

CHAPTER 4 - ADJUDICATION OF CLAIMS

- 4-1 PURPOSE AND SCOPE.** To furnish the information and instructions necessary for the development and adjudication of claims for compensation benefits under Subchapter 23 of the Comprehensive Merit Personnel Act (CMPA) (D.C. Official Code § 1-623.01 *et seq.*).
- 4-2 AUTHORITY.** D.C. Official Code §1-623.02 authorizes the District of Columbia government to provide compensation for the disability or death of an employee resulting from personal injury arising out of and in the course and scope of employment.
- 4-3 ELIGIBILITY.**
- A. Generally. To be eligible for workers' compensation benefits under the CMPA, an injured worker must be a District of Columbia government employee who sustains an injury arising out of and in the course and scope of employment. The term "employee" is broader than just those in an employer-employee relationship with the District government. D.C. Official Code §1-623.01(5) (*see* Section 4-5(C) below). Compensation benefits for employees may include medical indemnity, wage loss indemnity, or permanent disability in the form of a schedule award. In the event of an employee's death that is directly caused by a compensable work injury, the employee's qualified dependents may be eligible for death benefits.
- 4-4 BENEFIT TYPE.**
- A. Medical Indemnity. Medical indemnity is the provision of medical services, appliances, and supplies for District of Columbia government employees, who are injured during the course and scope of employment. The CMPA requires the Public Sector Workers' Compensation Program (PSWCP) to manage and direct medical care provided to employees with compensable injuries. Payment for medical services, appliances and supplies must be prescribed by qualified health professionals and provided by healthcare providers. Healthcare providers must be on the Program's Panel of Healthcare Providers and subject to prior-authorization requirements by the PSWCP, unless otherwise authorized by law.
- (1) Limitations. Eligibility for or receipt of retirement benefits for District government employment does not limit an injured worker's right to medical treatment for a compensable work injury. Medical services, appliances and supplies rendered must be necessary and appropriate for the treatment of an injury, disease or condition that is causally related to a work injury. Payment for medical benefits and services, beyond initial furnishing of medical care, shall only be made where a claim has been accepted.

- (a) Initial furnishing of medical care may be provided where the immediate superior of the employee certifies that the expense was incurred in respect to an injury accepted by the Employing Agency (EA) as properly compensable under the CMPA. If the EA denies that the employee's injury is properly compensable under the CMPA, the Program must issue a compensability determination prior to authorizing medical treatment.
 - (b) Initial furnishing of medical care includes medical services, appliances and supplies prescribed by a qualified health professional that are:
 - (i) Likely to cure, give relief, reduce the degree or period of disability, or aid in lessening the amount of monthly compensation; or
 - (ii) Necessary to issue a compensability determination.
 - (c) Initial furnishing of medical care shall not exceed the earlier of:
 - (i) Sixty (60) days from the date the Program receives notice of injury; or
 - (ii) The date the Program issues a compensability determination.
- B. Wage-loss Indemnity. An employee with a compensable injury that results in loss of wage-earning capacity may be eligible for temporary total or temporary partial disability benefits pursuant to D.C. Official Code §§ 1-623.05, 06 and 47(e).
- (1) *Types of Wage-Loss Indemnity.*
 - (a) Temporary Total Disability. An injured worker, who suffers a total loss of ability to work is eligible for temporary total disability benefits.
 - (b) Temporary Partial Disability. An injured worker, who has been medically released to return to work with restrictions that prohibit resumption of one's full duties, is eligible for temporary partial disability benefits, if there has been a loss in wage earning capacity, as determined by D.C. Official Code § 1-623.15.
 - (2) *Limitations.*
 - (a) While receiving wage-loss indemnity benefits, an employee is restricted from receiving salary, pay or remuneration from the District of Columbia for District government employment, except for work actually performed.

- (b) A claimant who is eligible for another benefit for the same injury must make an election between wage-loss indemnity benefits and any other benefits to which he or she may be entitled for the same injury within one (1) year of the date of injury, unless there is good cause for extending the election period. The election, once made, is irrevocable. *See* D.C. Official Code §1-623.16 and 7 DCMR § 134.
 - (c) Employees hired after December 31, 1979 are eligible to receive wage-loss indemnity benefits for up to 500 weeks, provided the employee can establish a temporary loss of wage-earning capacity that is causally related to the compensable injury. In all instances, once medical evidence supports a determination that a disability is no longer temporary in nature, but has become permanent, the employee is no longer eligible for temporary disability benefits and the Claims Examiner (CE) should take appropriate steps to modify a claimant's benefits accordingly. *See* D.C. Official Code §1-623.07(3)(A) and 7 DCMR § 140.10 and 140.11.
 - (d) A claimant may not receive wage-loss indemnity concurrently with any retirement pay for District government employment. 7 DCMR §§ 134.3, 134.4.
- C. Permanent Disability. An employee with compensable injury that results in permanent loss or loss of use of a member of function of the body or disfigurement is eligible for permanent disability benefits in the form of a schedule award, as provided at D.C. Official Code §1-623.07, unless the employee was awarded permanent disability benefits prior to February 26, 2015, when the statute was amended to limit permanent disability compensation to schedule awards.
- (1) *Limitations.* A claimant may not receive permanent disability benefits until all temporary disability indemnity benefits have terminated. Once a claimant has received permanent disability benefits, the claimant is no longer eligible to receive temporary wage-loss benefits for the same injury. A request for a permanent disability award must be made by filing Form 12 with supporting medical documentation within 180 days after termination of temporary disability indemnity benefits where the claimant has reached maximum medical improvement (MMI), absent good cause to extend this period. 7 DCMR §§ 140.2(a), 140.5. Otherwise, a request may be made at any time within one (1) year after MMI is reached. 7 DCMR § 140.2(b).
 - (a) A claimant, who is receiving permanent disability benefits for one compensable injury may concurrently receive temporary disability indemnity benefits or permanent disability benefits that result from a subsequent compensable injury.

- (b) A claimant receiving retirement pay for District government employment may receive schedule award payments for a permanent disability concurrently.
 - (c) A claimant who received an initial award for medical indemnity without any temporary wage-loss indemnity may only be entitled to receive a schedule award for any permanent disability after MMI has been reached for the compensable injury.
- (2) *Determination.* The fact that an employee has not returned to work for years, or even decades, is not sufficient evidence to establish permanent disability. Unless there is prima facie evidence of permanent total disability, as defined by D.C. Official Code §1-623.05(b), a determination of permanent disability must be based on medical evidence that establishes an impairment rating in accordance with the most recent edition of the *AMA Guides to the Evaluation of Permanent Impairment*. 7 DCMR § 140.5.
- (a) An employee, who suffers a loss of use of both hands, both arms, both feet, both legs, or the loss of sight of both eyes establishes prima facie permanent total impairment for the complete loss of function in the paired body parts. Where there is such prima facie evidence, the PSWCP may immediately issue an award for permanent disability for 100 percent loss of use based on the schedule provided at D.C. Official Code § 1-623.07 without awarding temporary disability benefits. However, such a decision would only be justified in the rarest of circumstances. In the ordinary course, the extent of impairment cannot be determined and an impairment rating cannot be performed until after the condition has been stabilized and the claimant is at a state of “permanency.” Permanency is synonymous with MMI, and is the point at which the impairment has become well stabilized with or without medical treatment and is not likely to improve in the future with additional treatment. *See* Robert D. Rondinelli, et al., *AMA Guides to the Evaluation of Permanent Impairment*, Ch. 2.5f, 26 (6th Ed. 2008) (*AMA Guides*). Even in the case of dual amputation, the level of amputation and associated proximal problems, which may not be immediately known and if known are not likely to be deemed stabilized, will impact the resulting impairment rating pursuant to the *AMA Guides*. *See AMA Guides*, Chapters 15.6 and 16.6. While the CMPA seemingly permits the issuance of an initial award that includes compensation for permanent disability in these very limited circumstances, there is likely no practical application of this provision in the initial adjudication of a claim. The only likely appropriate course in practice is to issue a schedule award after MMI has been reached for the amputated members or injured

eyes and any associated proximal problems – not as part of an initial award.

