

OFFICE OF RISK MANAGEMENT NOTICE OF EMERGENCY 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 (2016 Supp.)); the Office of Administrative Hearings Establishment Act of 2001 (OAH Act), effective March 6, 2002 (D.C. Law 14-76, D.C. Official Code § 1-1831.01 *et seq.*) (2012 Repl.), Section 7 of Reorganization Plan No. 1 of 2003 for the Office of Risk Management, December 15, 2003; and Mayor's Order 2004-198, effective December 14, 2004, hereby gives emergency notice of the adoption of the following amendments to Chapter 1, Title 7 of the District of Columbia Municipal Regulations (DCMR).

Concurrent with this emergency rulemaking, ORM is publishing a Notice of Proposed Rulemaking to add new sections 100 through 199 to Chapter 1 (Public Sector Workers' Compensation Benefits) (PSWCP) of Title 7 (Employment Benefits) of the DCMR, and replacing Sections 100-199 of said Chapter in their entirety. To avoid confusion during the comment period, the emergency rules that will be in place during the comment period will be placed in chapter 33, except subsections 100.5, 111.6 – 111.11, 112.1 and 120.4. The last two digits of the emergency rules in chapter 33 correspond to the last two digits in the proposed rules. Subsection 100.5 will be adopted and subsections 111.6 – 111.11, 112.1 and 120.4 of the current rules will be amended to conform with the emergency rules.

The purpose of these rules is to establish that portion of the proposed rulemaking that needs to take effect as of November 30, 2016. The need for these rules to take effect on that date is for the immediate preservation and promotion of the health, safety, and welfare of the residents of the District by establishing: (1) new PSWCP hearing procedures and standards to be employed by the Office of Administrative Hearings for the adjudication of public sector workers' compensation claims under sections 2323(a-2)(4), 2324(b)(1), and (d)(2) of the CMPA, pursuant to jurisdiction established in OAH by D.C. Official Code § 2-1831.03 (b)(1) (2012 Repl.); (2) uniform procedures for accurate calculation and timely delivery of benefits; and (3) support for the direct payment of benefits to injured workers through the District's payroll system, rather than through a third-party vendor.

The emergency rules were adopted on November 17, 2016 and became effective on November 30, 2016. They will remain in effect for a period of one hundred twenty (120) days or until they are earlier replaced by permanent rules

Sections 101, 105, 106, 111.6 – 111.11, 112.1, 120.4, 114, 115, 116, 118, 120.4, 121, 126, 127, 128, 129, 130, 132, 134, 135, 141, 142, 144, and 199 of Chapter 1 of Title 7 of the DCMR are repealed:

A new subsection 100.5 is adopted to read as follows:

- 100.5 These regulations shall apply to all new, pending, and existing claims, whether the injury giving rise to such claim, occurred before or after the date of these rules.

Section 111.6 – 111.11, 112.1, and 120.4 are replaced as follows:

- 111.6 If one (1) of the circumstances in § 111.5 occurs, the Program shall issue an amended ID.
- 111.7 The Program shall issue an amended ID 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, 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 ID 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 ID 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 ID either awarding or denying the claim for an amended ID 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 ID pursuant to §§ 112.3 through 112.7 of this chapter.
- 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 IDs under § 111.5(b) or claims of recurrences of injuries under § 120 of this chapter.

- 120.4 The Program shall issue a Decision on Recurrence of Disability (DRD) 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. DRDs shall be issued in accordance to the manner in which the Program issues IDs, as provided at § 111.3 of this chapter.

A new Chapter 33 entitled “REVISED PUBLIC SECTOR WORKERS’ COMPENSATION BENEFITS” is adopted to read as follows:

CHAPTER 33 – REVISED PUBLIC SECTOR WORKERS’ COMPENSATION BENEFITS

3302 FORMS

- 3302.1 Any notices, claims, requests, applications, or certificates that the Act or this chapter requires to be made shall be on approved forms.
- 3302.2 All approved forms shall be obtained from the Program.
- 3302.3 The following forms are approved:
- (a) Form A-1 – Employee Request for Calculation and Certification of Award;
 - (b) Form 1 – Employee’s Notice of Injury / Claim for Continuation of Pay;
 - (c) Form CA1 – Request to Reinstate COP;
 - (d) Form 2 – Employing Agency’s Report of Injury / Response to COP Request;
 - (e) Form CA2 – Election of COP Charge Back;
 - (f) Form 3 – Physician’s Report;
 - (g) Form 3RC – Annual Medical Recertification;
 - (h) Form 3A – Employee Statement of Medical History;
 - (i) Form CA3 – Employing Agency Report of Return to Work;

- (j) Form 4 – Employee Authorization for Release of Medical Records;
- (k) Form 5 – Employee Authorization for Release of Earnings and Tax Records;
- (l) Form 6 – Employee Authorization for Release of PSWCP Records;
- (m) Form 7 – Employee Request for PSWCP File;
- (n) Form CA7, Part A – Employee Claim for Compensation;
- (o) Form CA7, Part B – Employing Agency Statement;
- (p) Form 8 – Employee Report of Earnings;
- (q) Form 9 – Employee Application for Hearing;
- (r) Form CA10 – Request for Leave Restoration;
- (s) Form 10 – Agreement to Off-set;
- (t) Form 11 – Employee Request for Travel Reimbursement;
- (u) Form 12 – Employee Claim for Permanent Disability Compensation;
- (v) Form 12A – Employee Request for Hearing on Permanent Disability;
- (w) Form M1 – Itemization of Professional Services of Medicinal Drugs;
- (x) Form M2 – Itemization of Hospital Charges;
- (y) Form M3 – Request to Change Treating Physician; and
- (z) Form M4 – Request for Pre-authorization of Medical Procedure.

3302.4 Nothing in this section shall be construed to limit the number of forms approved by the Program.

3326 MEDICAL BILLS

3326.2 Medical care and services shall be billed at the rate established in the medical fee schedule adopted by the Program. This fee schedule shall be based on one hundred-thirteen percent (113%) of Medicare's reimbursement amounts.

3327 UTILIZATION REVIEW

- 3327.1 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.
- 3327.2 A utilization review organization or individual used pursuant to the Act shall be certified by the Utilization Review Accreditation Commission.
- 3327.3 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.
- 3327.4 The necessity, character or sufficiency of medical services should be reviewed for treatment of the accepted condition(s) only.
- 3327.5 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.
- 3327.6 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 claimant and the Program.
- 3327.7 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.
- 3327.8 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.
- 3327.9 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.
- 3327.10 The request for reconsideration shall:
- (a) Be in writing;

- (b) Contain reasonable medical justification;
- (c) Provide additional information, if the medical care or service was denied because insufficient information was initially provided to the utilization review organization; and
- (d) Be made within sixty (60) calendar days of the claimant's receipt of the utilization review report if the claimant is requesting reconsideration, or within sixty (60) calendar days of the medical provider's receipt of the utilization review report, if the medical care provider is requesting reconsideration.

3327.11 Disputes pursuant to section 2323(a-2)(4) of the Act may be resolved upon an application for a hearing before the OAH within thirty (30) days of the date of the utilization review report or reconsideration decision.

3327.12 Requests for a hearing pursuant to § 3327.11 of this chapter may be made by the Program, medical provider, or claimant.

