments in the calculation of the unadjusted average weekly wage would result in an unadjusted average weekly wage that does not reasonably or fairly represent the annual earning capacity of the employee, the Program may use a sum that incorporates these payments and that reasonably and fairly represents the annual earning capacity of the employee, for the purpose of determining the employee's unadjusted average weekly wage. The term "regularly" as used in this subparagraph means that the employee received the additional payments during the 12 (twelve) consecutive months immediately preceding the injury, including the month that includes the date of injury.

- (3) Annual earnings calculated pursuant to this sub-paragraph may not be less than one hundred-fifty (150) times the average daily wage the employee earned during the days employed within one (1) year preceding his or her injury.
- (b) If the employee was hired by the District government on or after January 1, 1980, determine the employee's adjusted average weekly wage by multiplying the unadjusted average weekly wage by sixty-six and two-thirds percent (66 2/3%); or
- (c) If the employee was hired by the District government before January 1, 1980, determine the employee's adjusted average weekly wage by multiplying the unadjusted average weekly wage by sixty-six and two-thirds percent (66 2/3%), or by seventy-five percent (75%) if the employee is entitled to augmented pay pursuant to section 2310 of the Act;
- (d) Determine the employee's unadjusted bi-weekly compensation rate by multiplying the adjusted average weekly wage by two (2);
- (e) Determine the employee's adjusted bi-weekly compensation rate by deducting the total sum of the employee's benefits premiums as determined pursuant to § 113 from the unadjusted bi-weekly compensation rate. The remaining rate will be the employee's bi-weekly indemnity payment; or
- (f) If the employee does not have any benefit premiums to deduct from his or her payments under § 113, the unadjusted bi-weekly compensation rate will constitute the employee's bi-weekly indemnity payments.

114.4 To determine temporary partial disability (TPD) indemnity payments, the Program shall review the employee's pay stub(s) and:

- (a) Determine the employee's unadjusted average weekly wage by following the process described in § 114.3(a);
- (b) If the employee was hired by the District government on or after January 1, 1980, determine the employee's adjusted average weekly wage by multiplying the difference between his or her unadjusted average weekly wage and his or her monthly earning capacity by sixty-six and two-thirds percent (66 2/3%); or
- (c) If the employee was hired by the District government before January 1, 1980, determine the employee's adjusted average weekly wage by multiplying the difference between his or her unadjusted average weekly wage and his or her monthly earning capacity by sixty-six and two-thirds

percent (66 2/3%) or seventy-five percent (75%) if the employee is entitled to augmented pay pursuant to section 2310 of the Act;

- (d) Determine the employee's unadjusted bi-weekly compensation rate by multiplying the adjusted average weekly wage by two (2); and
- (e) Determine the employee's adjusted bi-weekly compensation rate by deducting the total sum of the employee's benefits premiums as determined pursuant to § 113 of this chapter from the unadjusted bi-weekly compensation rate. The remaining rate will be the employee's bi-weekly indemnity payment; or
- (f) If the employee does not have any benefit premiums to deduct from his or her payments under § 113 of this chapter, the unadjusted bi-weekly compensation rate will constitute the employee's bi-weekly indemnity payments.

114.5 The Program shall calculate the average annual earnings of an employee who served the District government without pay or with nominal pay by following the requirements of this section. If the average annual earnings cannot be determined reasonably and fairly under this section, the average annual earnings shall be determined using the reasonable value of the service performed by the employee, but the reasonable value shall not exceed three thousand six hundred dollars (\$3,600) per year.

114.6 Permanent total disability (PTD) indemnity compensation shall be calculated pursuant to § 114.3.

115 MAXIMUM AND MINIMUM RATES OF COMPENSATION

115.1 Employees hired on or after January 1, 1980, who make a claim for compensation after December 29, 1994, may not earn a monthly rate of indemnity compensation that is:

- (a) More than seventy-three percent (73%) of the monthly pay of the maximum rate of basic pay for the non-union, District career service (general) pay scale of Grade 12, Step 10; or
- (b) In the case of total disability, less than seventy-five percent (75%) of the monthly pay of the minimum rate of basic pay for the non-union, District career service (general) pay scale of Grade 2, Step 1, or the amount of monthly pay of the employee, whichever is less.

115.2 The indemnity compensation limits in § 115.1 are inclusive of any augmented pay an employee may be authorized to receive pursuant to section 2310 of the Act.

- 115.3 The indemnity compensation limits in § 115.1 are not inclusive of any pay for attendants or vocational rehabilitation that an employee is authorized to receive pursuant to section 2311 of the Act.
- 115.4 There is no minimum monthly pay limit for employees who receive compensation for temporary partial disability (TPD) or who earn compensation for loss of wage earning capacity (LWEC).
- 115.5 Employees who make a claim for compensation on or before December 29, 1994, may not earn a monthly rate of indemnity compensation that is:
- (a) More than seventy-five percent (75%) of the monthly pay of the maximum rate of basic pay of the federal general schedule pay scale of Grade GS-15, as provided in § 5332 of title 5 of the United States Code; or
 - (b) In the case of total disability, less than seventy-five percent (75%) of the monthly pay of the minimum rate of basic pay of the federal general pay scale of Grade GS-2, as provided in § 5332 of title 5 of the United States Code, or the amount of the monthly pay of the employee, whichever is less.

116 COST-OF-LIVING ADJUSTMENT OF COMPENSATION

- 116.1 Claimants receiving indemnity compensation for TTD, PTD, LWEC, or death benefits under this chapter shall receive cost-of-living increases whenever a cost-of-living adjustment (COLA) is awarded to District employees pursuant to D.C. Official Code §§ 1-611.05 and 1-611.06 (2006 Repl. & 2012 Supp.). The percentage amount and effective date of the COLA shall be the same as for any COLA granted under those sections of the Code.

117 ASSIGNMENT OF CLAIM AND DELIVERY OF COMPENSATION

- 117.1 An assignment for a claim of compensation under this chapter is void.
- 117.2 Compensation received under this chapter is exempt from the claims of creditors. This subsection does not apply in the case of a valid court order to garnish wages for child support or other lawful purposes.
- 117.3 A payment of compensation, schedule award, settlement payment, or any other payment made under this chapter shall not be delivered to any person other than the claimant entitled to that payment or that claimant's legal guardian unless the employee has submitted a request in writing that the payment be delivered to another specified person, including the claimant's attorney, and which is not in violation of section 2330 or any provision of the Act. This subsection shall not apply to attorneys' fees that a judicial entity may order the Program to pay an attorney under the Act.

118 ELECTION OF COMPENSATION

118.1 A claimant receiving indemnity compensation under this chapter shall not:

- (a) Receive other salary, pay, or remuneration of any type from the District of Columbia, including retirement pay for employees hired by the District of Columbia on or after October 1, 1987. The prohibition in this paragraph does not apply to service actually performed in a part-time or modified duty capacity pursuant to § 137 of this chapter;
- (b) Receive disability benefits from the federal government if he or she was employed by the District of Columbia or the federal government before October 1, 1987; or
- (c) Recover damages from the District government because of the claimant's compensable injury or death, as a result of a judicial proceeding in a civil action or in admiralty, or by an administrative or judicial proceeding under another workers' compensation statute or federal tort liability statute.

118.2 The phrase "salary, pay, or remuneration" as used in this section includes severance pay and "buy-out" payments to a claimant from the claimant's employment agency.

118.3 An employee who is receiving retirement pay from the District of Columbia, or from the federal government pursuant to subchapter III of chapter 83 of title 5 of the United States Code, may also receive a schedule order pursuant to § 121 of this chapter, as well as medical benefits pursuant to this chapter, at the same time that he or she receives retirement pay.

118.4 When a claimant begins receiving indemnity compensation under this chapter, the Program shall inform the claimant of the prohibitions in § 118.1 and of the claimant's obligation to inform the Program if the claimant receives such compensation, both at the time of the Program's initial acceptance of the claim and for as long as the claimant receives indemnity compensation from the Program.

118.5 Whenever the Program determines that an employee or claimant is receiving or may be entitled to receive the salary, pay, remuneration, or benefits listed in § 118.1, it shall forward to the employee or claimant a form for the election of which compensation the employee or claimant wishes to receive. If the employee or claimant has already received salary, pay, remuneration, or benefits in violation of § 118.1, the Program may initiate overpayment proceedings pursuant to § 142 of this chapter.