- D. Death Benefits. The spouse or domestic partner, child, or other eligible dependent of a District of Columbia government employee, who died as a direct result of a compensable injury, may be eligible for death benefits as discussed in Section 4-7 and D.C. Official Code §§ 1-623.33 and 1-623.34.
- E. Post-Mortem Rights to Benefits. An initial claim for compensation benefits must be made within the life of the injured employee, unless the Estate establishes that there is good cause for why a claim could not be filed prior to the injured employee's death and no prejudice to the Program results from the delay in filing. Otherwise, after an employee's death, the Estate may only make a claim to recover any underpayment of benefits paid prior to the employee's death within three (3) year from the date of the employee's death and any claim to such benefits shall be subject to the limitations of D.C. Official Code § 12-301(8).

4-5 INITIAL DEVELOPMENT OF COMPENSATION CLAIMS (EXCLUDING DEATH CLAIMS). A person claiming compensation benefits under subchapter 23 of the CMPA has the burden of proving the five (5) basic elements of a claim (time, employee status, fact of injury, performance of duty, and causal relationship) by a preponderance of the evidence. *See* 7 DCMR § 119.1. The evidence submitted must be reliable, probative and substantial.

- A. General Claim Development. **All evidence that forms the basis of a decision must be in the claimant's case file.** Evidence may not be incorporated by reference. Evidence relied upon must be placed into the claim file being adjudicated. Information obtained by telephone must be carefully documented in writing and included in the claim file.
- (1) *Claimant Responsibilities*. To be eligible to receive compensation benefits, a claimant must present evidence sufficient to establish all five (5) elements of a claim. A claimant is responsible for responding to all Program requests for information, documentation, and submitting to medical examination necessary to adjudicate the claim. Additionally, the claimant is responsible for ensuring his or her treating physician provides medical evidence necessary to substantiate the claim for benefits.
- (2) *PSWCP Responsibilities*. The Program is responsible for investigating and developing the evidence obtained from the claimant, the employing agency, and the representative, if any. The Program is responsible for issuing a decision within thirty (30) days of claim filing and notifying the claimant and employing agency of its decision in all cases.
- (a) Subrogation. The Claims Examiner (CE) should identify claims where a party other than the District, its agencies or employees, may be responsible for the injury. The claimant should be notified promptly of his or her obligation to pursue a claim against the

responsible third party and consequences for failure to do so, including the requirement to assign rights to pursue such claims to the District.

- (b) Requesting Additional Information. The CE should contact the claimant in writing to obtain information or clarification wherever possible. If upon initial examination of a claim, it is determined that the evidence is not sufficient to establish the five (5) elements of a claim, the CE should inform the claimant of the additional evidence needed and the time allotted for a reply. The CE should initiate any investigation necessary to adjudicate the claim.
- (i) When requesting information from a claimant, the CE should state what evidence is already in the case record and why it is not sufficient to make a decision. The claimant should be informed of the time allotted for a response, and that action may be taken based on the information contained in the file following the expiration of the response period.
- (ii) The CE must allow the response time to lapse prior to issuing a decision denying a claim or taking other adverse action.
- (c) Evaluating Medical Evidence. The CE should evaluate all medical evidence that has been submitted prior to adjudicating a claim. In general, medical reports must provide a history of injury or work factors; a diagnosis; objective findings supporting the diagnosis; a rationalized medical opinion on the issue of causal relationship; and medical work status.
- (d) Additional Medical Examinations (AME). AMEs should be conducted prior to adjudication of a claim where the nature of the exposure is in question, the diagnosis is not clearly identified, the relationship of the condition to the work environment is not obvious, the claimant suffers from a pre-existing condition, or where a claim is filed for non-traumatic injuries, latent injuries, and aggravation of pre-existing condition issues.
- (e) Adjudication. If upon initial review the medical evidence is not sufficient to support a claim, a request for additional information should be sent to the claimant and treating physician if appropriate, as discussed above. Following the expiration of the submission period, the file should be reviewed, and all medical evidence evaluated for claim adjudication within thirty (30) days of claim filing, unless extenuating circumstances prevent the Program from issuing such a determination. If such circumstances exist, the CE shall issue claimant a Notice of Abeyance advising claimant of the

extenuating circumstances that prevents the CE from timely adjudicating the claim.

When reviewing claims for adjudication, there is a presumption of compensability that is established when a claimant presents evidence of (1) a death or injury and (2) a work-related event, activity or requirement which has the potential to result in or contribute to the death, injury or disability. If the claimant presents sufficient evidence to trigger the presumption, the burden shifts to the employer to produce “substantial evidence” that the death, injury or disability did not arise out of and in the course of employment. Thus, to deny a claim for compensation, there should be substantial evidence in the claim file to support the CE’s determination.

- (3) *Employing Agency Responsibilities.* The EA is required to report to the PSWCP any injury resulting in death or probable work-related injury before the end of the shift during which the supervisor learned of the injury, but no later than three (3) days after learning of the injury. Reports of injury shall be made through the ERisk web portal. EAs must submit any further information requested by PSWCP and provide available modified duty assignments to injured workers with compensable injuries who are released to return to work with medical restrictions.

B. Time. Claimants must first satisfy the statutory filing requirements for giving notice and for filing a claim.

- (1) *Notice of Injury or Death.* Notice must be given to the employee’s immediate superior within thirty (30) days of the traumatic injury, death, or the date the claimant becomes aware of the non-traumatic injury and is aware, or should have been aware, of a relationship between the disease or condition and the employment. *See* D.C. Official Code § 1-623.19(a)(1) and 7 DCMR § 104. Notice is perfected upon the immediate superior or Program’s receipt of a completed Form 1 or electronic reporting via ERisk, and Form 4 and IRS Form 4506-T. All forms must be completed and received by the employer within 30 days of the injury for notice to be timely.
 - (a) The thirty (30)-day limitation period does not apply to a minor until he or she reaches 21 years of age or has had a legal representative appointed, or to an incompetent individual while he or she is incompetent and has no duly appointed legal representative.
 - (b) Failure to comply with the thirty (30)-day notice requirement shall not bar a claim for compensation benefits if:

- (i) The employer or the Program had *actual knowledge*, as defined at 7 DCMR § 104.5, of the injury or death **and** its relationship to the employment and the employer is not prejudiced by the failure of the employee to give notice;
 - (ii) The Chief Risk Officer excuses the failure by finding a satisfactory reason notice could not have been given; or
 - (iii) Objection to the failure to give notice is not raised at the first hearing of a claim for compensation benefits. *See* D.C. Official Code § 1-623.19(b).
- (c) The mere fact that an immediate superior may have been a witness to the incident or is aware of the occurrence is not sufficient to constitute “actual knowledge” of the injury or death. For there to be actual knowledge, circumstances of the incident or occurrence must have reasonably placed the immediate superior on notice that the employee more likely than not sustained the compensable injury later claimed by the employee. If following the occurrence, the employee expressly denies injury, notwithstanding the immediate superior’s observations or awareness of the occurrence, the *actual knowledge* exception shall not apply.

Example 4-5B(1)(a):

An employee suffers an epileptic seizure while at work, causing him to fall from his chair and strike his head on the floor, resulting in a bruise on the temple. The immediate supervisor is present at the time of the incident. The employee later files a claim alleging the seizure was caused by exposure to fumes in the work place. The supervisor was not aware of fumes at the employee’s work place. While the supervisor was aware of the seizure, the mere fact of the supervisor’s presence cannot be deemed “actual knowledge” of the alleged relationship between the seizure and resulting injury and the work environment.

Example 4-5B(1)(b):

An employee is picking up a heavy object under the supervision of her immediate supervisor. The employee makes no outward sign of pain or discomfort while performing the task. The employee tells the supervisor that she did not feel good without specifying her illness and left work early that day. Two months later, the employee files a claim alleging a back strain due to picking up the heavy object. The mere fact of the supervisor’s presence cannot be deemed “actual knowledge” of the employee’s alleged work-related injury.

- (2) *Original Compensation Claims.* An original claim for compensation must be filed within two (2) years of the traumatic or non-traumatic injury. *See* D.C. Official Code § 1-623.22 and 7 DCMR § 115.15. A claim is not

considered filed until all required forms are completed and filed with the Program. The Program must receive Form CA7 or Electronic claim through ERisk; and Form 3, Form 3A, Form 4, and IRS Form 4506-T. *See* 7 DCMR § 115.