3327.13 The Superior Court of the District of Columbia may review the OAH'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.

3327.14 The District of Columbia government shall pay the cost of a utilization review if the claimant seeks the review and is the prevailing party.

3329 COMPUTATION OF WAGE INDEMNITY; TOTAL DISABILITY

3329.1 If the disability is total, subject to the limitations in section 2306a, the employee's monthly monetary compensation shall be sixty-six and two-thirds percent ($66\frac{2}{3}\%$) of the employee's monthly pay.

3329.2 The employee's monthly pay shall be calculated based on the employee's Average Annual Earning (AAE) as follows:

- (a) One-twelfth ($\frac{1}{12}$) of the employee's AAE at the time of injury (or recurrence, if the employee returned to regular, full-time employment for six months or more prior to recurrence).

3329.3 Average Annual Earnings (AAE) are determined based on the nature and duration of the employment in accordance with the Act as follows:

- (a) Section 2314(d)(1) is used if the employee worked substantially the whole year prior to the injury.
- (b) Section 2314(d)(2) is used if the employee did not work substantially the whole year prior to the injury, but would have been employed for substantially a whole year had it not been for the injury.
- (c) Section 2314(d)(3) is used if the employee was not employed for substantially the whole year and the employment would not have lasted for substantially the whole of the year.
- (d) Section 2314(d)(4) is used when an employee works without pay or nominal pay.

3329.4 When determining a pay rate, the criteria listed at § 3329.3 should be considered in the order listed, so that only if the method prescribed in 2314(d)(1) of the Act cannot be reasonably and fairly applied, should consideration be given to the method stated in 2314(d)(2), and so forth.

3329.5 Substantially the Whole-Year Employment – Section 2314(d)(1) of the Act – If the claimant worked substantially the whole year prior to the injury and:

- (a) Has a fixed Annual Rate of Pay, then the claimant's Average Annual Earnings (AAE) is their Annual Rate of Pay (ARP).
- (b) Does not have a fixed ARP, then the claimant's AAE, shall be calculated as follows:
 - (1) Daily Wage multiplied by three hundred (300), if the employee regularly worked six (6) days per work week;
 - (2) Daily Wage multiplied by two hundred-eighty (280), if the employee regularly worked five and one-half (5½) days per work week;
 - (3) Daily Wage multiplied by two hundred-sixty (260), if the employee regularly worked five (5) days per work week;
 - (4) Daily Wage multiplied by two hundred (200), if the employee regularly worked four (4) days per work week; or
 - (5) Daily Wage multiplied by one hundred-fifty (150), if the employee regularly worked three (3) or fewer days per work week.

3329.6 “Substantially the whole year” under section 2314 of the Act means the employee worked in the position in which he was employed at the time of the injury for at

least eleven (11) out of the immediate twelve (12) months prior to the injury, unless the employee worked in one of the following positions:

- (a) Career seasonal employment – This is an arrangement where the employee regularly works just part of a calendar year, usually for the same general period each year and at the same type of job. The employee must have a prior written agreement with the employer to continue seasonal employment from year to year to be considered a career seasonal employee. Such an employee is entitled to receive compensation on the same basis as an employee with the same grade and step who has worked the whole year. An employee should not be considered career seasonal without explicit written documentation by the agency of his or her status.
- (b) School year employment – Employees whose employment is limited to school years (i.e. teachers, bus drivers) are not considered to fall under the provisions of career seasonal employment as set forth above, but they are considered whole-year employment by nature of the position. Although “substantially the whole year” is normally defined as at least eleven (11) months, in order to determine the average annual earnings for an employee whose employment by nature is governed by school years, consideration must be given to whether the claimant worked substantially the whole actual school year, i.e., eleven-twelfths ($^{11}/_{12}$) of the school year, and whether he or she would have been employed for substantially a whole school year had it not been for the injury.

3329.7 Concurrent employment can be included in monthly pay determinations made under section 2314(d)(1) and (2) of the Act only to the extent that it establishes the ability to work full time, meaning forty (40) hours per week. When a claimant has been employed for forty (40) or more hours per week for substantially the whole year prior to injury, but not all of these hours are with the District government, he or she has demonstrated the ability to work full time and is entitled to compensation at the rate of a regular full-time employee in the same position as follows:

- (a) Similar Employment – If a claimant’s concurrent employment was similar to his or her District employment, the Program shall combine the actual earnings from District employment with the actual earnings for the similar employment to obtain the average annual pay the employee earned. (The combination of District and non-District employment hours shall not exceed forty (40) hours per week of employment.) District employment hours shall take precedence in this calculation. This total would be divided by twelve (12) to obtain the monthly pay.
- (b) Dissimilar Employment - If a claimant’s concurrent employment was dissimilar to his or her District employment and the claimant worked part-time for the District government, the Program shall treat the hours worked

at the concurrent employment as a demonstrated ability to work more than part-time. The Program shall compute the claimant's weekly hours worked by adding the total number of hours worked at the District and non-District employment. The total hours worked, not to exceed forty (40) hours per week, would be multiplied by the hourly rate of pay the claimant received for his or her District employment to compute the claimants weekly pay. The weekly pay would be multiplied by fifty-two (52) and divided by twelve (12) to obtain the monthly pay.

- (c) For the purpose of concurrent employment, attending school and sporadic employment does not demonstrate the ability to work more than part time.
- (d) Pay rates based on full-time 40-hour per week employment may not be expanded to include pay earned in any other concurrent employment, even if that employment is similar to the District duties. Pay rate based on full-time career seasonal or school year employment may not be expanded to include the pay earned "off season" or "off school year."

3329.8 Anticipated Whole-Year Employment – Section 2314(d)(2) of the Act – If the claimant did not work substantially the whole year, but the position was one which would have afforded employment for substantially a whole year, the claimant's average annual earnings are determined as described at § 3329.5 and § 3329.7 shall also apply.

3329.9 Irregular Employment – Section 2314(d)(3) of the Act – If the claimant did not work substantially the whole year and the position was not one which would have afforded employment for substantially the whole year (for example - intermittent, non-career seasonal, on-call, and discontinuous work), the claimant's AAE are determined as follows:

- (a) If the claimant is entitled to compensation for wage loss and further investigation is required to determine the claimant's AAE, the Program shall use the "150 Formula" as a provisional pay rate to calculate compensation. Compensation under the "150 Formula" pay rate shall remain in effect until the investigation is completed.
- (b) In order to compute the claimant's AAE for the immediate twelve (12) months preceding the injury, the Program shall add the claimant's total earnings per position(s) worked within that period. To do so, the Program shall pro-rate the claimant's earnings by the period worked for each position employed, in the following order:
 - (1) If the claimant was employed by the District in more than one (1) position within the immediate twelve (12) months preceding the injury:

- (A) Calculate the claimant's total base earnings and number of weeks worked for the entire period that the claimant was employed with the District government at his or her position at the time of injury; and
 - (B) Calculate the claimant's total base earnings at any other District employment, not to exceed the immediate twelve (12) months prior to the date of injury. This information should be obtained from the Employing Agency or other District agency, where the claimant worked. This information shall be obtained through PeopleSoft.
- (2) If the claimant was collectively employed with the District government for less than twelve (12) months, immediately preceding the injury, include one (1) or more of the following categories, if applicable, to complete the calculation such that the total wage accounts for one (1) full year of employment prior to the injury:
- (A) Similarly-employed worker – The Program should determine the earnings of another District employee working the greatest number of hours during the year prior to the injury in the same or most similar class, in the same agency.
 - (i) "Same or most similar class" refers both to the kind of work performed and the kind of appointment held. A similarly situated employee would most likely hold the same type of appointment and the same pay grade and step as the claimant. For example, a seasonal life guard should not be compared to a career full-time life guard, as these are different types of appointments. If the claimant's job was temporary and seasonal in nature, it should be compared to that of another temporary and seasonal employee.
 - (ii) If the "same or most similar class" contains more than one employee, the employing agency should be asked to state the earnings of the employee who worked the greatest number of hours and therefore had the highest earnings. If the claimant's term of employment is less than a year, the earnings of the similar employee should be pro-rated to match the same term of employment as the claimant's.