- 118.6 A claimant receiving indemnity compensation under this chapter may receive the following benefits from the federal government at the same time that he or she receives indemnity compensation under this chapter:
- (a) Pension for service in the United States armed services;
 - (b) Other benefits administered by the United States Veterans Administration unless such benefits are payable for the same injury or the same death;
 - (c) Retirement pay for service in the armed forces or other uniformed services, subject to the reduction of such pay in accordance with title 5 § 5532 of the United States Code; and
 - (d) Retirement pay for employees hired by the District government prior to October 1, 1987, who receive retirement benefits pursuant to subchapter III of chapter 83 of title 5 of the United States Code.

119 TIME FOR MAKING A CLAIM

- 119.1 In order to be eligible to receive benefits pursuant to this chapter, an employee or an employee's representative must file an initial claim for benefits within two (2) years after the date of the injury or death.
- 119.2 The Program shall not accept any claim for benefits that is filed later than two (2) years after the date of the injury or death unless:
- (a) The official superior had actual knowledge of the injury or death within thirty (30) days of the injury or death; or
 - (b) The employee suffered a latent injury and did not become aware of the causal relationship between the injury and his or her employment until after a period of time following the injury. In this circumstance, the employee must file a claim within two (2) years after the employee became aware, or should have become aware after exercise of reasonable diligence, of the causal relationship between the injury and his or her employment.
- 119.3 The time limitation of this section does not begin to run against:
- (a) A minor until the minor reaches twenty-one (21) years of age or has a legal representative appointed;
 - (b) An individual adjudged incompetent until a legal representative is appointed; and

- (c) An employee whose exceptional circumstances, as determined at the discretion of the Chief Risk Officer, justify the filing of a claim.

119.4 In the event an injury results in death, a workers' compensation claim that was timely filed for the initial injury satisfies the notice requirements for the death claim.

120 RECURRENCE OF INJURY

120.1 An employee who received indemnity compensation for which payments have ceased who suffers a recurrence of the same compensable injury must notify the Program in writing of the recurrence. The employee shall provide notice of the recurrence within thirty (30) days of the recurrence or within thirty (30) days of when the claimant first became aware or reasonably should have become aware of the recurrence and its relationship to the original claim.

120.2 An employee who reports a recurrence of an injury shall provide the Program with medical evidence that the recurrence is the same injury for which the claim was originally accepted, and shall follow all requirements in this chapter relevant to receiving benefits, including the requirements of §§ 123 and 124 of this chapter.

120.3 The Program shall begin paying the employee indemnity payments again if:

- (a) The employee's notification to the Program of the recurrence meets the requirements of § 120.5; and
- (b) The Program determines after considering all relevant factual evidence, including all relevant medical evidence received pursuant to §§ 123 and 124 of this chapter that:
 - (1) The injury is the same injury for which the claim was initially accepted; and
 - (2) The recurrence of the injury prevents the claimant from being able to work.

120.4 The Program shall issue an NOD either awarding or denying the claim for a recurrence of injury within thirty (30) days of the Program's receipt of the information required in § 120.2. The Program may controvert a claim for a recurrence of injury pursuant to §§ 112.3 through 112.7 of this chapter.

120.5 The Program shall not begin payment of indemnity compensation to the employee again if three hundred sixty-six (366) days or more has passed since:

- (a) The employee received a payment of compensation; or

- (b) A final order was issued by a judicial entity regarding the employee's indemnity payments.

121 SCHEDULE AWARDS

121.1 In accordance with section 2307(c) of the Act, the following is the compensation schedule for permanent total loss of use of a member, function, or organ of the body:

- (a) Arm Three hundred twelve (312) weeks;
- (b) Leg Two hundred eighty-eight (288) weeks;
- (c) Eye One hundred sixty (160) weeks;
- (d) Hand Two hundred forty-four (244) weeks;
- (e) Thumb Seventy-five (75) weeks;
- (f) First Finger Forty-six (46) weeks;
- (g) Second Finger Thirty (30) weeks;
- (h) Third Finger Twenty-five (25) weeks;
- (i) Fourth Finger Fifteen (15) weeks;
- (j) Foot Two hundred five (205) weeks;
- (k) Great Toe Thirty-eight (38) weeks;
- (l) Non-Great Toe Sixteen (16) weeks;
- (m) Complete loss of hearing in one ear Fifty-two (52) weeks;
- (n) Complete loss of hearing in both ears Two hundred (200) weeks;
- (o) Breast (one) Fifty-two (52) weeks;
- (p) Kidney (one) One hundred fifty-two (152) weeks;
- (q) Larynx One hundred sixty (160) weeks;
- (r) Lung (one) One hundred fifty-six (156) weeks;

- (s) Penis Two hundred five (205) weeks;
- (t) Testicle Fifty-two (52) weeks; and
- (u) Tongue One hundred sixty (160) weeks;

- 121.2 If, in the case of an arm or a leg, the member is amputated above the wrist or ankle, compensation is the same as for loss of the arm or leg, respectively.
- 121.3 Compensation for loss of more than one (1) phalanx of a digit is the same as for loss of the entire digit. Compensation for loss of the first phalanx is one-half (1/2) of the compensation for loss of the entire digit.
- 121.4 Compensation for loss of use of two (2) or more digits or one (1) or more phalanges of each of two (2) or more digits of a hand or foot is proportioned to the loss of the use of the hand or foot occasioned thereby.
- 121.5 For serious disfigurement of the face, head, or neck of a character likely to handicap an individual in securing or maintaining employment, proper and equitable compensation not to exceed seven thousand five hundred dollars (\$7,500) shall be awarded in addition to any other compensation payable under this schedule.
- 121.6 Compensation for loss of binocular vision or for loss of eighty percent (80%) or more of the vision of any eye is the same as for loss of the eye.
- 121.7 Compensation for partial bilateral loss of hearing is computed on the loss as affecting both ears.
- 121.8 The degree of loss of vision or hearing under this schedule is determined without regard to correction.
- 121.9 In the case of the loss of use of more than one (1) member or parts of more than one (1) member as enumerated by this section, the scheduled award is for the loss of the use of each member or part thereof and the awards run consecutively.
- 121.10 Compensation for permanent total loss of use of a member is the same as for loss of the member.
- 121.11 Compensation for permanent partial loss of use of a member may be for proportionate loss of use of the member.
- 121.12 If medical records or other objective evidence substantiates a pre-existing impairment or other impairments or conditions unrelated to the work-related injury, the Program shall apportion the pre-existing or un-related medical

impairment from that of the current work-related injury or occupational disease in accordance with the American Medical Association Guides to the Evaluation of Permanent Impairment.

- 121.13 A claimant may request a schedule award under this section from the Program. The request shall be in writing and provide supporting information and documentation, including a permanent partial disability (PPD) rating from a qualified physician.
- 121.14 The Program shall review the request, and may request additional information or action as necessary, including the scheduling of a physical examination(s) to evaluate the extent of permanency.
- 121.15 The Program shall make a determination on a request made under § 121.13 within sixty (60) calendar days of receipt of the request.
- 121.16 An employee's return to full duty in his or her pre-injury job shall constitute prima facie evidence that the employee has not suffered permanent wage loss as a result of his or her injury.
- 121.17 When making any determination under this section, the Program shall consider medical reports by physicians with specific training and experience in the use of American Medical Association Guides to the Evaluation of Permanent Impairment.
- 121.18 The program shall issue its decision in the form of a Notice of Determination. The NOD shall inform the employee or claimant of his or her right to appeal the decision by requesting a hearing before the OHA within thirty (30) days of the date of the Program's decision.
- 121.19 An employee or claimant may not receive indemnity compensation and a schedule award at the same time. If the Program grants a request for a schedule award under this section, it shall inform the employee or claimant of when the employee's or claimant's indemnity compensation payments will be suspended and when the schedule award payments will begin. The employee or claimant may request that the indemnity compensation payments be suspended and the schedule award payments begin on a certain date.

122 DEATH BENEFITS

- 122.1 In the case of the death of an employee, the Program shall determine the compensation owed to the employee's beneficiary or beneficiaries by following the requirements of section 2333 of the Act.
- 122.2 The maximum and minimum limits on compensation included in section 2333 of the Act shall be determined by following the federal general pay scale when using

section 5332 of title 5 of the United States Code, and by following the non-union, District career service (general) pay scale when using the District pay scale.

- 122.3 A beneficiary or beneficiaries receiving death benefits are not entitled to continuation of pay pursuant to § 109 of this chapter.
- 122.4 When a beneficiary begins to receive compensation under this section, the Program shall notify the beneficiary of the condition(s) under which death benefits may cease, including upon the beneficiary's marriage, re-marriage, or entering into a domestic partnership, or upon the beneficiary's reaching eighteen (18) years of age, pursuant to section 2333 of the Act.
- 122.5 On a regular basis, the Program may require a beneficiary to confirm his or her marital or domestic partnership status and age, and the Program may conduct any investigation necessary pursuant to § 102 to confirm this information. Any beneficiary receiving death benefits under this section shall cooperate with such investigation by providing all relevant information that the Program requests and by notifying the Program when his or her eligibility for benefits under this section changes. Failure to notify the Program when his or her eligibility for benefits under this section changes may result in the Program initiating overpayment proceedings pursuant to § 142 of this chapter.