- (a) A claim for compensation filed beyond the 2-year limitation period **may** be permitted if:
 - (i) The immediate supervisor had *actual knowledge* of the injury or death or written notice of the injury or death was given within thirty (30) days. *See* D.C. Official Code § 1-623.22(a); and
 - (ii) The claimant establishes good cause for why the claim could not be timely filed within the 2-year limitation period.
- (b) The CE may deem the claim filed where a claimant submits all forms that are within the claimant's sole control: Form CA7 or Electronic claim through ERisk; and Form 3 or other equivalent medical record(s), Form 3A, Form 4, IRS Form 4506-T. *See* 7 DCMR 199(q).
- (c) Where notice is received by the Program, the Chief Risk Officer, Program Administrator, or his or her designee may waive certain Program forms and adjudicate the claim based on evidence in the claim file for reasonable cause shown. *See* D.C. Official Code § 1-623.21.
- (d) The 2-year limitation period for filing a compensation claim begins to run for:
 - (i) Traumatic Injury Claims -- from the date of the traumatic injury.
 - (ii) Aggravation Claims -- from *the discrete event or occurrence* that accelerated, worsened, or exacerbated the employee's pre-existing disease, illness, or condition, resulting in substantially greater disability or death. *See* 7 DCMR §§ 115.12 and 199.1(c).
 - (iii) Non-traumatic Injury or Latent Disability Claims -- from the earlier of:
 - a. The date the employee sought medical attention for the condition and was aware, or by the exercise of reasonable diligence should have been aware, of the

- causal relationship between the employee's condition and employment; or
- b. The date on which the employee becomes disabled and was aware, or by the exercise of reasonable diligence should have been aware, of the causal relationship between the employee's disability and employment. *See* D.C. Official Code § 1-623.22(b), 7 DCMR §§ 115.13 and 199.1.
- (iv) Supplemental Claims. An employee seeking to supplement an original claim that remains open to add an additional medical condition arising out of the same injury that was not already considered by the Program in prior adjudications must file a supplemental claim from the earlier of:
- a. The date the employee sought medical attention for the additional disability or condition and was aware, or by the exercise of reasonable diligence should have been aware, of the causal relationship between the employee's condition and employment; or
 - b. The date on which the employee becomes disabled and was aware, or by the exercise of reasonable diligence should have been aware, of the causal relationship between the employee's disability and employment. *See* 7 DCMR § 115.11.
- (e) The 2-year limitation period does not apply to:
- (i) A minor until he or she reaches 21 years of age or has had a legal representative appointed;
 - (ii) An incompetent individual while he or she is incompetent and has no duly appointed legal representative; or
 - (iii) Any individual whose failure to comply is excused by the Chief Risk Officer due to exceptional circumstances. *See* D.C. Official Code § 1-623.22(d).
 - (iv) *Recurrence Claims.*
 - a. Pursuant to D.C. Code § 1-623.22(e). A claim for medical or wage-loss indemnity compensation for a recurrence of medical condition or disability, where both medical and wage-loss indemnity compensation have terminated and the file has been closed, must be filed within one (1) year of the date of last indemnity

termination or, if such termination is appealed, within one (1) year after the date the final order was issued by a judicial entity.

- b. **Recurrence of Disability.** If medical indemnity benefits have not been terminated, a claim for recurrence of wage-loss indemnity compensation may be filed at any time.
- (v) *Permanent Disability Claims.* A request for a schedule award shall be made after initial acceptance of the claim:
- a. Within 180 days of the termination of temporary wage-loss benefits where the claimant has reached MMI, except where good cause for delay can be established;
 - b. At any time within one (1) year after a claimant has been deemed to have reached MMI and to have a permanent impairment involving the loss of use of a member or function of the body, or disfigurement; or
 - c. Within fifty-two (52) weeks after receipt of the 448th week of temporary disability indemnity benefits. *See* 7 DCMR §§ 140.2 and 140.3.

Example 4-5B(2)(a):

An employee suffers a compensable knee injury and is diagnosed with a knee sprain that keeps her out of work for 3 months, during which time she received medical and indemnity benefits. After treatment the employee is released to return to work without restrictions and all compensation benefits are terminated. Fourteen (14) months after returning to work, the employee seeks medical care for discomfort in her knee. The employee files a recurrence claim seeking medical and indemnity compensation benefits. As more than 1 year has passed after her indemnity and medical benefits were terminated, Claimant's recurrence claim should be denied pursuant to D.C. Official Code § 1-623.22(e).

Example 4-5B(2)(b):

An employee suffers a compensable knee injury and is diagnosed with a torn meniscus that keeps her out of work. She is awarded medical and wage-loss indemnity benefits. After three (3) months the employee is released to return to work and wage-loss indemnity benefits are terminated, but she continues to treat medically. After an additional fourteen (14) months of conservative treatment, the treating physician recommends surgery and places the employee in an out of work status. The employee files a recurrence claim seeking wage-loss indemnity compensation benefits. Although more than 1 year has passed since her wage-loss indemnity benefits were terminated, the recurrence claim for wage-loss benefits should be accepted because her medical indemnity benefit was still active, and her case was never closed.

Example 4-5B(2)(c):

An employee suffers a compensable knee injury and is diagnosed with a knee sprain that keeps her out of work for 3 months, during which time she received medical and indemnity benefits. After treatment the employee is released to return to work without restrictions and all compensation benefits are terminated. Fourteen (14) months after returning to work, the employee seeks medical care for discomfort in her knee. Her treating physician diagnoses her with a torn meniscus that he relates to her original work injury and recommends surgery. The employee files a recurrence claim seeking medical and indemnity compensation benefits. As more than 1 year has passed after her indemnity and medical benefits were terminated, Claimant's recurrence claim should be denied pursuant to D.C. Official Code § 1-623.22(e). Additionally, a recurrence claim must be made for the same condition as was originally accepted. Claimant's current diagnosis is a torn meniscus, not a knee sprain, and the recurrence claim should be denied on that basis as well. However, a claim for the torn meniscus may be compensable as a consequential injury. *See* Section 4-5G(1)(b) below.

Alternatively, if the employee had continued to treat medically following her return to work, it would remain inappropriate to accept a recurrence claim for wage-loss indemnity compensation benefits due to a newly diagnosed torn meniscus when the claim was initially accepted for a knee sprain. A recurrence claim must be for the same condition originally accepted. While the recurrence claim should be denied, the CE should inform the employee of her right to supplement her claim to include the new condition of torn meniscus.

- C. **Employee Status.** The injured or deceased worker must be a District of Columbia government employee as defined by D.C. Official Code § 1-623.01(1). An immediate supervisor's completion of a report of injury identifying the worker as an employee is *prima facie* proof of the "employee" status of the claimant. Where a claimant's status is unclear, the CE shall verify the claimant's employment status through PeopleSoft, the Department of Human Resources, or the EA. Verification of a claimant's employment status may include requesting a copy of the claimant's SF-50 and position description. The claimant's position

description may become necessary later in the claim process, if a claimant is given a medical release to return to work at less than full duty.

- (1) *Volunteers.* In general, the District Government is prohibited from receiving voluntary services, except in the case of an emergency or where otherwise specifically authorized by law. 31 U.S.C. § 1342. In most cases not involving an emergency, voluntary services may be performed only pursuant to a donation agreement that has been approved in accordance with § 446(b) of the Home Rule Charter. D.C. Code § 1-204.46(b). The EA should be asked to describe the exigent circumstances that necessitated acceptance of voluntary services, to cite the statutory basis for accepting the services of volunteers, or to provide a copy of the donative services agreement approved by the Office of Partnerships and Grant Services. Sufficient evidence must be submitted to establish that the service performed by the volunteer was of a kind usually performed by an employee of the District of Columbia. This may be established with the submission of a statement which fully describes the services rendered by the injured or deceased individual and shows whether the EA has persons on its payroll who render similar services and, if so, the job titles for those positions.
 - (2) *Jurors.* An individual serving as a grand or petit juror within the Federal court system or D.C. Superior Court will be considered an employee for purposes of the CMPA only if he or she is otherwise an employee as defined by D.C. Official Code § 1-623.01(1)(A) or (B). This means that only jurors who are actually employed by the District are eligible to receive workers' compensation benefits. Coverage of jurors is limited to injury arising out of and in the course and scope of situations where the juror is:
 - (a) In attendance at court pursuant to a summons;
 - (b) In deliberation;
 - (c) At a location, such as a scene of crime, for the purpose of taking a view; or
 - (d) Sequestered by order of a judge.
- D. *Fact of Injury.* The claimant must establish that the incident, accident, untoward event, or employment factors alleged actually occurred; **and** that a medical condition has been diagnosed in connection with the event or employment factors.
- (1) For traumatic injury and latent disability claims, emphasis is on time, place, and circumstances of the injury.