- (iii) The selected employee's grade and step should also be provided for reference so that it will be on file for wage-earning capacity purposes.
 - (iv) If there are no other "same or most similar class" employees at the employing agency, the Program need not consider the "Similarly-employed worker" factor.
- (B) Claimant's prior-year non-District employment – Only earnings in employment which is the same as, or similar to, the work the employee was doing when injured may be considered.
 - (i) To make this determination, the Program shall explore the claimant's full employment history for the twelve (12) months preceding the injury to determine the nature of the prior-year non-District employment.
 - (ii) The annual earnings should be pro-rated such that it reflects the period of time worked, not to exceed twelve (12) months preceding the date of injury.
 - (iii) Any other relevant factors which may pertain to the employee's AAE in the employment in which he or she was working at the time of the injury may be considered.
- (C) The pay rate determined by the "150 Formula" – The "150 Formula," provided at section 2314(d)(3) of the Act provides that a claimant's AAE may not be less than one hundred-fifty (150) times the average daily wage that the employee earned in the employment during the year just before the injury.

3329.10 The "rate of pay" for District employment under section 2314 of the Act shall be determined by referring to the employee's official personnel folder.

3329.11 Daily wage under section 2314 of the Act shall be computed by dividing the employee's total earnings for the immediate twelve (12) months prior to the injury by the total number of days worked in that period.

3329.12 To convert the monthly monetary compensation into bi-weekly installments, the monthly compensation rate shall be multiplied by twelve (12) and divided by twenty-six (26).

3329.13 To calculate monetary compensation due between pay periods, the total number of hours that the employee was absent due to the work related injury that was not otherwise covered by COP shall be divided by the total number of hours in which the employee was scheduled to work, then multiplied by the bi-weekly compensation rate as follows:

$$\text{Bi-weekly Compensation Rate} \times \frac{(\text{Total nonCOP work hours absent during pay period})}{(\text{Total hours scheduled to work during pay period})}$$

3330 COMPUTATION OF WAGE INDEMNITY; PARTIAL DISABILITY

3330.1 A disability is partial, when a qualified physician determines that a claimant can perform work with restrictions, provided that:

- (a) The restrictions arise out of a work-related injury;
- (b) A claim has been filed for the work-related injury and accepted by the Program; and
- (c) The physician has examined the employee and reviewed his or her medical records.

3330.2 If the disability is partial, subject to the limitations in section 1-623.06a, the claimant's monthly monetary compensation shall be sixty-six and two-thirds percent ($66\frac{2}{3}\%$) of the difference between the claimant's monthly pay, as defined at section 2301(4) of the Act, and the claimant's monthly wage earning capacity after the beginning of the partial disability.

3330.3 If the claimant has actual earnings which fairly and reasonably represent his or her wage-earning capacity, those earnings will form the basis for payment of compensation for partial disability. If the employee's actual earnings do not fairly and reasonably represent his or her wage-earning capacity, or if the claimant has no actual earnings, the Program shall use the factors stated in section 2315 of the Act to select a position which represents his or her wage-earning capacity. The factors considered include the nature of the injury, the degree of physical impairment, the usual employment, the age of the claimant, the claimant's qualifications for other employment, and the availability of suitable employment. However, the Program will not secure employment for the claimant in the position selected for establishing a wage-earning capacity.

3330.4 The formula which the Program uses to compute the compensation payable for partial disability employs the following terms:

- (a) Pay rate for compensation purposes, which is defined in § 3399.1(cc) of this chapter;
 - (1) Current pay rate is the “pay rate” as defined in § 3399.1(cc) at the time of the determination; and
- (b) Earnings, which means one-twelfth ($\frac{1}{12}$) of:
 - (1) The claimant’s actual annual earnings, if they fairly and reasonably represent his or her wage earning capacity; or
 - (2) The average annual earning potential derived from the labor market survey conducted by the Program as representing the claimant’s wage-earning capacity.

3330.5 The phrase “labor market survey,” means a determination of the types of jobs that a claimant is capable of doing, based on the following factors:

- (a) The nature of his or her injury;
- (b) The degree of physical impairment;
- (c) His or her age;
- (d) His or her qualifications for other employment;
- (e) The availability of suitable employment; and
- (f) Other factors or circumstances which may affect his or her wage-earning capacity as a worker with a disability.

3330.6 The phrase “average annual earning potential,” means the average of all annual earnings for jobs that were available and considered by the Program at the time it conducted the labor market survey.

3330.7 The claimant’s wage-earning capacity, in terms of percentage, is computed by dividing the claimant’s earnings by the current pay rate. The comparison of earnings and “current” pay rate for the job held at the time of injury need not be made as of the beginning of partial disability. The Program may use any convenient date for making the comparison as long as both wage rates are in effect on the date used for comparison.

3330.8 The claimant’s salary, if he or she was an employee under section 2301(1)(A) of the Act, for the purposes of § 3330 shall be determined according to grade and step reflected in the claimant’s official personnel record at the time of injury, disability or recurrence.

3330.9 The claimant's wage-earning capacity in terms of dollars is computed by first multiplying the pay rate for compensation purposes by the percentage of wage-earning capacity. The resulting dollar amount is then subtracted from the pay rate for compensation purposes to obtain the claimant's loss of wage-earning capacity.

3330.10 The formula for calculating partial disability based on a monthly rate of pay shall be as follows:

$$\text{Partial Disability Compensation} = \frac{2}{3} \text{ OR } \frac{3}{4} [(\text{Pay Rate}) - ((\text{Payrate})(\frac{\text{Earnings}}{\text{Current Pay Rate}}))]$$

3330.11 To convert the monthly partial disability monetary compensation into bi-weekly installments, the monthly compensation rate shall be multiplied by twelve (12) and divided by twenty-six (26).

3330.12 Cost-of-living adjustments shall be applied to the partial disability compensation rate in accordance with § 3339.2(d) of this chapter.

3331 AUGMENTED PAY

3331.1 Pursuant to section 2310 of the Act, amended September 24, 2010, only employees hired before January 1, 1980 are entitled to an augmented benefits rate for dependents.

3332 COMPUTATION OF WAGE INDEMNITY; STATUTORY MAXIMUM AND MINIMUM

3332.1 The statutory maximum and minimum for wage indemnity shall be calculated in accordance to section 2312 of the Act. The calculation 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.

3333 OVERPAYMENT

3333.1 If the Program makes an overpayment to a claimant as a result of an error of fact or law, the Program shall recoup the overpayment from the claimant or, if a claimant is receiving compensation from the Program, adjust the claimant's compensation payments to correct and recoup the overpayment, as provided in this section.