123 MEDICAL SERVICES AND SUPPLIES: TREATING PHYSICIANS

- 123.1 Pursuant to section 2303(a) of the Act, the District government shall furnish to a claimant who is injured while in the performance of duty the services, appliances, and supplies prescribed or recommended by a qualified treating physician, which the Program considers likely to cure, give relief, reduce the degree or injury length, or aid in lessening the amount of the monthly compensation.
- 123.2 In order for the Program to pay for the services provided by a treating physician, the physician must be a member of a panel of treating physicians. The panel shall be selected by the Program.
- 123.3 Physicians shall apply to be members of the panel. The Program shall select members of the panel based on the physicians' likelihood of meeting the goals of § 123.1. The Program may add and remove physicians from the panel at its discretion.
- 123.4 The Program shall inform a claimant whose claim has been accepted of the requirement in § 123.2 and shall provide the claimant with a list of panel physicians who provide the type of treatment needed by the employee.
- 123.5 If the Program decides to remove a physician from the panel of treating physicians, the Program shall give all of the claimants currently being treated that

physician notice of the decision, as well as a list of alternative treating physicians on the panel, thirty (30) days before the physician is removed from the panel.

- 123.6 If a claimant decides to receive treatment from a non-panel physician after the Program provides the claimant with a list of panel physicians, the claimant is not entitled to reimbursement for the cost of services provided by the non-panel physician.
- 123.7 An injured claimant may, when the claimant is first injured, select a non-panel physician to provide medical services, appliances, and supplies if the claimant is unable to make an appointment with a panel physician due to the urgency of the need for treatment.
- 123.8 If there is a need for immediate medical treatment and, due to the nature of an injury, the injured claimant is unable to contact a physician, the injured claimant may seek treatment at an emergency care facility. Notice of the provision of emergency care shall be provided to the Program no later than thirty (30) days after the care is rendered.
- 123.9 Once a panel treating physician is selected to provide treatment under the Act, an injured claimant shall not change to another physician or hospital without authorization of the Program, except in an emergency.
- 123.10 If the injured claimant is not satisfied with the medical care provided by a panel physician, a request for change shall be submitted, in writing, with justification to the Program. The Program shall permit a change where the Program finds the change to be in the best interest of the injured claimant.
- 123.11 Upon a request from the Program, the claimant and panel or non-panel treating physicians 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.
- 123.12 After the claimant's first appointment with a treating physician, the physician shall file a comprehensive medical report with the Program containing a diagnosis of physical findings or examination, a statement concerning the injury's relationship to employment, the treatment plan, if any, and an opinion regarding the claimant's prognosis within ten (10) business days of an examination of the injured employee or claimant.
- 123.13 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 a claimant's benefits:
- (a) Date(s) of examination and treatment, if any;

- (b) History given by the claimant;
- (c) Physical findings;
- (d) Results of diagnostic tests;
- (e) Diagnosis;
- (f) Course of treatment, if any;
- (g) Description of any other conditions found that are not due to the claimed injury;
- (h) Treatment given or recommended for the claimed injury, if any;
- (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 claimant's ability to work due to the injury;
- (k) Prognosis for recovery, including an estimate regarding when the claimant will be able to return to work; and
- (l) All other material findings.

123.14 Any physician who continues to treat an injured employee or claimant shall, at no cost, provide periodic progress reports, treatment records, and bills to the Program, in compliance with § 123.12.

123.15 The Program may require an injured claimant to submit to physical examinations at times and places reasonably convenient for the claimant in order to continue to investigate a claimant's eligibility for benefits under the Act. The Program may suspend a claimant's benefits if the claimant fails to attend or otherwise obstructs a physical examination that is required by the Program.

123.16 If the Program denies authorization for payment for any treatment or procedure, the Program shall provide a claimant with written notice of the denial, using a form that the Program creates, no later than thirty (30) days after the treating physician makes a written request to the Program for this authorization.

123.17 If the Program fails to provide written notification to the claimant within thirty (30) days of the request, it shall be deemed that the Program authorized the

treatment or procedure, unless the Program commences a utilization review pursuant to § 126 of this chapter within thirty (30) days of the request.

- 123.18 If a claimant or treating physician is unsatisfied with a decision of the Program under this subsection, the claimant or physician may make a written request that the Program initiate the utilization review process pursuant to § 126 of this chapter within thirty (30) days of receipt of the Program's decision.
- 123.19 All medical providers shall include in each medical report and bill for services rendered under the Act, the code, as published by the American Medical Association (AMA) in the most current edition of the Physicians Current Procedural Terminology (CPT Codes), for detailing the billing of all medical procedures and the codes established by the most recent edition of the International Classification of Diagnosis (ICD) code, as published by the U.S. Department of Health and Human Services, for diagnosing the conditions.
- 123.20 The Program shall require a medical report and/or invoice from a medical care provider to substantiate payment of bills. All reports shall be typewritten on the physician's letterhead and signed and dated by the attending physician.
- 123.21 Fees and other charges for treatment or medical services shall be limited to those that are reasonable and customary charges prevailing in the local medical community as the Program determines.
- 123.22 The cost of physical examinations ordered by the Program shall be paid by the Program, unless the examination is conducted by a non-panel physician. A panel physician shall not attempt to collect a disputed payment for medical services in connection with a compensable claim under the Act from the injured employee or claimant.

124 ADDITIONAL MEDICAL EXAMINATIONS

- 124.1 The Program may require a claimant who has filed a claim for benefits or who is receiving benefits to participate in an Additional Medical Examination (AME) with a physician selected by the Program.
- 124.2 The Program shall maintain a list of AME physicians. AME physicians shall have expertise and board certification in various specialties that are consistent with claimants' most common injuries, as determined by the Program. AME physicians shall be selected on the basis of several factors, including:
- (a) Experience in their field;
 - (b) Experience with and understanding of workers' compensation procedures and guidelines;

- (c) Reputation for honesty and integrity;
- (d) Positive records with licensing boards; and
- (e) Availability to provide timely appointments, reports, depositions, and court appearances.

124.3 AME physicians may be added to and removed from the Program's list of AME physicians at the discretion of the Program.

124.4 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.

124.5 The Program may schedule an AME when:

- (a) Diagnosis does not match the claim;
- (b) The duration of claimant's inability to work is longer than generally accepted guidelines allow for that particular injury, including the Official Disability Guidelines published by the Work Loss Data Institute, or similar guidelines;
- (c) Surgery is recommended;
- (d) There is a question regarding the underlying accuracy or consistency of the opinion of the treating physician; or
- (e) There is any reason to verify that the treatment or care provided is appropriate, adequate and solely for the injury incurred in the performance of the employee's duty.

124.6 The Program shall inform a claimant in writing of the requirement that he or she attend an AME appointment, and that failure to attend the appointment, failure to bring medical records under the claimant's possession and control, or any other obstruction of the examination, may result in a suspension of the employee's benefits.

124.7 If the claimant does not attend the AME appointment, fails to bring medical records under the claimant's possession and control, or otherwise obstructs the examination, the Program may suspend the claimant's benefits.

124.8 If the Program suspends benefits pursuant to this section, it shall issue a NOD to the claimant informing him or her of the suspension and how the claimant can have his or her benefits reinstated.

- 124.9 If the claimant attends a newly scheduled appointment, provides requested records, or otherwise cooperates with the examination as directed by the Program, the claimant's benefits shall be reinstated as of the date of compliance. The date of compliance is the date the claimant attends the newly scheduled appointment, the date the Program receives requested records, or the date the claimant otherwise cooperates with the examination as directed by the Program.
- 124.10 An AME report shall be conclusive and responsive to the requests from the Program as part of a complete professional evaluation and shall comply with the requirements of §§ 123.12, 123.13, and 123.20.
- 124.11 Prior to any determination of coverage based upon an AME's recommendation(s), the claimant's treating physician shall have thirty (30) days from receipt of a copy of the AME to submit written comments to the Program regarding the AME finding(s). If an employee or claimant has not treated with a treating physician for his or her injury for one (1) year or more, the Program does not have to share a copy of the AME's recommendation with the claimant's treating physician.