- (2) In non-traumatic injury claims, the evidence should establish that the claimant was in fact exposed to the claimed work factors (nature of exposure, amount, volume, duration, etc.).
 - (3) Claimant has the burden to produce medical documentation from a qualified physician, as defined by D.C. Official Code § 1-623.01(2), that establishes a diagnosis linked to the injury and provides a diagnosis code established by the most recent edition of the International Classification of Diseases (ICD), as published by the U.S. Department of Health and Human Services, for diagnosing the claimant's condition. **Findings of pain or discomfort alone do not satisfy this requirement.** Pain is a symptom and not a diagnosed medical condition.
 - (a) The diagnosis does not have to match the exact condition claimed provided that the diagnosis is reasonably supported by the mechanism of injury. For example, the employee claims an injury to the right arm as the result of slipping and falling on ice. A diagnosis of a right hand condition, a right shoulder condition, or even a neck or back condition may all be acceptable diagnoses. However, a diagnosis of hypertension or diabetes could in no way be reasonably supported by a slip and fall.
 - (b) The requirement for a medical report may be waived and a claim may be adjudicated with authorization of the Program Administrator where:
 - (i) The condition reported is a minor one which can be identified on visual inspection by a lay person (such as a laceration, bee sting, or dog bite);
 - (ii) The injury was witnessed or reported promptly and no dispute exists as to the occurrence of an injury; **and**
 - (iii) No time was lost from work due to disability.
 - (c) Where a compensable injury results in an aggravation of the claimant's pre-existing condition, the claimant must establish, through medical evidence, the mechanism of injury, the claimant's medical baseline in light of the pre-existing condition and extent to which the work injury aggravated the pre-existing condition.
- E. *Performance of Duty.* A claimant must establish that the employee was performing official duties (or an activity incidental to employment) at the time of the injury or death. The injury or death must arise out of and in the course of District government employment for the performance of duty element to be met.
- (1) ***Arise out of employment.*** To establish that an injury arose out of the employment, the claimant must show that the injury is causally related to

the duties and responsibilities of said employment. This jurisdiction applies the *positional-risk standard*, which provides that an injury arises out of employment if the injury would not have occurred but for the fact that conditions and obligations of the employment placed the claimant in a position where he or she was injured. *See Clark v. District of Columbia Dept. of Employment Services*, 743 A.2d 722, 727 (D.C. 2000). “Fault has nothing to do with whether or not compensation is payable. The economic impact on an injured workman and his family is the same whether the injury was caused by the employer's fault or otherwise.” *Grayson v. Dist. of Columbia Dept. of Employment Services*, 516 A.2d 909, 912 (D.C. 1986) (citations omitted).

- (a) *Cause of Injury*. “[A] worker's compensation claimant need not prove that his employment was the sole cause of his disability.” *Spartin v. District of Columbia Dep't of Employment Servs.*, 584 A.2d 564, 570, n. 9 (D.C.1990). “Under the ‘two causes’ rule if a disability has two causes, one related to employment and one unrelated, benefits are allowed.” *Shelton v. Ennis Bus. Forms, Inc.*, 1 Va.App. 53, 334 S.E.2d 297, 299 (1985) “The law does not weigh the relative importance of the two causes ... it merely inquires whether the employment was a contributing factor. If it was, the concurrence of the personal cause will not defeat compensability.” *Georgetown Univ. v. Dist. of Columbia Dept. of Employment Services*, 971 A.2d 909, 919 (D.C. 2009) citing 1 Larson, *The Law of Workers’ Compensation* § 4.04 (2008).
- (b) *Idiopathic Fall Doctrine*. An idiopathic fall is one where a known, personal, non-occupational pathology causes an employee to collapse. An injury due to a fall caused by a personal and non-occupational pathology, such as a heart attack, fainting spell, or epileptic seizure, is not covered under the CMPA.

If there is intervention or contribution to the injury by some hazard or special condition of the employment, including normal furnishings of an office or other workplace, the employee may have coverage under the CMPA for the results of the injury but not for the idiopathic condition which caused the fall.

If a fall is not shown to be caused by an idiopathic condition, it is simply unexplained and may be compensable if it occurred in the performance of duty. An unexplained fall is one where the cause is unknown even to the employee.

Example 4-5E(1)(a):

An employee with a known seizure disorder experiences a seizure at work. During the seizure the employee falls to the ground, striking his head on the ground several times. As a result of the fall, the employee sustains a head contusion and shoulder injury. Neither the head contusion nor shoulder injury is compensable under the CMPA. The injuries were the sole result of the employee coming into contact with the ground, without any intervention or contribution to the injury by an element of the employment or work environment.

Example 4-5E(1)(b):

A building inspector was working on a ladder inspecting a roof when he falls and sustains a broken leg and head contusion. It is later determined that the employee suffered a heart attack which caused the fall. Both the broken leg and head contusion may be compensable injuries because working on the ladder and the distance of the fall contributed to the injuries. The heart attack and underlying cardiac condition(s), however, are not compensable injuries or conditions under the CMPA.

- (2) *Arise in the course of employment.* “[A]n accident occurs ‘in the course of employment’ when it takes place within the period of employment, at a place where the employee may reasonably be expected to be, and while he or she is reasonably fulfilling duties of his or her employment or doing something *reasonably incidental* thereto.” *Bentt v. District of Columbia Dept. of Employment Services*, 979 A.2d 1226, 1235 (D.C. 2009) (citations omitted) (emphasis added).
- (a) *Reasonably Incidental.* An employee is doing something reasonably incidental to employment, when “engaging in a reasonable and foreseeable activity that [was] reasonably related to ... her employment.” *Id. citing Kolson v. District of Columbia Dep’t of Employment Servs.*, 699 A.2d 357, 361 (D.C.1997).
- (b) *Related to Employment.* An activity is related to employment if it carries out the employer's purposes or advances the employer’s interests directly or indirectly. This may include an activity of mutual benefit to employer and employee. *However, the key is whether the activity at issue relates to the claimant’s employment.* An activity that is beneficial to both the employer and the claimant may, but does not necessarily, illustrate that relation.” *Id. citing Kolson* at 360.
- (c) *Social or Recreational Activity.* Generally, recreational or social activities are within the course of the employment when:

- (i) They occur on the premises during a lunch or recreation period as a regular incident of the employment; or
- (ii) The employer, by expressly or impliedly requiring participation, or by making the activity part of the services of an employee, brings the activity within the orbit of the employment; or
- (iii) The employer derives substantial direct benefit from the activity beyond the intangible value of improvement in employee health and morale that is common to all kinds of recreation and social life.

In the Matter of Carroll Harvey, Claimant v. D.C. Water & Sewer Auth., & Pma Mgmt. Corp., Employer/third-Party Adm'r, AHD 06-434A, 2007 WL 1456114, at *4 (D.C. Dept. Emp. Srvs. 2007) citing 2A LARSON, Workers' Compensation Law §22.01 (2006)

- (d) *Personal Acts*. Injuries sometimes occur while the employee is engaged in a personal act for the employee's comfort, health, convenience, or relaxation. In these cases, it is particularly essential to determine whether the act was one which is regarded as a normal incident of the work experience, or was one which is foreign or extraneous to the work experience, and the extent to which the employee diverted for duty to perform the act. Some examples of personal acts that may be covered include a coffee break in the employee lounge, a walk to the nearest vending machine for a snack, or using the restroom.
- (e) *"Going and Coming" Rule*. "The occurrence of employee injuries sustained off the work premise, while enroute to or from work, do not fall within the category of injuries 'in the course of employment.'" *Grayson v. Department of Employment Services*, 516 A.2d 909, 911 (D.C.1986) referencing 1 LARSON, *The Law of Workmen's Compensation* § 15.00 (1997).
 - (i) Excessive Work Hours. Additional investigation by the CE may be warranted if the injury occurs on the premises, but outside of the employee's scheduled work hours. If the interval before or after the work hours is excessive, steps should be taken to establish why the employee was on the premises outside of work hours. What constitutes "excessive" will be determined on a case by case basis. For example, being on the work premises 15 minutes before the scheduled start time may not be considered excessive, but being on the premises 1 hour after the end of shift may be.

- (ii) Parking Facilities. A parking facility that is owned, controlled, or managed by the employer is covered. The fact that a non-government parking lot is known to be routinely used by employees is not sufficient to establish that an injury may be compensable under the CMPA, unless the employee was expressly directed to utilize the lot by the employer. However, even if it is determined that the parking facility constitutes part of the employer premises, the CE must still conduct analysis to determine if the injury arose “out of employee” prior to making a compensability determination.