3333.2 In order to adjust or recoup an overpayment, the Program must make a preliminary finding as to whether the claimant was "at fault," as defined under section 2329(b)(2)(A)(i) of the Act, in the creation of the overpayment.

- 3333.3 If the Program makes a preliminary finding that the claimant was at fault in the creation of the overpayment, the Program shall issue a notice of adjustment or recoupment forthwith.
- 3333.4 If the Program preliminarily finds that the individual was not at fault in the creation of the overpayment, a notice of adjustment or recoupment shall only issue where the Program has determined that the adjustment or recoupment would not defeat the purpose of the Act or be against equity and good conscience, as provided under section 2329(b) of the Act.
- 3333.5 A notice of adjustment or recoupment shall advise the claimant 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 and present evidence within thirty (30) days of the notice to challenge
 - (1) The fact and amount of the overpayment; or
 - (2) The Program's preliminary finding of claimant's fault in the creation of the overpayment; and
 - (e) That the claimant's failure to present evidence within the thirty (30) days provided shall result in a final determination supporting recoupment of the overpayment, unless the deadline to present evidence is extended pursuant to § 3333.9 of this chapter.
- 3333.6 Any request for a waiver or challenge to a preliminary finding of overpayment must be submitted to the Program within thirty (30) days of the date of the overpayment notice issued by the Program.
- 3333.7 Failure to submit evidence to challenge the overpayment or in support of a waiver pursuant to section 2329(b-1)(2) of the Act within thirty (30) days of the date of the overpayment notice shall result in the issuance of a final determination without participation of the claimant.
- 3333.8 Final determinations on overpayment shall be determined based section 2329(b-1)(2) of the Act.

- 3333.9 If a claimant fails to request a waiver or challenge a preliminary finding of overpayment within thirty (30) days of the date of the overpayment notice and
- (a) A final determination has not issued pursuant to § 3333.6, the claimant may submit the request directly to the Program for consideration pursuant to section 2329(b-1)(2) of the Act.
 - (b) A final determination has issued pursuant to § 3333.6, the claimant may appeal the Program's final determination to the Chief Risk Officer pursuant to § 3356.1 of this chapter. The Chief Risk Officer shall grant the appeal and remand the belated challenge or waiver of overpayment to the Program for consideration pursuant to section 2329(b-1)(2) of the Act, only where the claimant submits evidence that establishes the claimant's inability to timely act resulted from:
 - (1) Good cause;
 - (2) Mental or physical incapacity; or
 - (3) Lack of timely receipt of the notice of adjustment or recoupment.
- 3333.10 The Program may treat any overpayment as an employee debt to the District pursuant to section 2902 and 2904 of the Act. Pursuant to section 2901(g) of the Act, sections 2901(a) through (f) of the Act shall not apply to limit the Program's ability to collect overpayments; and
- 3333.11 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, the Program shall refer the matter to the Office of the Inspector General, the United States Attorney's Office, or another appropriate law enforcement entity.

3334 ELECTION OF COMPENSATION

- 3334.1 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 § 3337 of this chapter; or
 - (b) 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.

- 3334.2 The phrase “salary, pay, or remuneration” as used in this section includes:
- (a) Severance pay, separation pay and “buy-out” payments to a claimant from the claimant’s Employment Agency; and
 - (b) Federal retirement benefits accrued as a result of District employment.
- 3334.3 A claimant may not receive indemnity compensation concurrently with retirement pay or PSWCP death benefits concurrently with survivor annuity from the District of Columbia. The claimant must elect the benefit that he or she wishes to receive, provided that such election is permitted per the terms of the applicable retirement pay or survivor annuity. Once made, if permitted, the election is only revocable prospectively. A claimant may, however, receive compensation schedule payments pursuant to section 2307 of the Act, at the same time that he or she receives District government retirement pay.
- 3334.4 A claimant may not receive indemnity compensation concurrently with federal retirement pay. Once a claimant applies and receives federal retirement pay, the claimant is no longer eligible for temporary indemnity compensation. A claimant may, however, receive compensation schedule payments pursuant to section 2307 of the Act, at the same time that he or she receives federal civil service retirement pay.
- 3334.5 A claimant may only receive compensation concurrently with military retired pay, retirement pay, retainer pay or equivalent pay for service in the United States Armed Forces or other uniformed services.
- 3334.6 When a claimant begins receiving indemnity compensation under this section, it shall be the claimant’s obligation to inform the Program if the claimant receives prohibited compensation under this subsection for as long as the claimant receives indemnity compensation from the Program.
- 3334.7 Whenever the Program determines that a claimant is receiving or may be entitled to receive the salary, pay, remuneration, or benefits listed in this section, it may forward to the claimant a form for the election of which compensation the employee or claimant wishes to receive. If the claimant has already received salary, pay, remuneration, or benefits in violation of this section, the Program shall initiate overpayment proceedings.
- 3334.8 A claimant shall not be eligible for indemnity compensation, if he or she was employed by the District of Columbia or the federal government before October 1, 1987, and is receiving disability benefits from the federal government for the same injury.
- 3334.9 Remuneration, such as severance pay, received pursuant to § 3334.1(a) of this chapter, shall be off-set against:

- (a) Any compensation benefits due or paid to claimant; or
- (b) Lump sum payment a claimant received in commutation installment payments.

3339 COST OF LIVING ADJUSTMENTS

3339.1 Cost of living adjustments shall be applied to compensation calculated pursuant to section 2305 or 2306 of the Act.

3339.2 The following cost-of-living adjustments apply in the calculation of compensation for disability or death:

- (a) Cost-of-Living Adjustments under 5 U.S.C. § 8146a, FECA Bulletin No. 14-03

<u>EFFECTIVE DATE</u>	<u>RATE</u>	<u>EFFECTIVE DATE</u>	<u>RATE</u>
10/01/66	12.5%	06/01/75	4.1%
01/01/68	3.7%	01/01/76	4.4%
12/01/68	4.0%	11/01/76	4.2%
09/01/69	4.4%	07/01/77	4.9%
06/01/70	4.4%	05/01/78	5.3%
03/01/71	4.0%	11/01/78	4.9%
05/01/72	3.9%	05/01/79	5.5%
06/01/73	4.8%	10/01/79	5.6%
01/01/74	5.2%	04/01/80	7.2%
07/01/74	5.3%	09/01/80	4.0%
11/01/74	6.3%	03/01/81	3.6%

- (b) Cost-of-Living Adjustments under D.C. LAW 2-139, § 2341, 25 DCR 5740 (March 3, 1979)

<u>EFFECTIVE DATE</u>	<u>RATE</u>	<u>EFFECTIVE DATE</u>	<u>RATE</u>
11/01/81	5.1%	02/01/87	3.8%
12/01/82	4.0%	12/01/87	4.2%
10/01/83	3.7%	12/01/88	4.0%
09/01/84	4.6%	05/01/89	3.7%
09/01/85	4.1%		

- (c) Cost-of-Living Adjustments under D.C. CODE § 1-623.41, 37 DCR 778 (March 15, 1990)

<u>EFFECTIVE DATE</u>	<u>RATE</u>	<u>EFFECTIVE DATE</u>	<u>RATE</u>
10/03/93	5.0%	10/05/03	2.5%
04/02/95	-4.0%	07/10/05	3.5%
10/01/95	4.2%	10/02/05	4.0%
10/11/98	6.0%	10/01/06	3.0%
04/09/00	6.0%	10/14/07	3.25%
10/08/00	4.0%		

- (d) Cost-of-Living Adjustments under D.C. Law 21-0039, 62 DCR 13744-13745 (October 23, 2015)

After December 15, 2015, the percentage amount and effective date of an across-the-board salary increase reflected in any Career Service (General) District Government Salary Schedule that is approved in accordance with sections 1105 and 1006 of the Act.