125 TRANSPORTATION AND MILEAGE

- 125.1 The Program may provide a claimant with transportation to and from a physical examination or medical treatment that is authorized by the Program pursuant to this chapter.
- 125.2 A claimant who needs transportation to and from a physical examination or medical treatment shall request such transportation from the Program no later than five (5) business days before the authorized physical examination or medical treatment.
- 125.3 The Program shall authorize transportation to a routine physical examination only if the claimant provides the Program with documentation from his or her treating physician that the transportation is necessary due to medical necessity. "Medical necessity," as used in this section, means that the claimant is not capable of driving himself or herself or using public transportation to get to the examination, due to his or her work-related injury.
- 125.4 The Program shall authorize transportation to an AME if the examination is within a reasonable distance of the claimant's home address, work address, or public transportation, only if the claimant provides the Program with documentation from his or her treating physician that the transportation is necessary due to medical necessity. If the AME is not within a reasonable distance of the claimant's home address, work address, or public transportation, the Program shall provide the claimant with transportation to the examination upon the claimant's request.

- 125.5 The Program shall authorize transportation to an outpatient or inpatient surgical procedure upon the claimant's request.
- 125.6 Upon a claimant's request, the Program may reimburse a claimant for expenses incident to the claimant's attendance at a routine physical examination, Additional Medical Examination, or medical treatment that is authorized by the Program, including for the cost of public transportation, mileage, and parking expenses.
- 125.7 Claimants shall be reimbursed for the cost of mileage based upon the distance from either his or her place of employment to the physician's office or treating facility, or from his or her home to the physician's office or treating facility. The cost per mile reimbursed by the Program shall be at the same rate as the United States General Services Administration Privately Owned Vehicle Mileage Reimbursement Rates. The cost per mile shall be included on the form required in § 125.8 and shall be posted on the ORM's website.
- 125.8 If a claimant requests reimbursement of expenses pursuant to § 125.6, the Program shall send the claimant a form requesting information on and documentation of the cost of the expenses. A claimant shall not be reimbursed for expenses under this section if the claimant has not returned the form and documentation as requested by the Program.
- 125.9 In order to be reimbursed for transportation expenses pursuant to § 125.6, the claimant must submit a written request for reimbursement within ninety (90) days of the date that the claimant incurred the expense. The Program shall deny requests received after ninety (90) days of the date that the claimant incurred the expense. If the claimant's request for reimbursement of expenses meets the requirements of this section, the Program shall reimburse the claimant within ninety (90) days of the Program's receipt of all of the information and documentation required to make a decision on the claimant's request.

126 UTILIZATION REVIEW

- 126.1 Any medical care or service furnished or scheduled to be furnished under the Act shall be subject to utilization review. The review may be performed before, during, or after the medical care or service is provided.
- 126.2 A utilization review organization or individual used pursuant to the Act shall be certified by the Utilization Review Accreditation Commission.
- 126.3 The claimant or the Program may initiate utilization review where it appears that the necessity, character, or sufficiency of medical services is improper or clarification is needed on medical service that is scheduled to be provided.
- 126.4 If a review of medical care or a service is initiated under this section, the utilization review organization must make a decision no later than sixty (60) days

after the utilization review is requested. If the utilization review is not completed within one hundred-twenty (120) days of the request, the care or service under review shall be deemed approved.

- 126.5 The report of the review shall specify the medical records considered and shall set forth rational medical evidence to support each finding. The report shall be authenticated or attested to by the utilization review individual or by an officer of the utilization review organization. The report shall be provided to the employee and the Program.
- 126.6 Any decision issued by the utilization review organization under this section shall inform the claimant of his or her right to reconsideration or appeal of the decision.
- 126.7 A utilization review report which conforms to the provisions of this section shall be admissible in all proceedings with respect to any claim to determine whether medical care or service was, is, or may be necessary and appropriate to the diagnosis of the claimant's injury.
- 126.8 If the medical care provider or claimant disagrees with the opinion of the utilization review organization or individual, the medical care provider or claimant may submit a written request to the utilization review organization or individual for reconsideration of the opinion.
- 126.9 The request for reconsideration shall be in writing and contain reasonable medical justification, and may provide additional information if the medical care or service was denied because insufficient information was initially provided to the utilization review organization. The request for reconsideration shall be made within sixty (60) calendar days of the claimant's actual receipt of the utilization review report if the claimant is requesting reconsideration, or within sixty (60) calendar days of the medical provider's actual receipt of the utilization review report, if the medical care provider is requesting reconsideration.
- 126.10 If the utilization review organization denies the medical care provider's or claimant's request for reconsideration, the medical care provider or claimant may appeal the reconsideration decision by applying for a hearing before the OHA within thirty (30) days of the date of the reconsideration decision.
- 126.11 The Superior Court of the District of Columbia may review the ALJ's decision without an appeal to the Compensation Review Board. The decision may be affirmed, modified, reversed, or remanded at the discretion of the court. The decision shall be affirmed if supported by substantial competent evidence of the record, pursuant to the District of Columbia Superior Court Rules of Civil Procedure Agency Review.

126.12 A medical provider or claimant may not appeal a decision of a utilization review organization to the OHA without first requesting reconsideration under §§ 126.8 and 126.9.

126.13 The District of Columbia government shall pay the cost of a utilization review.

127 MODIFYING, SUSPENDING, OR TERMINATING BENEFITS

127.1 The Program may make an ED to modify, suspend, or terminate a claimant's benefits.

127.2 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 section.

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

- (a) The award of compensation was for a specific period of time which has expired;
- (b) The death of the claimant;
- (c) Clear evidence that the claimant has returned to work;
- (d) Clear evidence that the claimant has been released to return to work;
- (e) The claimant has been released to or has returned to work on a part-time or modified duty basis, notwithstanding that the claimant has been directed to undergo vocational rehabilitation under section 2304 of the Act;
- (f) The claimant has been convicted of fraud in connection with the claim;
- (g) The claimant's failure to participate in vocational rehabilitation, failure to cooperate with the Program's request for a physical examination by a treating or AME physician, or failure to follow prescribed and recommended courses of medical treatment;
- (h) The claimant's failure to cooperate with the subrogation process pursuant to § 143 of this chapter;
- (i) Controversion of the claim for two (2) years pursuant to § 112.7;
- (j) Retirement of the claimant;
- (k) Clear evidence that the claimant has knowingly and willfully received benefits to which he or she was not entitled under the Act;

- (l) The cessation or lessening of a compensable injury;
- (m) The condition is no longer causally related to the claimant's employment with the District government;
- (n) The condition has changed from a total disability to a partial disability;
- (o) The Program has offered the claimant a modified duty position and the claimant has refused to accept the position, pursuant to § 137 of this chapter;
- (p) The Program determines based upon strong compelling evidence that the ID was in error; or
- (q) Any other ground demonstrating that the Act requires the claimant's benefits to be modified.

127.4 With the exception of the factors set forth in paragraphs 127.3(a) through (k) and § 127.5, compensation benefits subject to an ED shall not be modified or terminated until the period for requesting reconsideration set forth in § 128 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.

127.5 The Program may modify or terminate compensation benefits subject to an ED simultaneous with notice to the claimant, pursuant to §§ 127.3 and 127.4, when:

- (a) A claimant's treating physician has released a claimant to return to work; or
- (b) An AME physician has released a claimant to return to work and the claimant's treating physician has either agreed with the AME physician's opinion or has not disagreed with the AME physician's opinion.

127.6 If the claimant's treating physician disagrees with the AME physician's opinion, then the Program shall not modify or terminate the claimant's benefits until the period for requesting reconsideration set forth in § 128 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.

127.7 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.

127.8 Medical reports that fail to meet the requirements of § 123.13 may be deemed to be invalid and compensation claims based thereon may be denied.

127.9 The ED is effective unless the claimant succeeds on a Request for Reconsideration under § 128 of this chapter or prevails at a hearing under § 129 of this chapter, or the Program revises the ED.

128 APPEAL OF INITIAL DETERMINATIONS AND ELIGIBILITY DETERMINATIONS

128.1 An employee or claimant who is not already receiving benefits and is dissatisfied with an ID may request a hearing under § 129 of this chapter.

128.2 An employee or claimant who is already receiving benefits and is dissatisfied with an ED may either submit a request for reconsideration to the ORM, or appeal the ED as provided in the Act, but not both at the same time.

128.3 In the event an employee or claimant submits both a request for reconsideration to the Program and a request for a hearing to the OHA, the employee shall be entitled only to the appeal process with the agency that first received the request. The other request shall not be considered by the other agency.