Example 4-5E(2)(a):

A school teacher arrives at work at 7:45 am and parks in the school’s employee parking lot. The teacher’s shift begins at 8:00 am. While walking across the parking lot, he steps in a pothole and sustains a knee injury. This injury may be compensable because the employee was on the work premises when the injury occurred. Although the injury occurred prior to his scheduled start time, the time period is not excessive.

Example 4-5E(2)(b):

An employee arrives at work in the morning and parks in a public parking lot across the street from his building. The employee’s position did not require him to drive to work. He was not required or directed to use the lot by his employer. The employee trips and falls over the curb while leaving the parking lot and suffers a knee injury. His injury is not compensable because employee was not on the work premises, had not yet begun his shift, and was not acting at his employer’s direction when he chose to park in the lot.

- (f) *Exceptions to the “Going and Coming” Rule*. The current law in the District of Columbia provides that the only exceptions to the going and coming rule are “*Special Errands*” / “*Travelling*” *Exception* and “*Employer-Provided Transportation*” / “*Employee-Mandated Work Vehicle*.” Examples include bus drivers, building inspectors, and social workers. For these employees, the CE should inquire whether the employee (1) was performing assigned duties; (2) was engaged in a reasonable and foreseeable activity that was reasonably incidental to the assignment; or (3) had deviated from the assignment and was engaged in a personal activity that was not related to the work.
- (i) “Special Errands” / “Travelling” Exception. “When an employee, having identifiable time and space limits on the employment, makes an off-premises journey which would normally not be covered under the usual going and coming

rule, the journey may be brought within the course of employment by the fact that the trouble and time of making the journey, or the special inconvenience, hazard, or urgency of making it in the particular circumstances, is itself sufficiently substantial to be viewed as an integral part of the service itself.” *Vieira v. Dist. of Columbia Dept. of Employment Services*, 721 A.2d 579, 584 (D.C. 1998) citing 1 LARSON, *Larson’s Workmen’s Compensation* § 16.11 (1998). “When a traveling employee is injured while engaging in a reasonable and foreseeable activity that is reasonably related to or incidental to his or her employment, the injury arises in the course of employment.” *Kolson v. Dist. of Columbia Dept. of Employment Services*, 699 A.2d 357, 361 (D.C. 1997). “[I]njuries arising out of the necessity of sleeping in hotels or eating in restaurants away from home are usually held compensable.” *Kolson* at 360 citing 2 LARSON, *supra*, § 25.00 (1997).

Example 4-5E(2)(c):

A social worker arrives at a client’s home for a site visit and parks on a public street in front of the home. The employee trips over the curb, falls to the ground, and sustains a knee injury. This injury may be compensable because the employee’s position required her to be off the work premises and she was engaged in work duties at the time of the injury.

- (ii) “Employer-Provided Transportation” / “Employee-Mandated Work Vehicle” An injury is compensable, if sustained “while being transported to or from work in a vehicle furnished by the employer as an incident of the employment; or on the ground of mutual benefit, convenience, advantage, or interest; or when the transportation is included as part of the employee's remuneration.” 99 C.J.S. *Workers' Compensation* § 493

“Proof that the employer's provision of transport is a necessity for the employer's business, and not a mere accommodation of the employee, is sufficient in itself to establish that the travel originated in the employer's business.” 99 C.J.S. *Workers' Compensation* § 493

This exception does not apply where the employee abandons the employment-related purpose for using the vehicle. An employee's unrestricted and exclusive right of personal use of a company vehicle does not bring an employee's injuries during such personal use within the

exception for employer provided transportation. 99 C.J.S. Workers' Compensation § 493

- (g) *Paid Lunch Exception.* The continuance of an employee's wages during the lunch period is sufficient to bring activities occurring off the work premises during the lunch period within the "course of employment." However, an analysis must still be done to determine whether the injury arose "out of employment" to determine compensability – i.e. would not the injury have occurred but for the fact that conditions and obligations of the employment placed the claimant in a position where he or she was injured?

Example 4-5E(2)(d):

In *Grayson v. D.C. Dept. of Employment Services*, 516 A.2d 909 (D.C. 1987), an employee on her paid lunch break, was pulling her personal vehicle out of a parking space located off the work premises, when her car was struck by another vehicle, resulting in bodily injury. The injury was found to have occurred "in the course of employment" even though her injury was sustained off the work premises because the injury occurred during a paid lunch break. However, the claim was found to be not compensable because it did not "arise out of employment." The employee's break was unsupervised and there were no restrictions on what she could do or where she could go during the break. Because no control was exercised over the employee during her paid lunch break, the injury was not found to have arisen out of the employment.

- (h) *Use of Exercise Facilities.* An injury sustained by an employee resulting from the use of an employer provided exercise facility may be compensable if the employee's position has a physical fitness requirement, the injury was sustained during their scheduled work shift, and the terms of employment permit exercise during the scheduled work shift.
- (i) *Assaults.* Where the injury or death is caused by the assault of another person, it is necessary to establish, to the extent possible, whether the assault arose out of an activity directly related to the work or work environment, or arose out of a personal matter having no connection with the employment. See D.C. Official Code §1-623.01(5)(B)(i)
- (i) Where it is clear, by substantial evidence, that the employment contributed nothing to the assault, whether by engendering or exacerbating a quarrel or facilitating the assault, the assault should be held non-compensable. However, injury may be compensable, where the cause/motivation of the assault is unknown, or where the only connection of the employment with the injury is that

its obligations placed the employee in the particular place at the particular time when he or she was injured by some neutral force, meaning by “neutral” neither personal to the claimant nor distinctly associated with the employment. LARSON, 1 LARSON’S WORKERS’ COMPENSATION LAW, §3.05 (1999).

- (ii) The CE should obtain copies of police reports, employer incident reports, and statements from the injured worker, assailant and any witnesses, of the events and circumstances which immediately proceeded, led up to, and resulted in the assault.

G. *Causal Relationship.* The claimant must establish a causal relationship between the injury and work environment. In addition, a claimant seeking indemnity benefits must also establish a causal relationship between the injury and inability to work. 7 DCMR 119.1(e) and (f).

(1) *Causal relationship between the injury and work environment.* The question of causation is a medical issue which requires reasoned medical opinion for resolution. Neither the fact that the condition manifests itself during a period of District government employment nor the belief of the claimant that factors of employment caused or aggravated the condition is sufficient in itself to establish causal relationship. 7 DCMR 119.1(e).

- (a) Direct causation is established when the injury or factors of employment, through a natural and unbroken sequence, results in the condition claimed. For example, a fractured arm sustained in a fall would be considered a direct result of the fall. Hearing loss might likewise be caused directly by occupational noise exposure over a period of time. In non-traumatic injury cases, greater medical rationale may be required to establish causation than in traumatic injury cases.

Example 4-5G(1)(a):

An employee strikes his right shin against the loader of a waste removal truck causing pain and a deep bruise. Treatment is sought at a hospital emergency room, where an x-ray of the right leg is taken. The x-ray reveals advanced arthritis in the right knee. The employee files a claim for the bruise and arthritis. Because arthritis is a condition that is developed over time, the work injury - striking the shin against the truck loader - cannot have caused advanced arthritis. There is no causal relationship between the arthritis and the work injury. There is a causal relationship between the bruise and the work injury. The file should be carefully reviewed to determine if aggravation issues exist with regard to the arthritis that may be causally related to the work injury.

- (b) Consequential Injury. After the original acceptance of a claim, an injury occurring outside the performance of duty may affect the compensability of an existing accepted injury. A Consequential Injury is an injury that occurs because of weakness or impairment caused by a work-related injury, and it may affect the same part of the body as the original injury or a different area altogether. When the primary injury is shown to have arisen in performance of duty, every natural consequence that flows from the injury is deemed to arise out of the employment, unless it is the result of an independent intervening cause which is attributable to the employee's own intentional conduct. *See* D.C. Official Code §1-623.01(5)(A)(ii). Subsequent injuries that are not a direct and natural result of the original compensable injury do not arise out of and in the course of the employment. Additionally, a subsequent injury will not be compensable if it can be said to be a direct and natural result of an independent intervening cause attributable to the employee's intentional conduct or occurring outside of employment. *See* 2 Modern Workers Compensation § 116:14 Direct and natural result (citations omitted); Section 4-5(G)(1)(c) Intervening Injury. If such an injury is claimed, the CE should:
- (i) Ask the claimant to provide a factual statement. Depending on the circumstances of the case, this statement should include the following:
- (a) Why he/she believes the claimed consequential condition (and resulting disability, if any) is related to the already accepted work-related conditions.
 - (b) A detailed factual statement describing the claimed consequential condition from the date of first medical care through the present, including a description of whether symptoms were occasional or constant, and what made any symptoms worse or better.
 - (c) A description of the medical care received, and all periods of disability from work, from the date he/she returned to work.
 - (d) A description of the claimant's work activities since returning to work.
 - (e) A statement regarding whether the claimant has sustained any other injuries/illnesses, either on or off the job, since the original injury/illness.