3339.3 Notwithstanding consideration of any permitted premium pay, the application of any cost of living adjustment shall not result in a monthly pay rate that exceeds sixty-six and two-thirds ($66\frac{2}{3}$) percent (or seventy-five (75) percent, if an augmented rate of indemnity compensation is permitted) of the current monthly pay rate (i.e. $\frac{1}{12}$ of the current annual salary) for the grade and step of the claimant's pre-injury position.

3340 PERMANENT DISABILITY

3340.1 A claimant may be eligible for permanent disability indemnity compensation upon:

- (a) Reaching maximum medical improvement for a disability and temporary disability compensation has ceased;
- (b) Receiving four hundred-forty-eight (448) weeks of temporary total or partial disability; or
- (c) Loss of use of both hands, both arms, both feet, or both legs, or the loss of sight of both eyes.

3340.2 Claims for permanent disability by claimants, who are eligible to request an award pursuant to § 3340.1(a) of this chapter shall be filed with the Program within one hundred and eighty (180) days of the termination of temporary disability indemnity benefits. Claimants who fail to request an award within one hundred and eighty (180) days of termination of temporary disability indemnity benefits shall not be entitled to permanent disability indemnity benefits thereafter, unless there is good cause to excuse the delay.

- 3340.3 Claims for permanent disability by claimants, who are eligible to request an award pursuant to § 3340.1(b) of this chapter shall be filed as a hearing for permanent disability with the Office of Administrative Hearings within fifty-two (52) weeks after receipt of the 448th week of temporary total or partial disability indemnity benefits. Claimants who fail to request a hearing within the last fifty-two (52) weeks of five hundred (500) weeks of benefits shall not be entitled to permanent temporary or partial disability indemnity benefits thereafter.
- 3340.4 A claimant eligible for permanent disability pursuant to § 3340.1(c) of this chapter may be awarded a scheduled award for permanent disability in lieu of temporary disability upon filing a claim for indemnity compensation.
- 3340.5 To file a claim for permanent disability under section 2307 of the Act, the claimant shall complete Form 12 and provide supporting information and documentation, including a permanent disability rating performed in accordance to the most recent edition of the AMA Guides from a qualified physician.
- 3340.6 If a claimant requests a schedule award pursuant to § 3340.1(a) of this chapter, the Program shall:
- (a) Review the request;
 - (b) Request additional information or action as necessary, including the scheduling of a physical examination(s), to evaluate the extent of permanency; and
 - (c) Issue a written decision within thirty (30) days of receipt of all required documents that shall:
 - (1) Sets forth the basis for accepting or denying the request; and
 - (2) Be accompanied by information about the claimant's right to appeal the Program's decision to the Chief Risk Officer, as provided in § 3356 of this chapter.
- 3340.7 Permanent disability compensation shall be computed pursuant to § 3329 of this chapter and in accordance with the schedule provided at section 2307 of the Act and shall not be subject to cost-of-living-adjustments.
- 3340.8 Permanent partial disability shall be computed by:
- (a) Calculating the monthly compensation less COLAS pursuant to § 3329 of this chapter;
 - (b) Converting the monthly compensation to weekly compensation by multiplying the monthly compensation rate by twelve (12) and dividing

the product by fifty-two (52);

- (c) The adjusted award schedule for partial disability shall be computed by multiplying the total number of weeks available for the impairment member under section 2307(c) of the Act by the percentage impairment rating provided by the physician; and
- (d) The total award for partial disability shall be computed by multiplying the adjusted award schedule for partial disability by the weekly compensation rate computed pursuant to § 3340.8(b).

3340.9 Medical reports establishing eligibility and determination for schedule awards under section 2307 of the Act shall be prepared by physicians with specific training and experience in the use of the most recent edition of the American Medical Association Guides to the Evaluation of Permanent Impairment.

3340.10 A claimant who requests or receives a schedule award pursuant to section 2307 of the Act is ineligible for further indemnity payment(s) for temporary disability arising out of the same injury for which a schedule award has been approved or paid.

3340.11 A claimant may not receive indemnity compensation for temporary disability and a schedule award at the same time.

3344 MODIFICATION, FORFEITURE, SUSPENSION OR TERMINATION OF BENEFITS

3344.1 A claimant's benefits shall be modified if the Program has reason to believe that the claimant's PSWCP file and records establish the following:

- (a) The disability for which compensation was paid has ceased or lessened;
- (b) The disabling condition is no longer causally related to the employment;
- (c) The claimant's condition has changed from total disability to partial disability;
- (d) The employee has been released to return to work in a modified or light duty basis; or
- (e) The Program determines based on strong compelling evidence that the initial decision was in error.

3344.2 A claimant's benefits shall be forfeited if substantial evidence in the claimant's PSWCP file establishes that claimant failed to complete a report of earnings pursuant to § 3338.

- 3344.3 A claimant's benefits shall be terminated if the Program has reason to believe that the claimant's PSWCP file establishes the following:
- (a) The disability for which compensation was paid has ceased;
 - (b) The disabling condition is no longer causally related to the employment;
 - (c) The employee has been released to return to work or has returned to work based upon clear evidence;
 - (d) The claimant has failed to complete a report of earnings for more than ninety (90) days; or
 - (e) The claimant has been offered a modified duty assignment and has elected not to accept the modified duty assignment.
- 3344.4 A claimant's benefits shall be suspended if the Program has reason to believe that the claimant's PSWCP file establishes the following:
- (a) The claimant failed to attend an appointment for Additional Medical Examination (AME), bring medical records under the claimant's possession and control, or any other obstruction of the examination;
 - (b) The claimant failed to follow prescribed and recommended course of medical treatment from the treating physician; or
 - (c) A claimant hired on or after January 1, 1980, without good cause failed to apply for or undergo vocational rehabilitation when so directed by the Program.
- 3344.5 If substantial evidence in the claimant's PSWCP file establishes that a claimant hired before January 1, 1980, without good cause fails to apply for or undergo vocational rehabilitation, when directed by the Program:
- (a) The Program may propose a reduction of indemnity compensation and present the proposed reduction to the Compensation Review Board (CRB) for review; and
 - (b) The CRB shall affirm the reduction in benefits, if it determines that there is substantial evidence in the record to show that the wage-earning capacity of the individual would probably have substantially increased, absent the claimant's failure to attend vocational rehabilitation, as directed by the Program.
 - (1) "Substantially increase" means an increase in wage-earning

capacity by fifty percent (50%) or more.