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

- (a) The award for compensation was for a specific period of time which has expired;
- (b) The claimant has died;
- (c) The claimant has returned to work;
- (d) The claimant has been released to return to work and the requirements of § 127.5 have been met;
- (e) The claimant has been convicted of fraud in connection with the claim;
- (f) The claimant has been released to or has returned to work on a part-time or modified duty basis notwithstanding individuals directed to undergo vocational rehabilitation under section 2304 of the Act.
- (g) The claimant's compensation benefits have been suspended due to the claimant's failure to participate in vocational rehabilitation, failure to cooperate with the Program's request for a physical examination by a treating or AME physician, failure to follow prescribed and recommended courses of medical treatment;

- (h) The claimant has failed to cooperate with the subrogation process pursuant to § 143 of this chapter;
- (i) The claimant has voluntarily retired and been awarded retirement benefits in lieu of workers' compensation benefits; or
- (j) The claimant knowingly and willfully received benefits to which he or she was not entitled under the Act.

- 128.5 If a Request for Reconsideration is properly and timely submitted pursuant to this section, the ORM may affirm, modify, vacate, or remand the ED for further examination by the claims examiner, in full, or in part.
- 128.6 A request for reconsideration shall be written and shall contain medical, vocational, or factual justification.
- 128.7 A Request for Reconsideration shall be delivered to the ORM by hand, or by first-class mail, postage prepaid, within thirty (30) days of the date of issuance of the 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.
- 128.8 If the ORM receives a Request for Reconsideration after the thirtieth (30th) day following the issuance of the ED, it shall deny the Request for Reconsideration as untimely without ruling on the merits.
- 128.9 A claimant may request a waiver of the filing deadline in § 128.7 on the grounds that good cause existed during the thirty (30) days following the ED decision sufficient to justify the ORM's late receipt of the Request for Reconsideration. The claimant shall provide factual justification and supporting 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 one hundred eighty (180) days from the date of issuance of an ED.
- 128.10 The ORM shall rule on the merits of a Request for Reconsideration. The standard to prevail on a Request for Reconsideration shall be 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 § 123.13.
- 128.11 The ORM shall, using a standard form developed by the ORM, provide a brief written explanation of its decision and mail the decision to the employee.

- 128.12 If the ORM grants a Request for Reconsideration, ORM shall remand the claim back to the claims examiner and instruct the claims examiner to issue a new NOD that is consistent with the Reconsideration decision.
- 128.13 If the ORM grants 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 ORM grants 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 within thirty (30) days.
- 128.14 If the ORM denies a Request for Reconsideration, ORM shall issue a reconsideration decision from which the claimant shall have thirty (30) calendar days to appeal to the OHA. A claimant shall not be entitled to receive continuing benefits pending a hearing.
- 128.15 The ORM decision shall not be binding upon a OHA Administrative Law Judge (ALJ).

129 REQUEST FOR HEARING

- 129.1 In accordance with section 2324 of the Act and §§ 111 and 127 of this chapter, the Program shall notify a claimant, in writing, of its ID or ED upon any claim submitted and its findings of fact upon which the determination is based.
- 129.2 A form for requesting a hearing pursuant to section 2324(b) of the Act shall accompany the notice of determination.
- 129.3 If the individual claiming benefits under the Act wishes to request a hearing pursuant to section 2324(b) of the Act, that individual shall sign the request for hearing which was forwarded to him or her pursuant to this section and deliver it by first-class mail or in person to the Office of Hearings and Adjudication within thirty (30) days of the issuance of the determination.

130 HEARING PROCEDURES

- 130.1 Hearings pursuant to section 2324(b) of the Act shall be conducted by an OHA ALJ who has been duly designated by the Mayor.
- 130.2 The OHA shall set the time and place of the hearing, and shall mail or deliver in person written notices to the claimant and the Office of the Attorney General for the District of Columbia (OAG) at least ten (10) days prior to the hearing.
- 130.3 The hearing shall, when practicable, be set at a time and place convenient for the claimant and the OAG.

- 130.4 The ALJ may, and when so requested by the claimant or the OAG, afford the parties a prehearing conference to clarify the issues involved in the claim and, when necessary, shall postpone the hearing for this purpose.
- 130.5 A hearing may be rescheduled or dismissed upon the oral or written request of the claimant and the OAG if the request is received by the ALJ assigned to conduct the hearing at least forty-eight (48) hours prior to the time of the hearing or at the option of the ALJ.
- 130.6 In conducting a hearing, evidence may be presented orally or in the form of written statements and exhibits.
- 130.7 All evidence available to the claimant and the OAG on the date of the hearing shall be presented to the ALJ at the time of the hearing.
- 130.8 The ALJ, in his or her discretion, may leave the record open for a reasonable period subsequent to the hearing to receive any additional evidence prior to making a decision.
- 130.9 The hearing shall be recorded and transcribed. Upon request, a copy of the complete transcript shall be provided to all interested parties at cost as established by the OHA.
- 130.10 If the claimant fails to appear at the time and place set for the hearing and does not, no later than ten (10) days after the time set for the hearing, show good cause for the failure to appear, the official record shall be closed.
- 130.11 The ALJ shall fix the time within which he or she will receive evidence to reflect findings of fact and conclusions of law.
- 130.12 The ALJ shall then issue an order to reverse, modify, affirm, or remand a determination rendered by the claims examiner.
- 130.13 The final decision shall be rendered within thirty (30) days after the hearing ends or the record closes, and then mailed or delivered to the claimant and the OAG at their last known address.
- 130.14 The final decision shall put the claimant and the OAG on notice of their right to file an appeal from the ALJ's final decision.

131 REPRESENTATION

- 131.1 Any claimant who wishes to be represented in any proceeding before an ALJ under the Act shall submit a written appointment of the individual who he or she is authorizing to undertake the representation to the OHA or shall make the appointment on the record at a hearing.

- 131.2 A duly appointed representative may make or give, on behalf of the claimant he or she represents, any request or notice relative to any proceeding before the OHA under the Act, including formal hearing and review.
- 131.3 A representative shall be entitled to present or elicit evidence and make allegations as to facts and law in any proceeding affecting the claimant he or she represents and to obtain information with respect to the claim of the claimant.
- 131.4 A copy of a notice to any claimant of any administrative action, determination, or decision or request to any party for the production of evidence shall be sent to the representative of the claimant, and the copy of the notice or request shall have the same force and effect as if it had been sent to the claimant.

132 CLAIMS FOR FEES FOR REPRESENTATION

- 132.1 Claims for fees for representation of a claimant shall be submitted in writing to the ALJ, if a hearing has been requested, within thirty (30) days of the issuance of a decision under § 130.12.
- 132.2 A copy of the claim shall be simultaneously forwarded by the representative to the claimant who was represented.
- 132.3 All claims shall include an itemized statement describing the services rendered. The itemization shall contain at least the following information:
- (a) The dates that services began and ended and all dates on which conferences were held, documents or letters prepared, or telephone calls made;
 - (b) A description of each service rendered with the amount of time spent on each type of service;
 - (c) The amount of the fee which the representative desires for services performed;
 - (d) The amount of fees requested, charged, or received for services rendered on behalf of the claimant before any state or federal court or agency, in a similar or related matter; and
 - (e) A statement explaining the basis for the amount of the fee requested.
- 132.4 No claim shall be approved by the ALJ pursuant to section 2327(b) of the Act unless the representative submitting the claim was duly appointed by the claimant in accordance with § 131.1 of this chapter.

132.5 In determining whether to approve a claim, the ALJ shall consider at least the following factors:

- (a) The nature and complexity of the claim;
- (b) The actual time spent on development and presentation of the claim;
- (c) The amount of compensation accrued and potential future payments;
- (d) Customary local charges for similar services; and
- (e) Professional qualifications of the representative.

132.6 The decision approving or disapproving a claim shall be forwarded to the representative and to the claimant who was represented.

133 CLAIMANT AND ATTORNEY ACCESS TO PROGRAM CLAIM FILES

133.1 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 Public Sector Workers' Compensation are District of Columbia property.

133.2 A claimant and his or her attorney may contact the Program to request an appointment to review the Program's file and make one (1) copy of the documents. The Program shall schedule an appointment to be held at a mutually convenient time within five (5) business days of receiving the employee's request.

133.3 The Program shall provide the claimant with one (1) set of copies of the documents in the file without charge. If the employee makes more than one (1) request for a copy of any document in the file within one (1) year, the Program may charge the claimant for the cost of making the copies, pursuant to the fee schedule set under chapter 1 of title 4 of the District of Columbia Municipal Regulations (DCMR).