- (f) A description of claimant's hobbies or activities, such as sports, volunteering, or another job, which may have affected the accepted work-related conditions and serve as independent intervening causes that would break the chain of causation.
- (ii) Ask the claimant to furnish medical evidence. Though the request will vary depending on the circumstances in the case, this request should typically include the following:
 - (a) Copies of all medical records for the work-related condition from the date of discharge or date of last medical care through the present, including office visit notes, treatment notes, diagnostic test results, etc., if these are not already on file and/or a significant period of time has passed since receipt of any medical evidence.
 - (b) A comprehensive medical report from the claimant's physician that addresses the following:
 - (i) A description of the original mechanism of injury/work exposure and summary of the medical care received.
 - (ii) A description of the current symptoms.
 - (iii) Current objective findings upon examination.
 - (iv) Results of all current diagnostic studies.
 - (v) Current diagnosis.
 - (vi) The physician's opinion supported by a medical explanation as to the relationship between the accepted work-related condition(s) and the claimed consequential condition, if any.
 - (vii) If disability is claimed as a result of the consequential condition, a description of the work duties that the claimant cannot perform and the objective medical findings that form the basis of renewed disability for work.
 - (viii) The recommended course of treatment.

- (iii) The CE should allow a reasonable time period for submission of the evidence (30 days). After the time period has passed, the CE should adjudicate the claim for a consequential condition and issue an acceptance letter or formal denial with appeal rights. The CE may also seek further clarification from a panel physician prior to adjudicating the claim for a consequential condition.

Example 4-5G(1)(b):

A claimant with an accepted knee injury may fall at home because the weakened knee buckled. This incident will constitute a consequential injury whether the affected part of the body is the knee or some other area, such as the back or arm. Or, a claimant with an injured eye may compensate for loss or functioning by overuse of the other eye, which may result in a consequential injury. The CE should direct the claimant to file a supplemental claim for the consequential injury.

- (c) Intervening injury. An Intervening Injury is an injury occurring outside the performance of duty to the same part of the body originally injured. The CE must determine whether the disability is due to the second injury alone, or whether the effects of the first injury still contribute to the disability. *Unless the second injury breaks the chain of causation between the original injury and the disability claimed, the disability will be considered related to the original work-related incident.* “Another situation which may infer an independent intervening cause is a case scenario where the employee is found to have knowledge of her potentially disabling condition, and such knowledge combined with participation in a triggering activity classified as unreasonable will be sufficient to support a finding of an independent intervening cause.” 2 Modern Workers Compensation § 116:15 Independent intervening cause (citations omitted).

Example 4-5G(1)(c):

An employee is recovering from a wrist sprain (due to a work-related injury) for which he has been placed out of work for 2 weeks. If the claimant is recovering from the wrist injury and slips on ice leaving the house and lands on the same wrist and breaks it, this would be considered an intervening injury. But since the claimant had not fully recovered from the accepted wrist sprain, the effects of the original injury would still be contributing to the disability (at least for the remainder of the 2 weeks that he had been placed out of work due to the wrist sprain); therefore, the chain of causation was not completely broken.

- (d) Aggravation exists if there is exacerbation, acceleration, or worsening of a pre-existing condition by an injury arising in the course of employment. For example, a claimant who falls on his

or her knee while performing work duties may aggravate the claimant's pre-existing degenerative knee condition, and compensation would be payable for the duration of the aggravation as medically determined. Aggravation must be diagnosed by a qualified physician to be compensable. Prior to accepting a claim for aggravation, the CE must establish a medical baseline, which factors in the pre-existing condition, based on the medical evidence in the file. The medical baseline is needed to establish the nature and extent of aggravation caused by the compensable work injury. An aggravation may be temporary or permanent; and may also accelerate an underlying condition.

- (i) **Temporary Aggravation** involves a limited period of medical treatment and/or disability, after which the employee returns to baseline (his or her previous medical status). Compensation is payable only for the period of aggravation established by the weight of the medical evidence, and not for any disability caused by the underlying disease. This is true even if the claimant cannot return to the job held at the time of injury because the pre-existing condition will worsen if he or she does so. If the medical evidence establishes that a temporary aggravation has ceased at the time of acceptance, the acceptance letter should note the end date of the accepted temporary aggravation.
- (ii) **Permanent Aggravation** occurs when a condition will persist indefinitely due to the effects of the work-related injury or when a condition is materially worsened such that it will not revert to its previous level of severity. For example, an allergy in a severely asthmatic employee which would have persisted in any event may be permanently aggravated by exposure to construction dust and fumes in the workplace such that subsequent episodes are more severe than they otherwise would have been.

A claim should be accepted for permanent aggravation only after careful evaluation of all medical evidence of record. *The CE must refer the claimant for Additional Medical Examination* in order to establish that no additional medical treatment is available to restore the claimant to baseline, pre-aggravation condition *before accepting the claim for a permanent aggravation.* An Initial Determination accepting a permanent condition should be limited to exceptional circumstances. *See Section 4-4(C)(2) above.*

- (iii) **Acceleration.** When a work-related disease or condition hastens an underlying condition, causing it to develop more quickly than it ordinarily would, a claim may be accepted for acceleration of the underlying condition. For example, a claimant's pre-existing knee arthritis may have been accelerated by a fall to the knees on the job such that surgery is now required. An acceptance for acceleration of a condition carries the same force as an acceptance for direct causation and claims for acceleration shall be filed pursuant to rules that apply to claims for latent disability. That is, the condition has been accepted with no set limitation on its duration or severity.
- (iv) **Evidence Required if a Pre-existing Condition Exists.** In a case where a pre-existing condition involving the same part of the body is present and the issue of causal relationship involves aggravation, the physician must provide a rationalized medical opinion which differentiates between the effects of the work-related injury or disease and the pre-existing condition. Additional information may be requested by the CE and specific written questions may be provided to the treating physician to assist in evaluating the effect of the pre-existing condition on the work injury, if any.
- (a) **Burden of Proof.** The claimant has the burden of providing medical evidence establishing a rationalized medical opinion discussing the nature of the condition, including its natural or traditional course, and how the underlying condition was affected by the employment.
- (b) The CE should obtain full details of the pre-existing condition, including the approximate date it first manifested, the names and addresses of all physicians who examined or treated the claimant for the condition, and the approximate dates of such examinations and treatment. The CE should request copies of medical records from all physicians who treated claimant for the pre-existing condition.
- (e) **Recurrence** of disability is caused by a *spontaneous change in a medical condition which resulted from a previous injury or illness* without an intervening injury, condition or new exposure to the work environment that caused the illness. For example, a claimant who suffers a knee injury may later need surgery to the knee as a natural progression of the knee injury without any intervening injury. A claimant must produce medical evidence to establish, by

a preponderance of the evidence, that the disabling condition is causally related to the original accepted work injury.

- (f) Latency. A latent condition which would not have become manifest but for the employment is said to have been precipitated by factors of the employment. For instance, tuberculosis may be latent for a number of years, and then become manifest due to renewed exposure in the workplace. The claim would be accepted for latent disability, but the acceptance would be limited to the period of work-related tuberculosis and the Program's responsibility for the condition would cease once the person recovered.

- (2) ***Causal relationship between the injury and inability to work***. Claimants seeking wage-loss indemnity compensation must establish that the nature, extent and duration of his or her inability to work are causally connected to the work-related injury.

Example 4-5G(2):

An employee has a congenital defect of the left foot for which her treating physician has suggested surgical correction. The employee suffers a fall at work on a Tuesday, sustaining a contusion to the left knee and is prescribed 3 days of bed rest. The employee follows up with the treating physician on Friday and is released to resume regular work duties without any restrictions. On Saturday, the employee undergoes surgery to correct the foot defect and is unable to work for 2 weeks. There is no causal connection between the work-related injury, the knee contusion, and the employee's inability to work after Friday. The employee would not be entitled to wage-loss benefits from Monday forward.