- (2) The claimant's wage-earning capacity is computed by conducting a labor market research based on the assumption the claimant has enrolled in vocational rehabilitation to arrive at the claimant's "average annual earning potential." The average annual earning potential shall be divided by twelve to arrive at the claimant's monthly wage-earning capacity. The claimant's monthly wage earning capacity shall be compared against the claimant's monthly pay. If the claimant's wage earning capacity exceeds the claimant's monthly pay by fifty percent (50%), the Program may propose a reduction of indemnity compensation.

3344.6 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.

3344.7 Prior written notice need not be given when an employee's benefits are suspended or forfeited pursuant to this section.

3344.8 In all claims, the claimant is responsible for continual submission, or arranging for the continual submission of, a medical report from the attending physician as evidence supporting the reason for continued payment of compensation.

3344.9 For indemnity compensation benefits, "reason to believe" that the disability for which compensation was paid has ceased pursuant to §§ 3344.1(a) and 3344.3(a) of this chapter includes a claimant's failure to provide contemporaneous medical evidence to show that

(a) The accepted condition remains disabling; and

(b) The nature and extent of the ongoing disability necessitate a claimant's continued absence from work or restriction from performing the full scope of pre-injury duties.

3344.10 For medical compensation benefits, "reason to believe" that the disability for which compensation was paid has ceased pursuant to §§ 3344.1(a) and 3344.3(a) of this chapter includes a claimant's lack of treatment for the accepted condition for one year or more.

3345 ADJUSTMENTS AND CHANGES TO BENEFITS

3345.1 Except as provided in §§ 3345.3, 3345.4, 3345.5 and 3345.6 of this chapter, the Program will provide the claimant with prior written notice of the proposed action and give the claimant thirty (30) days to submit relevant evidence or argument to

support entitlement to continued payment of compensation, prior to issuance of an Eligibility Determination (ED), where the Program has a reason to believe that compensation should be either modified or terminated due to a change of condition pursuant to section 2324(d)(1) and (4) of the Act. An ED shall be accompanied by information about the employee's appeal rights.

- 3345.2 Prior notice provided under this section will include a description of the reasons for the proposed action and a copy of the specific evidence upon which the Program is basing its determination. Payment of compensation will continue until any evidence or argument submitted has been reviewed and an appropriate decision has been issued, or until thirty (30) days have elapsed after the issuance of the notice if no additional evidence or argument is submitted.
- 3345.3 Prior written notice will not be given when a claimant dies, when the Program either reduces or terminates compensation upon a claimant's return to work, when the Program terminates only medical benefits after a physician indicates that further medical treatment is not necessary or has ended, or when the Program denies payment for a particular medical expense.
- 3345.4 The Program will not provide prior written notice when compensation is forfeited for:
- (a) A claimant's failure to report earnings from employment or self-employment; or
 - (b) A claimant's failure to accept a modified duty assignment, when one is offered to him or her.
- 3345.5 The Program will not provide prior written notice when compensation is suspended due to one of the following:
- (a) A claimant's failure to attend vocational rehabilitation;
 - (b) A claimant's failure to follow prescribed and recommended courses of medical treatment from the treating physician; or
 - (c) A claimant fails to cooperate with the Program's request for a physical examination.
- 3345.6 The Program will not provide prior written notice when compensation is terminated due to one of the following:
- (a) The award of compensation was for a specific period of time which has expired;
 - (b) The death of a claimant;

- (c) The claimant has been released to return to work or has returned to work based upon clear evidence; or
- (d) A claimant's conviction for fraud in connection with a claim under the Act.

3345.7 The Program shall provide written notice, but not an ED, where there are de minimus adjustments resulting from the application of COLAs or corrections of technical errors that affect five percent (5%) or less of the claimant's monetary benefits over the course of a 12-month period. The reasons for such de minimus changes shall be documented in claimant's PSWCP file.

3345.8 If the claimant submits evidence or argument prior to the issuance of the decision, the Program will evaluate the submission in light of the proposed action and undertake such further development as it may deem appropriate, if any. Evidence or argument that is repetitious, cumulative, or irrelevant will not require any further development. If the claimant does not respond within thirty (30) days of the prior written notice, the Program will issue a decision consistent with its prior written notice. The Program will not grant any request for an extension of this thirty (30) day period.

3345.9 Evidence or argument that refutes the evidence upon which the proposed action was based will result in the continued payment of compensation. If the claimant submits evidence or argument that fails to refute the evidence upon which the proposed action was based but which requires further development of the evidence and basis for the decision, the Program will not provide the claimant with another notice of its proposed action upon completion of such development. Once any further development of the evidence is completed, the Program will either continue payment or issue a decision consistent with its prior written notice or further developed evidence.

3346 WEIGHING MEDICAL EVIDENCE

3346.1 When the Program receives medical evidence from more than one source, it should evaluate the relative value, or merit, of each piece of medical evidence.

3346.2 In evaluating the merits of medical reports, no preference shall be given to treating physicians. The Program shall evaluate the probative value of the report and assign greater value to:

- (a) An opinion based on complete factual and medical information over an opinion based on incomplete, subjective or inaccurate information. Generally, a physician who has physically examined a patient, is knowledgeable of his or her medical history, and has based the opinion on an accurate factual basis, has weight over a physician conducting a file

review with no knowledge of the patient's medical history or fails to take into account or omits other relevant medical conditions that relate to or may be related to the condition at issue.

- (b) An opinion based on a definitive test(s) and includes the physician's findings. Some medical conditions can be established by objective testing. Medical reports that contain objective findings shall be assigned greater weight than those that fail to account for or include objective findings, where the condition can be established or excluded by such finding.
- (c) A well-rationalized opinion over one that is unsupported by affirmative evidence. The term "rationalized" means that the statements of the physician are supported by an explanation of how his or her conclusions are reached, including appropriate citations or studies. An opinion that is well-rationalized provides a convincing argument for a stated conclusion that is supported by the physician's reasonably justified analysis of relevant evidence. For example, an opinion which is supported by the interpretation of diagnostic evidence and relevant medical or scientific literature is well-rationalized. Conversely, an opinion which states a conclusion without explaining the interpretation of evidence and reasoning that led to the conclusion is not well-rationalized.
- (d) The opinion of an expert over the opinion of a general practitioner or an expert in an unrelated field. However, conclusive statements of an expert without any underlying justification, other than affirmation of the physician's expertise, are not to be viewed as carrying significant probative value over that of a general practitioner report that is well-rationalized and/or supported by applicable affirmative evidence.
- (e) An unequivocal opinion over one that is vague or speculative. A physician offering a clear, unequivocal opinion on a medical matter is to be viewed as more probative compared to an opinion that waivers or hesitates in its presentation or contains vague and speculative language. An opinion which contains verbiage such as "possibly could have" or "may have been" or provides a guess or estimation indicates speculation on the part of the physician.

3347 GOOD CAUSE DETERMINATION

3347.1 A good cause determination shall be supported by evidence that establishes good cause as defined at § 3399.1(q) and the proponent's failure to act does not result in undue prejudice to the opposing party.