134 PAYMENT OF COMPENSATION BENEFITS ON REMAND FROM APPEAL

134.1 If an ALJ orders the Program to pay compensation to a claimant pursuant to section 2324 of the Act, the Program shall pay compensation to the claimant within thirty (30) days of the date of the order, provided that the Program shall require a claimant to provide within fifteen (15) days of the order, prior to the payment, the following:

- (a) Verification of the injury 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 (such as, pay stubs, W-2, or 1099 income tax forms, and/or other related income earnings statements), and any other earnings information as authorized by § 104 of this chapter.

135 ADMINISTRATIVE AND JUDICIAL REVIEW

- 135.1 The provisions of 7 DCMR §§ 250 to 271 concerning administrative appeals to the Compensation Review Board (sometimes referred to in these regulations as the Board) established pursuant to the Directive of the Director of the Department of Employment Services (Director), Administrative Policy Issuance No. 05-01 (February 5, 2005), are incorporated herein by reference as fully as if stated and set forth in their entirety in this section.
- 135.2 Any party adversely affected or aggrieved by a compensation order or final decision issued by the OHA with respect to a claim for workers' compensation benefits pursuant to Title XXIII of the District of Columbia Government Comprehensive Merit Personnel Act of 1978 (D.C. Official Code §§ 1-623.1, *et seq.* (2006 Repl. & 2012 Supp.)) may appeal said compensation order or final decision to the Board by filing an Application for Review with the Board within thirty (30) calendar days from the date shown on the certificate of service of the compensation order or final decision in accordance with and pursuant to the provisions of 7 DCMR §258.

136 VOLUNTARY SETTLEMENTS

- 136.1 Pursuant to section 2335 of the Act, a claimant and the Chief Risk Officer or his or her designee may enter into a voluntary lump-sum settlement to be a complete and final disposition of the claimant's claim or case.
- 136.2 The settlement may terminate the Program's obligation to pay the claimant any workers' compensation benefits, including indemnity payments and medical or other services. When terminating medical services, the Program shall comply with all relevant District and federal requirements, including any requirements under the federal Medicare program.
- 136.3 All settlement agreements shall be in writing and shall be signed by the claimant and the Mayor or his or her designee. If the claimant is represented by an attorney, the attorney shall also sign the settlement agreement. Further, the attorney also shall certify that the terms and conditions of the settlement, particularly including its finality, have been explained to and discussed with the claimant.
- 136.4 Pursuant to the provisions of section 2316(d) of the Act, claimants and the Mayor or his or her designee may enter into voluntary settlements which do not preclude

the receipt of retirement benefits generally payable for District service under the federal civil service retirement system.

- 136.5 The United States Life Tables developed by the United States Department of Health and Human Services shall be utilized in determining the probability of the death of any claimant in reaching a voluntary lump-sum settlement agreement; however, the lump-sum payment to a surviving spouse or domestic partner of a deceased employee shall not exceed sixty (60) months of compensation which the spouse or domestic partner would have otherwise received.
- 136.6 A voluntary lump-sum settlement may provide for periodic or installment payments of the settlement sum if agreed to by the claimant and the Mayor or his or her designee.
- 136.7 Any voluntary lump-sum settlement entered into by the claimant and the Mayor or his or her designee may not be reviewed or modified pursuant to §§ 2324 or 2328 of the Act except in cases of fraud or misrepresentation by any party.

137 RETURN TO WORK PROGRAM

- 137.1 On a monitored, progressive basis, the Program may direct claimants with temporary or partial disabilities to participate in a modified work program designed to provide consistent and appropriate assistance to claimants to return to work quickly and safely.
- 137.2 Claimants must have the appropriate medical release from their treating physician to perform modified duty. The medical release must include any specified restrictions and their anticipated duration.
- 137.3 The Program shall attempt to place injured claimants within their pre-injury agency, or within another agency when modified work assignments are not available within the pre-injury employment agency. Once assigned to a modified duty placement, the pre-injury employment agency is responsible for the salary of the claimant.
- 137.4 The modified duty assignment may have a minimum duration of two (2) basic non-overtime workdays and a maximum duration of one-hundred eighty (180) days (assigned in ninety (90) day increments) in any twelve (12) month period. For those claimants whose basic non-overtime workday may exceed eight (8) hours, the basic non-overtime workday shall be the shift, or tour of duty, worked on a regularly recurring basis for the three (3) months immediately preceding the injury.
- 137.5 A claimant who is able to perform the duties of his or her pre-injury position during the modified duty assignment period is entitled to receive compensation at the same rate of pay as received prior to the injury.

- 137.6 A claimant who is not able to perform the full scope of duties of his or her pre-injury position shall receive a modified rate of compensation closest to the rate prior to the injury, without exceeding it. A partial disability benefit will be applied if appropriate, at the rate of sixty-six and two-thirds percent (66 2/3%) or, if the claimant is eligible for augmented pay pursuant to section 2310 of the Act, seventy-five percent (75%) of the difference between the pre-disability rate and the modified duty rate.
- 137.7 The pre-injury rate of pay shall not be exceeded during the modified duty assignment.
- 137.8 If a claimant is offered a modified duty assignment and elects not to accept the modified duty assignment, the Program shall terminate the claimant's benefits.
- 137.9 The Program shall advise the claimant orally and in writing of the available temporary modified duty assignment, including the location and hours of the assignment, the essential job functions, the restrictions specified by the physician, and the rate of compensation to be received by the claimant. This same information shall be shared orally and in writing with the human resources advisor of the claimant's pre-injury employment agency and the agency where the claimant is being assigned, if different from the claimant's pre-injury employment agency.

138 NOTICE OF RETURN TO WORK

- 138.1 In all cases reported to the Program, the official superior shall be required to notify the Program immediately when the claimant returns to work or when the injury ceases.
- 138.2 The official superior shall notify the Program if, after the claimant returns to work, the same injury causes the claimant to stop work again.

139 EMPLOYEE RETENTION

- 139.1 In the event an employee resumes employment with the District government after receiving indemnity compensation for a period of time, the entire time during which the employee was receiving compensation under this subchapter shall be credited to the employee for the purposes of within-grade step increases, retention purposes, and other rights and benefits based upon length of service. The credit shall be provided after the employee resumes employment with the District government.
- 139.2 If the employee resumes employment with the District government within two (2) years of the first date the employee received compensation or medical treatment, the employee's pre-injury employment agency shall immediately and unconditionally accord the employee the right to resume his or her former, or an

equivalent, position as well as all other attendant rights which the employee would have had or acquired in his or her former position had he or she not been injured, including the rights to tenure, promotion, and safeguards in reduction-in-force procedures.

- 139.3 In the event an employee resumes regular full time employment within two (2) years pursuant to § 139.2, and the employee suffers a recurrence of his or her injury that causes him or her to not be able to work, the two (2) years referenced in § 139.2, shall begin to accrue again after the first date the employee receives compensation or medical treatment following the recurrence of the injury. In the event the Program receives evidence that an employee has either fraudulently reported a recurrent injury or intended to bring a recurrent injury on herself or himself after resuming employment, then the employee will not accrue the rights afforded under this section and the Program shall refer the matter to the Office of Inspector General for investigation.
- 139.4 If an employee's injury or disability is overcome more than two (2) years after the date of commencement of payment of compensation or the provision of medical treatment by the Program, the employee's employment agency shall make all reasonable efforts to place, and accord priority to placing the employee in his or her former or equivalent position within either the employment agency or within any other department or agency in the District government.
- 139.5 Nothing in this provision shall exclude the responsibility of the employing agency to re-employ an employee in a full-duty or part-time status.
- 139.6 An employee is not entitled to accrue annual, sick, or any other leave while not working for the District government and receiving indemnity compensation under this chapter.

140 VOCATIONAL REHABILITATION

- 140.1 A claimant with a permanent or temporary injury who has been determined to be able to work in a modified duty capacity and who has not been able to otherwise find employment, shall undergo vocational rehabilitation. The Program shall assign the claimant to a vocational rehabilitation case worker, who shall provide the claimant with skills training, job search, and application services.
- 140.2 Claimants directed to undergo vocational rehabilitation, while undergoing such rehabilitation, shall continue to receive indemnity compensation, less the amount of any earnings received from remunerative employment other than employment undertaken pursuant to such rehabilitation.
- 140.3 If a claimant has reached maximum medical improvement or has been released to work with permanent restrictions, the vocational rehabilitation services shall be for a period not to exceed ninety (90) days.

140.4 After the ninety (90) day period has expired, the vocational rehabilitation services may be extended, at the discretion of the Program, for good cause shown, for incremental periods of ninety (90) days, not to exceed one (1) year from the initiation of the initial vocational rehabilitation plan. The term “good cause,” as used in this section, means that there is evidence that a claimant’s medical condition is improving, that the Program or case worker has identified viable job opportunities for the claimant, or that there is evidence that continuation of participation in vocational rehabilitation is likely to result in the employment of the claimant.