- (3) ***Medical Evidence***. The question of causation is a medical issue which requires a reasoned medical opinion for resolution. Medical evidence should include a qualified physician's diagnosis of the condition, the objective examination findings that established the diagnosis, and opinion concerning the relationship, if any, between the condition and the injury or factors of employment claimed. *Note: A chiropractor's opinion constitutes medical evidence only if a diagnosis of subluxation of the spine is made and supported by x-rays.*

- (a) Evaluating Medical Opinions.

- (i) ***Determining Causal Relationship***. The degree of difficulty in determining causal relationship depends mainly on:

- (a) The precise employment factors accepted as occurring within the performance of duty or the nature of the injury which is implicated;

- (b) The nature of the disability or the cause of death for which compensation is claimed;
 - (c) The elapsed time between the injury and the onset of the condition causing disability or death; and
 - (d) The employee's medical history.
- (ii) ***When no opinion regarding*** causal relationship is provided by the attending physician, the claim generally can be denied, provided appropriate development has been completed.
 - (iii) ***When the attending physician negates*** causal relationship between the condition and the employment factors, and no medical evidence to the contrary appears in the file, the case may be disallowed, provided appropriate development has been completed. No other medical opinion is required to support the denial.

Example 4-5G(3)(a):

An employee is struck by a truck while in the performance of duty and is immediately taken to a hospital, where a fracture of the right femur is found. It is clear that the fracture was caused by the truck accident. Thus, the report from the attending physician supporting causal relationship would not need to elaborate on medical rationale.

Ninety days after the injury, symptoms of a blood clot, another condition, appear in the right leg and compensation is claimed for the blood clot. The passage of this amount of time between the injury and the development of the clot would create uncertainties regarding causal relationship. The report from the attending physician would need to include a medical rationale to justify an opinion in support of causal relationship for the acceptance of the blood clot as part of the underlying claim.

Six months later, the employee suffers a stroke while sitting quietly in an easy chair at home. The employee claims additional benefits for the stroke, alleging it was caused by the original injury of being struck by a truck. Two reasons now exist for questioning causal relationship: (a) nine months elapsed between the injury and the stroke, and (b) the original injury involved the leg, whereas the stroke may have resulted from any number of medical reasons. Any medical opinion in support of causal relationship would have to be based on a complete factual and medical background and justified by detailed medical rationale within a reasonable degree of medical certainty. Otherwise, the claimant's burden of proof would likely not be met for acceptance of the stroke as part of the underlying claim.

Example 4-5G(3)(b):

A nurse is diagnosed with pulmonary tuberculosis after a year of continuous employment on a ward where active tuberculosis patients were housed. If all other factors were negative, any medical opinion supporting causal relationship would require little or no rationale, as it would be apparent that the most probable source of the infection was the employment.

If, however, investigation revealed that the employee lived with a spouse, who had advanced active pulmonary tuberculosis that was discovered just 60 days before, two probable sources of the infection now exist: the hospital where the employee was exposed for 40 hours per week to a known hazard, where appropriate precautions were taken; and home, where the hazard was unknown, no precautions were taken, contact was much more intimate, and far exceeded 40 hours per week. Under these facts, it would be more difficult to find the employment was the proximate cause for the disease and any medical opinion in support of causal relationship requires a full description of the medical reasons justifying such an opinion.

Another variation involves the supposition of massive exposure at work and no exposure in private life, but a positive skin test for tuberculosis prior to District employment. The major question would be whether the current illness is a new disease or reactivation of an old one. This issue requires careful consideration, and any opinion which did not discuss all relevant factors and contain detailed rationale would not form a sufficient basis for an acceptance.

H. *Statutory Exclusions.* If the five elements of a claim have been met, consideration must be given to statutory exclusions that may prevent compensability. The Program's denial of any claim for compensation must be supported by substantial evidence in the claim file.

(1) Injury to Self or Others. Where it is clear the employment contributed nothing to the assault, whether by engendering or exacerbating a quarrel or facilitating the assault, the assault should be held non-compensable. *See* D.C. Official Code §1-623.02(a)(2). However, injury may be compensable, where the cause/motivation of the assault is unknown, or where the only connection of the employment with the injury is that its obligations placed the employee in the particular place at the particular time when he or she was injured by some neutral force, meaning by "neutral" neither personal to the claimant nor distinctly associated with the employment. LARSON, 1 LARSON'S WORKERS' COMPENSATION LAW, §3.05 (1999).

(a) Statements should be obtained from the immediate supervisor, coworkers, and other witnesses that describe the employee's activities preceding the injury, and state whether they believed the injury or death was caused by the employee's intention to bring about the injury or death of self or another, with a fully detailed explanation for their belief.

- (2) Willful Misconduct. Willful misconduct issues may arise where, at the time of the injury, the employee was violating a safety rule, disobeying other orders of the employer, engaging in prohibited activity, or violating a law. All employees are subject to the orders and directives of their employers in respect to what they may do, how they may do certain things, the place or places where they may work or go, or when they may or shall do certain things. Disobedience of such orders may destroy the right to compensation only if the disobedience is deliberate and intentional, as distinguished from careless or heedless. *See* D.C. Official Code §1-623.02(a)(1). Prohibited activities include committing an act that is subject to disciplinary action under the District Personnel Manual (DPM) or other District agency policy statement, or knowingly committing any other act which has been prohibited by the employer and is not expressly stated in the DPM or other District agency policy statement.
- (a) If an employee commits an act that has been prohibited by the employer, but not expressly stated in the DPM or other District agency policy statement, it is essential to determine whether the employee was fully aware of the prohibition. Documentation should be collected to establish: (1) how and when the employee was informed of the prohibition; (2) the manner in which the prohibition was enforced and what disciplinary action, if any, had been taken against the employee or coworkers for prior violations; and (3) the extent to which the employee diverted from assigned duties, and whether the particular act was within the general scope of the assigned duties.
- (3) Mental Stress. Except for employees hired prior to January 1, 1980, injury in the form of mental stress, or an emotional condition or disease, resulting from a reaction to the work environment or to administrative action(s) taken by the employing agency, are not compensable under the CMPA. *See* D.C. Official Code §1-623.02(b) and (c). There is no bar to a compensation claim for a mental or emotional condition that arises as a direct consequence of a compensable physical injury. For mental stress claims arising out of a compensable physical injury, there is a presumption of compensability as long as the claimant can show, through competent medical evidence, that the physical work-related injury resulted in or contributed to the psychological injury claimed. *McCamey v. Department of Employment Services*, 947 A.2d, 1191 (2008).
- (a) Work Environment. An employee's work environment includes his or her regular or specially assigned work duties, activity incident to the employment, co-workers, and the public. When making a determination of what constitutes an employee's work environment and work duties, the CE should not only consider those duties specifically defined by the official position description, but also those implied (not specifically defined but

expected by the employing agency), if any. Special attention should be given to claims arising from extraordinary events and or conditions that could not reasonably be anticipated or characterized as part of the “work environment.” Such cases should be determined on a case by case basis.

- (i) Harassment or teasing of employees by coworkers constitutes an activity incident to the employment and coworkers and is therefore not compensable under the CMPA. Employees who are harassed, teased, or called derogatory names by coworkers may have a discrimination claim and should contact the D.C. Office of Human Rights (OHR) or the federal Equal Employment Opportunity Commission (EEOC).
 - (ii) An employee’s frustration, disappointment, or other negative reaction to an administrative action taken by the employing agency is not a compensable condition under the CMPA. Such administrative actions include promotion/denial of promotion, adverse personnel action, transfer, retrenchment/dismissal, or provision of employment benefits. *See* D.C. Official Code §1-623.02(b)(2)(6). An employee dissatisfied with an administrative action should seek review of the action through Human Resources.
- (b) Employees hired prior to January 1, 1980. There is a statutory presumption of compensability by showing a psychological injury and actual workplace conditions or events which could have caused or aggravated the psychological injury. The injured worker’s showing must be supported by competent medical evidence. If the presumption is invoked, the burden shifts to the employer to show, through substantial evidence, that the psychological injury was not caused or aggravated by workplace conditions or events. If the employer succeeds, the statutory presumption drops out of the case entirely and the burden reverts to the injured worker to prove by a preponderance of the evidence that the workplace conditions or events caused or aggravated the psychological injury.