3353 REQUESTS FOR AUDIT OF INDEMNITY BENEFITS

- 3353.1 A claimant who believes that the Program has incorrectly calculated his or her indemnity benefit may request an audit of the Program's calculation by completing Form A-1 and submitting it to the Chief Risk Officer.
- 3353.2 The Chief Risk Officer shall affirm the Program's calculations, if it is supported by substantial evidence in the record. Otherwise, at the discretion of the Chief Risk Officer, the Program's decision may be modified, revised or remanded to the Program with instructions.
- 3353.3 The Chief Risk Officer shall notify the claimant in writing of his or her decision on the audit request within thirty (30) days of the Program's receipt of the request, unless the Chief Risk Officer provides notice in writing that extenuating circumstances preclude him or her from making a decision within this period.
- 3353.4 If no decision or notice of extenuating circumstances is issued within thirty (30) days, the calculation which forms the basis of the claimant's request for an audit shall be deemed the final decision of the agency in response to the claimant's request and the claimant may seek review of the calculations before the Superior Court of the District of Columbia on timely petition for review by the claimant.
- 3353.5 Any retroactive benefits due to the claimant as result of a request made under this chapter are subject to the limitations of D.C. Code § 12-301(8).

3355 OFFICE OF ADMINISTRATIVE HEARINGS (OAH) AND OFFICE OF HEARINGS AND ADJUDICATION (OHA), JURISDICTION

- 3355.1 Beginning December 1, 2016, the following decisions shall be appealed to the Office of Administrative Hearings (OAH):
- (a) Initial awards for or against compensation benefits pursuant to section 2324(b) of the Act;
 - (b) Final decisions concerning the necessity, character or sufficiency of medical care or services following an appeal to a utilization review pursuant to section 2323(a-2)(4) of the Act; and
 - (c) Modification of awarded benefits pursuant to section 2324(d) of the Act.
- 3355.2 Requests for determination of whether claimant has a permanent disability pursuant to section 2306a shall be made to the Office of Administrative Hearings (OAH).
- 3355.3 All appeals filed prior to December 1, 2016, for decisions described at 7 D.C.M.R. §§ 3344.1(a), (b), and (c) (repealed by adoption of these regulations) shall be made to the Department of Employment Services, Office of Hearings and Adjudications (OHA).

3356 OFFICE OF RISK MANAGEMENT, JURISDICTION

3356.1 A claimant who is dissatisfied with any other decision issued by the Program may only appeal the decision to the Chief Risk Officer.

3356.2 Appeals to the Chief Risk Officer shall:

- (a) Be filed within ten (10) days from the date the decision was issued, unless otherwise provided;
- (b) Contain information required under this chapter; and
- (c) Include all documents and other evidence in support of the claimant's arguments.

3356.3 The Chief Risk Officer shall affirm the Program's decision, if it is supported by substantial evidence in the record. Otherwise, at the discretion of the Chief Risk Officer, the Program's decision may be modified, revised or remanded to the Program with instructions.

3356.4 The Chief Risk Officer shall notify the claimant in writing of his or her decision within thirty (30) days of the Program's receipt of the appeal. If no decision is issued within those thirty (30) days, the Program's decision shall be deemed the final decision of the agency.

3356.5 The final decision of the agency under § 3356.4 may be reviewed by the Superior Court of the District of Columbia on timely petition for review by the employee pursuant to District of Columbia Superior Court Rules of Civil Procedure Agency Review Rule 1.

3357 OAH AND OHA, HEARING RULES

3357.1 OAH Rules 2950 through 2969 contain the Rules for management of PSWCP cases filed pursuant to section 2324 of the Act with the Department of Employment Services, Office of Hearings and Adjudications (OHA) and Office of Administrative Hearings (OAH).

3357.2 If no procedure is specifically prescribed by these Rules, the Superior Court for the District of Columbia Rules may be used as guidance, to the extent practicable.

3357.3 The rules shall govern the conduct of hearing, unless the ALJ determines its application impairs the ALJ's ability to ascertain the claimant's rights pursuant to section 2324(b)(2) of the Act.

3358 Hearings, Standard of Review

3358.1 All appeals of Program decisions before the OAH and OHA shall be reviewed under a de novo standard of review.

3359 Hearings, Burden of Proof

3359.1 Burden of Proof, Initial Determination. Claimant has the burden to prove, by a preponderance of the evidence (more likely than not)

(a) That the injury was work related; and

(b) The extent and nature of Claimant's injuries and disability.

3359.2 Burden of Proof, Termination or Modification of Award. If the Agency seeks to terminate or modify an award, it must present substantial evidence that the Program had reason to believe the claimant's condition has sufficiently changed to warrant modification or termination of benefits. Once the Agency presents such evidence, the claimant has the burden to prove, by a preponderance of the evidence, the entitlement to ongoing benefits, as well as the nature and extent of disability.

3359.3 Burden of Proof, Recurrence of Disability. The claimant has the burden to prove by clear and convincing evidence that a recurrence of disability is causally related to the original injury.

3359.4 Burden of Proof, Permanent Disability. The claimant has the burden to prove, by a preponderance of the evidence that he or she is entitled to an award for permanent disability.

3360 HEARING DECISIONS, COMPLIANCE AND ENFORCEMENT

3360.1 The ALJ shall issue an order to reverse, modify, affirm, or remand a determination rendered by the claims examiner within thirty (30) days after the hearing ends or the record closes.

3360.2 Unless the OHA or OAH decision is appealed or otherwise stayed by a reviewing administrative or judicial forum, the Program shall comply with the decision within thirty (30) calendar days from the date the decision becomes final.

3360.3 If the Program fails to comply with the final decision within the time prescribed at § 3360.2 of this chapter:

(a) The claimant shall file Form A-1 with the General Counsel for the Office of Risk Management to request computation of benefits due pursuant to the compensation order;

- (b) Within thirty (30) days from the date the request was received, the Program shall certify an amount due to the claimant under the compensation order; and
- (c) Once a certification of compensation is issued, the claimant may file for a lien in the amount certified against the Disability Compensation Fund, the General Fund, or any other District fund or property to pay the compensation award with the Superior Court of the District of Columbia.

3360.4 A claimant may dispute the amount calculated and certified by the Program by appealing the decision to the Chief Risk Officer pursuant to § 3356.

3360.5 Increases in awards available under section 2324(g) of the Act shall be limited to awards for indemnity compensation.

3361 INTEREST ON COMPENSATION AWARDS

3361.1 Interest may only be awarded where the Program fails to make payment toward the compensation award within twelve (12) months after the date of the compensation order.

3361.2 Interest on compensation awards, when awarded, shall:

- (a) Be the lower of four percent (4%) per annum or the rate provided under D.C. Code § 28-3302(c),
- (b) Not begin to accrue until twelve (12) months have elapsed after the date of the compensation order; and
- (c) Not apply to any increase in award payment pursuant to section 2324(g) of the Act.

3361.3 Interest on compensation awards shall be limited to simple interest.

3362 ATTORNEY'S FEES

3362.1 “Actual benefits secured” for the purpose of section 2327 means the total amount of benefits secured by an attorney in connection with a hearing through the date of the compensation order only and shall not include future benefits.

3362.2 Attorney’s fees awarded under section 2327 of the Act shall be computed at fifty percent (50%) of the most current United States Attorney’s Office Attorney’s Fees Matrix. In no event shall the attorney’s fees exceed twenty percent (20%) of the lump sum indemnity benefit secured as of the issuance date of the compensation order.

3363 ADMINISTRATIVE AND JUDICIAL REVIEW

- 3363.1 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.
- 3363.2 Any party adversely affected or aggrieved by a compensation order or final decision issued by the OHA or OAH 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 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.