140.5 If a claimant hired on or after January 1, 1980, without good cause fails to apply for or undergo vocational rehabilitation when so directed by the Program, his or her right to compensation under this chapter shall be suspended until the non-compliance ceases. Failure to apply for or undergo vocational rehabilitation shall include failure to attend meetings with the vocational rehabilitation case worker, failure to apply for jobs that have been identified for the claimant, or failure to otherwise participate in good faith in the job application process.

140.6 The Program shall pay for all vocational rehabilitation services provided under this section.

141 LOSS OF WAGE EARNING CAPACITY

141.1 The Program may modify a claimant’s compensation by converting it from TTD, TPD, or PTD to compensation for Loss of Wage Earning Capacity (LWEC) under the following circumstances:

- (a) A qualified physician has released a claimant to return to work in a modified duty capacity with restrictions, after examining the claimant and reviewing his or her medical records; or
- (b) A claimant has failed to apply for and undergo vocational rehabilitation when so directed by the Program and the Program finds that, in the absence of such failure, the wage-earning capacity of the claimant would probably have substantially increased.

141.2 Before the Program may modify a claimant’s compensation pursuant to paragraph 141.1(a), the Program shall conduct a labor market survey. The phrase “labor market survey,” as used in this section, means:

- (a) A determination of the types of jobs that a claimant is capable of doing, based on the following factors:
 - (1) The nature of his or her injury;

- (2) The degree of physical impairment;
 - (3) His or her usual employment;
 - (4) His or her age;
 - (5) His or her qualifications for other employment;
 - (6) The availability of suitable employment; and
 - (7) Other factors or circumstances which may affect his or her wage-earning capacity as a worker with a disability,
- (b) A determination of the claimant's wage earning capacity, based on the wages that the claimant would be able to earn in the jobs identified pursuant to paragraph 141.2(a); and
 - (c) A determination regarding the availability of the jobs identified pursuant to paragraph (a) in the commuting area surrounding the claimant's residence.

141.3 After it is completed, the Program shall share the labor market survey with the physician who conducted the examination referenced by paragraph 141.1(a) and ask the physician to comment on whether or not the employee can perform the essential functions or requirements of the jobs listed in the labor market survey, in light of the claimant's medical restrictions. If the physician agrees that the claimant can perform the jobs in light of the claimant's medical restrictions, the Program may modify the claimant's benefits pursuant to § 141.4.

141.4 After the claimant has met all of the requirements of this section, the Program may modify a claimant's compensation to be sixty-six and two-thirds percent (66 2/3%) or, if the claimant is eligible for augmented pay pursuant to section 2310 of the Act, seventy-five percent (75%) of the difference between the claimant's average weekly wage at the time of injury and the claimant's wage-earning capacity.

141.5 Prior to modifying a claimant's compensation pursuant to this section, the Program must issue a NOD to the claimant that explains the basis of the Program's decision and that attaches supporting documentation, including the LWEC wage calculation, the physician's opinion, and the labor market survey. The notice shall also advise the claimant of his or her right to request reconsideration or a hearing pursuant to § 128 of this chapter.

142 OVERPAYMENT

- 142.1 If the Program makes an overpayment to a claimant as a result of an error of fact or law, the program may recover the overpayment from the claimant or, if the claimant is receiving compensation from the Program, adjust the claimant's payments to correct the overpayment.
- 142.2 Before recovering the overpayment or adjusting the claimant's compensation payments under this section, the Program shall advise the claimant in writing of the following:
- (a) That the overpayment exists and the amount of the overpayment;
 - (b) That a preliminary finding shows that the claimant either was or was not at fault in the creation of the overpayment;
 - (c) That the claimant has the right to inspect and copy the Program's records relating to the overpayment;
 - (d) That the claimant has the right to request a waiver of the adjustment or recovery if it will result in severe financial hardship and that if the claimant chooses to request a waiver for this reason, his or her request must be in writing and include relevant information and documentation; and
 - (e) That if the claimant disagrees with the preliminary finding of the Program, including the fact or amount of the overpayment, that he or she may challenge the finding by presenting evidence supporting his or her position to the ORM, using a form provided by the Program.
- 142.3 Any request for a waiver or challenge of a preliminary finding of overpayment must be submitted to ORM within thirty (30) days of the date of the overpayment notice issued by the Program. Failure to submit the waiver or challenge within thirty (30) days shall result in denial of a waiver or challenge. The Program may waive the thirty (30) day requirement for good cause, including a finding of mental or physical incapacity of the claimant, or lack of timely receipt of the notice of adjustment or recoupment.
- 142.4 The Program shall waive adjustment or recovery of the overpayment when incorrect payment has been made to a claimant who is without fault and recovery would defeat the purpose of the Act, or would be against equity and good conscience, pursuant to section 2329 of the Act.
- 142.5 If the Program sends a claimant a notice of overpayment and the claimant does not respond within thirty (30) days, and the claimant is currently receiving workers' compensation payments, the Program shall send the claimant a notice informing the claimant that it will begin to deduct a portion of the amount owed from the claimant's workers' compensation payments, and the date on which the

deductions will begin. The date the deductions begin shall be at least thirty (30) days from the date of the Program's notice regarding the deductions. The Program shall deduct an amount that will result in recoupment of the payment in a reasonable period of time that does not result in undue financial hardship on the part of the claimant.

142.6 If the Program has reason to believe that the overpayment may have occurred as a result of fraud or other criminal activity on the part of the claimant, ORM shall refer the matter to the Office of the Inspector General, the United States Attorney's Office, or another appropriate law enforcement entity.

143 SUBROGATION AND ADJUSTMENT AFTER RECOVERY FROM THIRD PARTY

143.1 If the Program determines that an injury or death for which indemnity compensation is payable under this chapter is caused under circumstances creating a legal liability on the part of a third party to pay the District or the employee damages, the Program may:

- (a) Require the claimant to assign to the District of Columbia government any right of action he or she may have to enforce the liability;
- (b) Require the claimant to assign to the District of Columbia any right that he or she may have to share in money or other property received in satisfaction of that liability; or
- (c) Require the claimant to prosecute the action in his or her own name.

143.2 If the Program identifies one of the circumstances enumerated in § 143.1 or § 143.6, it shall notify the claimant in writing of the District's right to compensation, as well as the claimant's obligations under this section.

143.3 The Program may refer to the OAG for civil prosecution a cause of action assigned to the District of Columbia government under paragraph 143.1(a).

143.4 If the Program recovers on a cause of action prosecuted pursuant to § 143.3, it shall deduct from the settlement or judgment the total amount of compensation already paid to the claimant in workers' compensation benefits, as well as the total amount of the expenses of the civil prosecution. The deducted amount shall be deposited into the Employees' Compensation Fund. The claimant is entitled to not less than one-fifth (1/5) of the net amount of a settlement or recovery remaining after expenses have been deducted.

143.5 If there are any funds remaining after the deductions and payments made pursuant to § 143.4, the Program shall deposit the remaining funds into the Employees'

Compensation Fund and the funds shall be used to pay the claimant future compensation payable for the same injury.

- 143.6 If a claimant prosecutes a third party for an injury or death for which compensation is payable under this chapter and recovers money or other property in satisfaction of the third party's liability, the claimant, after deducting the costs of the prosecution, reasonable attorneys' fees, and one-fifth (1/5) of the net amount of money or property remaining after payment of expenses and attorneys' fees, shall pay to the Program the amount of compensation already paid by the Program to the claimant under this chapter. The payment shall be credited to the Employees' Compensation Fund. If there are any funds remaining after the claimant's payment to the Program, the remaining sum shall be a credit for the same amount of future payments of compensation by the Program that the claimant is eligible for, for the same injury. The Program shall not pay the claimant the number of future payments that totals the amount of the credit.
- 143.7 No court, insurer, attorney, or other person shall pay or distribute to the claimant or his or her designee the proceeds of such suit or settlement without first satisfying or assuring satisfaction of the interest of the District of Columbia government pursuant to § 143.6.
- 143.8 If a claimant refuses to assign or prosecute an action in his or her own name when required to do so by the Program pursuant to § 143.1, the Program may suspend or terminate the claimant's indemnity compensation, pursuant to § 127 of this chapter.
- 143.9 If a claimant refuses to pay the Program the payment owed pursuant to § 143.6, the Program may withhold the amount due from the claimant's indemnity compensation payments.
- 143.10 If a claimant returns to work and is then required to appear as a party or witness in the prosecution of an action under this section, the claimant shall be considered to be in an active duty status while so engaged.

144 LIMITATION ON BENEFITS

- 144.1 Beginning on September 24, 2011, payment for workers' compensation benefits for any one injury causing temporary total or temporary partial disability shall not continue for more than a total of five hundred (500) weeks.
- 144.2 If a claimant is receiving temporary total disability or temporary partial disability benefits payments on September 24, 2011, he or she may not receive benefits for more than a total of five hundred (500) weeks under this section, with the counting of the five hundred (500) weeks starting on September 24, 2011.

- 144.3 When terminating a claimant's benefits pursuant to this section, the Program shall send the claimant a notice of determination that advises the claimant of his or her right to reconsideration or a hearing pursuant to § 128.
- 144.4 A claimant who has received temporary total disability or temporary partial disability payments for at least four hundred forty-eight (448) weeks after September 24, 2011, may, at any time prior to sixty (60) days before the five hundredth (500th) week of benefits, request that his or her disability be deemed a permanent injury pursuant to section 2306(a) of the Act. The request shall be made in writing and shall include supporting documentation, including medical evidence of the permanency of his or her disability.
- 144.5 The Program shall make a finding of facts and determine whether the claimant's disability is permanent within sixty (60) days of the Program's receipt of the claimant's request.
- 144.6 The claimant shall provide all information or documentation the Program requests when making its determination, including earnings and medical information or documentation, and shall participate in any physical examinations required by the Program.
- 144.7 A claimant not satisfied with a decision of the Program under § 144.5 may request a hearing within thirty (30) days of the date of the Program's decision.
- 144.8 The hearing shall be conducted pursuant to the provisions of section 2324(b) of the Act. The ALJ shall make a decision within thirty (30) days after the date of the hearing, and shall notify the claimant, the Office of the Attorney General, and the Program in writing of his or her decision, any permanent disability award that he or she may make, and the basis of the decision.
- 144.9 If the ALJ finds that the claimant is permanently disabled, the Program shall commence payment of permanent disability payments within thirty (30) days of the order of the ALJ.
- 144.10 The Program may appeal a decision of an ALJ under this section, pursuant to section 2328 of the Act.
- 144.11 The limitation of benefits authorized by this section shall not apply to any claimant whose date of hire by the District of Columbia government was before January 1, 1980.

199 DEFINITIONS

- 199.1 The definitions set forth in section 2301 of Title 23 (Workers' Compensation) of the District of Columbia Government Comprehensive Merit Personnel Act of 1978 (D.C. Law 2-139; D.C. Official Code §§ 1-623.01, *et seq.*) (2006 Repl. &

2012 Supp.) shall apply to this chapter. In addition, for purposes of this chapter, the following definitions shall apply and have the meanings ascribed:

Act – the District of Columbia Comprehensive Merit Personnel Act of 1978 (D.C. Law 2-139; D.C. Official Code §§ 1-623.01, *et seq.* (2006 Repl. & 2012 Supp.)), as amended and as it may be hereafter amended.

Administrative Law Judge or ALJ – a hearing officer of the Office of Hearings and Adjudication in the Administrative Hearings Division of the Department of Employment Services.

Alive and well check – an inquiry by the Program to confirm that a claimant who is receiving benefits still meets the eligibility requirements of the Program.

Beneficiary – an individual who is entitled to receive death benefits under the Act.

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 Public Sector Workers' Compensation field.

Claim – an assertion properly filed and otherwise made in accordance with the provisions of this chapter that an individual is entitled to benefits under the Act.

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 Public Sector Workers' Compensation industry, and under District of Columbia law.

Claimant – an individual who files a claim for benefits under the Act or who is receiving those benefits.

Compensation – the money allowance payable to a claimant or his or her dependents and any other benefits paid under the Act, including medical benefits.

Controversion – holding a claim in abeyance due to insufficient information to either accept or deny the claim.

Earnings – for the purposes of § 104, any cash, wages, or salary received from self-employment or from any other employment aside from the employment in which the worker was injured. It also includes commissions, bonuses, and cash value of all payments and benefits received in any form other than cash. Commissions and bonuses earned before disability but received during the time the employee is receiving workers' compensation benefits do not constitute earnings that must be reported.

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

Employee – (a) A civil officer or employee in any branch of the District of Columbia government, including an officer or employee of an instrumentality wholly owned by the District of Columbia government, or of a subordinate or independent agency of the District of Columbia government, as defined by D.C. Official Code § 1-603.01(7)(2012 Supp.);

(b) An individual rendering personal service to the District of Columbia government similar to the service of a civil officer or employee of the District of Columbia, without pay or for nominal pay, when a statute authorizes the acceptance or use of the service or authorizes payment of travel or other expenses of the individual, but does not include a member of the Metropolitan Police Department or the Fire and Emergency Medical Services Department who has retired or is eligible for retirement pursuant to D.C. Official Code §§ 5-707 through 5-730 (2008 Repl. & 2012 Supp.); and

(c) An individual selected pursuant to federal law and serving as a petit or grand juror and who is otherwise an employee for purposes of this chapter as defined by paragraphs (a) and (b) above.

The phrase “personal service to the District of Columbia government” as used for the definition of employee means working directly for a District government agency or instrumentality, having been hired directly by the agency or instrumentality; it does not mean working for a private organization or company that is providing service to the District government or a District agency or instrumentality.

Employment Agency – the agency or instrumentality of the District of Columbia government which employs or employed an individual who is defined as an employee by the Act.

Good Cause – Substantial or legally sufficient ground or reason, one that affords a legal excuse, depending on the circumstances of an individual case. The finding of its existence lies largely in the discretion of the official or court to which the decision is committed.

Indemnity payment or compensation – the money allowance paid to a claimant by the Program to compensate for the wage loss experienced by the claimant as a result of an injury sustained while in the performance of his or her duty, calculated pursuant to §§ 114 and 141 of this chapter.

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 chapter.

Loss of wage earning capacity (LWEC) payment – indemnity compensation payable to a claimant pursuant to § 141 of this chapter that is the difference between the employee’s pre-injury salary and the claimant’s current wage earning capacity.

Mayor – the Mayor of the District of Columbia or a person designated to perform his or her functions under the Act.

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 or claimant is capable of doing despite his or her impairments.

Office of Hearings and Adjudication – the office in the Administrative Hearings Division of the Department of Employment Services where Administrative Law Judges adjudicate workers’ compensation claims, including public sector workers’ compensation claims under D.C. Official Code §§ 1-623.01, *et seq.* (2006 Repl. & 2012 Supp.).

Office of Risk Management (ORM) – the agency within the Government of the District of Columbia that is responsible for the District of Columbia's Public Sector Workers’ Compensation Program or its designee.

Official Superior – the immediate supervisor of the employee. In the event the immediate supervisor is not available, official superior shall mean the person acting as the employee’s immediate supervisor or the officer having responsibility for the supervision, direction, or control of the employee.

Permanent Partial Disability (PPD) payment – a schedule award calculated and paid to a claimant who has suffered a permanently disabling injury to a member, body part or organ pursuant to § 121 of this chapter.

Permanent Total Disability (PTD) – indemnity compensation payable to a claimant pursuant to § 114 when a qualified physician has determined that a claimant has reached maximum medical improvement and is unable to work on a permanent basis. The indemnity compensation is calculated by the Program pursuant to § 114 of this chapter. Nothing shall prohibit the Program from obtaining or accepting a later opinion from a qualified physician that states that the claimant has recovered from his or her injury.

Program – the Public Sector Workers’ Compensation Program of the Office of Risk Management or its designee, including the third party administrator.

Qualified health professional or qualified physician – includes a surgeon, podiatrist, dentist, clinical psychologist, optometrist, orthopedist, neurologist, psychiatrist, chiropractor, or osteopath practicing within the scope of his or her practice as defined by state law. The term includes a chiropractor only to the extent that reimbursable services are limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray to exist and subject to regulation by the Mayor.

Temporary partial disability payment (TPD) – indemnity compensation payable to a partially disabled claimant pursuant to § 114 that is sixty-six and two thirds percent (66 2/3%) or seventy-five percent (75%) of the difference between the claimant’s pre-injury salary and the claimant’s current salary. The indemnity compensation is calculated by the Program pursuant to § 114 of this chapter.

Temporary total disability payment (TTD) – indemnity compensation payable to a completely disabled claimant pursuant to § 114 that is sixty-six and two thirds percent (66 2/3%) or seventy-five percent (75%) of the claimant’s pre-injury salary. The indemnity compensation is calculated by the Program pursuant to § 114 of this chapter.

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 or claimant.

Chapter 31 is repealed in its entirety.