3399 DEFINITIONS

- 3399.1 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. & 2016 Supp.) shall apply to this chapter. In addition, for purposes of this chapter, the following definitions shall apply and have the meanings ascribed:
- (a) The 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. & 2016 Supp.)), as amended and as it may be hereafter amended.
 - (b) 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 or Administrative Law Judge in the Office of Administrative Hearings.
 - (c) Aggravated injury -- The exacerbation, acceleration, or worsening of pre-existing disability or condition caused by a discrete event or occurrence and resulting in substantially greater disability or death.
 - (d) 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.
 - (e) Beneficiary -- an individual who is entitled to receive death benefits under

the Act.

- (f) Claim -- an assertion properly filed and otherwise made in accordance with the provisions of this chapter that an individual is entitled to compensation benefits under the Act.
- (g) Claim file -- all program documents, materials, and information, written and electronic, pertaining to a claim, excluding that which is privileged or confidential under District of Columbia law.
- (h) Claimant -- an individual who receives or claims benefits under the Act.
- (i) Claimant's Representative -- means an individual or law firm properly authorized by a claimant of this chapter to act for the claimant in connection with a claim under the Act or this chapter.
- (j) Controversion -- means to dispute, challenge or deny the validity of a claim for Continuation of Pay.
- (k) Disability -- means the incapacity, because of an employment injury, to earn the wages the employee was receiving at the time of injury. It may be partial or total.
- (l) Earnings -- for the purposes of § 138, 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.
- (m) Eligibility Determination (ED) -- a decision concerning, or that results in, the termination or modification of a claimant's existing Public Sector Workers' Compensation benefits that is brought about as a result of a change to the claimant's condition.
- (n) Employee -- means
 - (1) 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;
 - (2) 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. & 2016 Supp.). 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 services to the District government or its instrumentalities; and

- (3) An individual selected pursuant to federal law and serving as a petit or grand juror and who is otherwise an employee for the purposes of this chapter as defined by paragraphs (i) and (ii) above.
- (o) Employee’s Representative -- means an individual or law firm properly authorized by an employee in writing of this chapter to act for the employee in connection with a request for continuation of pay under the Act or this chapter.
- (p) Employing 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.
- (q) Good cause -- omissions caused by “excusable” neglect or circumstances beyond the control of the proponent. Inadvertence, ignorance or mistakes construing law, rules and regulations do not constitute “excusable” neglect.
- (r) Health care professional -- means a person who has graduated from an accredited program for physicians, advance practice nurses, physician assistants, clinical psychologist, and is licensed to practice in the jurisdiction where care is provided.
- (s) Immediate supervisor -- the District government officer or employee having responsibility for the supervision, direction, or control of the claimant, or one acting on his or her behalf in such capacity.
- (t) Indemnity 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 a disability directly arising out of an injury sustained while in the

performance of his or her duty, calculated pursuant to the provisions of this chapter.

- (u) Initial Determination (ID) -- a decision regarding initial eligibility for benefits under the Act, including decisions to accept or deny new claims, pursuant to this chapter.
- (v) Latent disability -- a condition, disease or disability that arises out of an injury caused by the employee's work environment, over a period longer than one workday or shift and may result from systemic infection, repeated physical stress or strain, exposure to toxins, poisons, fumes or other continuing conditions of the work environment.
- (w) Mayor -- the Mayor of the District of Columbia or a person designated to perform his or her functions under the Act.
- (x) Medical opinion -- a statement from a physician, as defined in section 2301 of the Act, that reflects judgments about the nature and severity of 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.
- (y) Office of Administrative Hearings (OAH) -- the office where Administrative Law Judges adjudicate public sector workers' compensation claims under sections 2323(a-2)(4), 2324(b)(1), and (d)(2) of the Act, pursuant to jurisdiction under D.C. Official Code § 2-1831.03 (b)(1) (2006 Repl.), section 2306a of the Act, and rules set forth in this chapter.
- (z) Office of Hearings and Adjudication (OHA) -- 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 sections 2323(a-2)(4), 2324(b)(1), and (d)(2) of the Act, and rules set forth in this chapter.
- (aa) 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 (PSWCP).
- (bb) Panel physician -- means a physician approved by the Program pursuant to § 124.2 of this chapter to provide medical treatment to persons covered by the Act.
- (cc) Pay rate for compensation purposes -- means the employee's pay, as determined under section 2314 of the Act, at the time of injury, the time

disability begins, or the time compensable disability recurs if the recurrence begins more than six months after the injured employee resumes regular full-time employment with the District of Columbia government, whichever is greater, except as otherwise determined under section 2313 of the Act with respect to any period. Consideration of additional remuneration in kind for services shall be limited to those expressly authorized under section 2314(e) of the Act.

- (dd) Permanent partial disability payment (PPD) -- schedule award indemnity compensation payable to a partially disabled claimant pursuant to section 2307 of the Act and § 3340 of this chapter.
- (ee) Permanent total disability payment (PTD) -- schedule award indemnity compensation payable to a completely disabled claimant pursuant to section 2307 of the Act and § 3340 of this chapter, when a qualified physician has determined that a claimant has reached maximum medical improvement and is unable to work on a permanent basis.
- (ff) Program -- the Public Sector Workers' Compensation Program of the Office of Risk Management, including a third party administrator thereof.
- (gg) 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.
- (hh) Recurrence of disability – means a disability that reoccurs within one (1) year after the date indemnity compensation terminates or, if such termination is appealed, within one (1) year after the date of the final order issued by a judicial entity, caused by a spontaneous change in a medical condition which had resulted from a previous injury or illness without an intervening injury or new exposure to the work environment that caused the illness. This term also means an inability to work that takes place when a modified duty assignment made specifically to accommodate an employee's physical limitations due to his or her work-related injury or illness is withdrawn or when the physical requirements of such an assignment are altered so that they exceed his or her established physical limitations. A recurrence of disability does not apply when a modified duty assignment is withdrawn for reasons of misconduct, non-performance of job duties or other downsizing or where a loss of wage-earning capacity determination is in place.

- (ii) Recurrence of medical condition -- means a documented need for further medical treatment after release from treatment for the accepted condition or injury when there is no accompanying work stoppage. Continuous treatment for the original condition or injury is not considered a “need for further medical treatment after release from treatment,” nor is an examination without treatment.
- (jj) Return to “Regular Full-Time” position -- means the claimant returned to employment or a position that is established and not fictitious, odd-lot or sheltered, not a job created especially for a claimant, for the same number of hours of work per week as prior to injury.
- (kk) Traumatic injury -- means a condition of the body caused by a specific event or incident, or series of events or incidents, within a single workday or shift. Such condition must be caused by external force, including physical stress or strain, which is identifiable as to time and place of occurrence and member or function of the body affected.
- (ll) Temporary partial disability payment (TPD) -- indemnity compensation payable to a claimant, who has a wage earning capacity and has not reached maximum medical improvement, calculated pursuant to section 2306 of the Act and § 3330 of this chapter.
- (mm) Temporary total disability payment (TTD) -- indemnity compensation payable to a claimant, who has a complete loss of wage earning capacity and has not reached maximum medical improvement, calculated pursuant to section 2305 of the Act and § 3329 of this chapter.
- (nn) Treating physician -- the physician, as defined in section 2301 of the Act, who provided the greatest amount of treatment and who had the most quantitative and qualitative interaction with the employee or claimant.