Example 4-5H(3)(a):

A Corrections Officer is assaulted by 2 inmates while at work and sustains severe physical injuries from which he ultimately recovers. After the employee is given a full duty release with respect to his physical injuries, he petitions for continuing benefits based on an inability to work due to a diagnosis of PTSD. The PTSD claim may be a compensable condition under the CMPA if it arose because of the physical assault.

Example 4-5H(3)(b):

A Corrections Officer files a mental/emotional stress claim due to anxiety from having to work with inmates who are hostile, combative, and menacing. Interacting with inmates is a regular work duty associated with being a Corrections Officer. If the employee was hired on or after January 1, 1980, the officer's anxiety would not be a compensable condition under the CMPA. If the employee was hired prior to January 1, 1980, his mental/emotional stress claim may be compensable under the CMPA.

- (4) Intoxication. An employee may not have the protection of the CMPA where the PSWCP can show that intoxication was the proximate cause of the injury. An intoxicant may be alcohol, prescription drugs, illicit drugs, or any other substance that impairs the employee. *See* D.C. Official Code §1-623.02(a)(3)
- (a) The claim record must contain evidence to show the extent to which the employee was intoxicated at the time of injury **and** the particular manner in which intoxication caused the injury. The Program must establish by substantial evidence that the intoxication caused the injury, not just that the employee was intoxicated at the time of the injury.
 - (b) The CE should obtain medical documentation, to include test results, from the physician or hospital where the employee was treated immediately following the injury to establish the extent of intoxication and the manner in which the intoxication was affecting the employee's activities.
 - (c) Statements should be obtained from the immediate supervisor, coworkers, and other witnesses that describe the employee's activities preceding the injury, with particular emphasis on personal conduct, apparent sobriety, and the extent to which the employee appeared to be inebriated or otherwise not in control of all faculties.

Example 4-5H(4):

An intoxicated employee is the passenger in a van transporting youth residents. The vehicle is involved in a motor vehicle accident (MVA) and the employee sustains a head contusion. The employee may have coverage under the CMPA for the injuries sustained.

However, if the same employee were driving the van and causes an accident due to his or her intoxication, there would not be coverage under the CMPA for the injuries sustained.

- I. *Subrogation.* All claims should be reviewed to determine if the potential for third party liability exists. If third party potential liability exists, the CE should initiate third party procedures in accordance with 7 DCMR § 151.

4-6 INITIAL DETERMINATIONS. The Program shall issue, within 30 days of the filing of an original claim for compensation, an Initial Determination (ID) to accept or deny the claim, or place the claim in abeyance. *See* D.C. Official Code §1-623.24(a) and 7 DCMR § 120.1. If the Program fails to issue an ID within 30 days of filing or to place the claim in abeyance, the claim shall be deemed accepted and compensation benefits shall be payable on the 31st day. *See* D.C. Official Code §1-623.24(a-3)(1). Payment of compensation benefits shall continue until such time as the Program issues an ID denying compensation benefits. *See* D.C. Official Code §1-623.24(a-3)(2). A claim for recurrence of disability, to supplement an accepted injury with additional conditions, or to add wage-loss compensation shall be treated as an original claim for compensation. The employing agency should be informed, in writing, of all initial determinations to accept or deny a claim. All IDs shall include a finding of facts and appeal rights and include documents to support the Program’s determination. All conditions and diagnoses presented before the Program expressly identified in an application for compensation benefits should be addressed in the initial determination and accepted or denied, as appropriate. The Program’s failure to address any condition expressly identified in an application for compensation shall be deemed denied. The extent of the Program’s acceptance of a claim shall be limited to that which is expressly stated in the ID.

- A. Notice of Abeyance. If “extenuating circumstances” exist that prevent the Program from accepting or denying a claim within 30 days of filing, the Program shall issue a Notice of Abeyance. Extenuating circumstances exist where:
 - (1) The Program does not have sufficient medical evidence to make a determination;
 - (2) The employee has failed to cooperate with the Program in the assessment of the claim; or
 - (3) There is a delay in receiving information from the Employing Agency that is beyond the reasonable control of the Employing Agency. *See* 7 DCMR § 121.3.

A Notice of Abeyance shall include detailed reasons for the abeyance, to include what information has been submitted and why it is not sufficient to adjudicate the claim. If the abeyance results from insufficient medical evidence, the notice shall inform the claimant that he or she has 30 days to provide the necessary medical records and/or submit for additional medical examinations as requested by the Program. The notice should also inform the claimant that a decision to accept or deny a claim may issue following the expiration of the submission period and include rights to review by the Chief Risk Officer pursuant to 7 DCMR § 156.

- B. Acceptances. An Initial Determination accepting a claim should include the following information: date of injury, name of employing agency, finding of facts, accepted work-related injury, accepted diagnosis or condition, information regarding entitlement to COP, information regarding entitlement to wage-loss benefits, and appeal rights.
- (1) *Burden of Proof*. A claimant must establish all five (5) elements of a claim by a preponderance of the evidence (more likely than not). The claimant is responsible for submitting, or arranging for submittal of, medical documentation from the treating physician. For wage-loss claims, the claimant must also submit medical evidence showing that the condition claimed is disabling and the nature and extent of the disability to justify payment of indemnity compensation. *See* 7 DCMR § 119.
 - (2) *Accepted injury, diagnosis, or condition*. The CE should accept each diagnosis or condition that is causally related to the work injury, regardless of severity or impact on disability. The diagnosis or condition accepted should be based on the diagnosis code provided in the medical documentation or Health Insurance Claim Form submitted by the medical provider in the claim file. Subjective complaints should not be accepted without objective physical findings or significant clinical abnormalities that support them. The medical documentation supporting the accepted diagnosis or condition must be attached to the ID.
 - (a) Multiple diagnoses or conditions. At the time of acceptance, the CE should address all diagnoses and conditions claimed. This is true even if medical management is not necessary for all causally related conditions. For example, a claimant slips and falls on ice in the course of employment and an emergency room physician diagnoses the employee with left hip contusion and left knee meniscus tear. Even if the left knee condition becomes the predominant cause for disability and need for further treatment, the CE should also accept the left hip contusion and indicate whether the condition has resolved, as appropriate.

If multiple conditions have been claimed, and the evidence of record supports acceptance of some but not all of the conditions claimed, the CE should issue a NOD of acceptance for the compensable conditions and deny the remaining claims with

reference to the medical documentation. Alternatively, the CE may concurrently issue a development letter for the remaining claimed conditions, holding the remaining conditions in abeyance subject to receipt of additional medical information. The development shall be undertaken in separate correspondence. Failure to address all claimed conditions in the ID results in denial of those conditions not addressed. The ID should state that acceptance is limited to those conditions expressly stated and that all other claimed conditions are deemed denied.

- (b) Aggravation claims and pre-existing conditions. If the medical evidence establishes that a pre-existing condition was aggravated, an aggravation should be accepted, but not the underlying condition itself. The CE should accept either a temporary or permanent aggravation, depending on the medical evidence. A determination shall be made to establish the claimant's medical baseline with regard to the pre-existing condition and the extent and duration of any aggravation must be made based on medical evidence, as discussed in the Causal Relationship section of this chapter.

If the aggravation is temporary and leaves no permanent residual impairment, the claimant is entitled to compensation only for the period of disability related to the aggravation. This is true even when the claimant is found medically disqualified to continue in his or her regular job because of the effect which the employment factors might have on the pre-existing condition in the future. When the claimant's inability to continue working is due to the underlying condition, without any contribution from the employment, compensation is no longer payable.

Example 4-6B(2):

A corrections officer is involved in an altercation with an inmate and suffers a back strain that temporarily aggravates his pre-existing degenerative disc disease, causing back pain. After a period of treatment, the back pain subsides and the claimant is able to return to work. However, the treating physician discourages a return to duty as a corrections officer because continued interaction with inmates could have a negative impact on the claimant's pre-existing degenerative condition. The claimant would not be entitled to compensation benefits after the back strain and pain resolved, as the inability to return to the date of injury position is related to the underlying pre-existing condition and not the temporary aggravation of the condition by the work injury, which had resolved.

- (c) Resolved conditions and limited periods of disability. If the medical evidence establishes that the work-related condition being accepted has resolved by the time of adjudication, a determination regarding ongoing entitlement to worker's compensation benefits

should be addressed in the ID in the form of a closed period acceptance.

Additionally, any award for wage-loss benefits must be supported by medical evidence. If the medical evidence establishes disability for a discrete period of time, wage-loss benefits should be limited to the documented period of disability in the form of a closed period. If the medical evidence establishes partial disability, wage-loss benefits shall be calculated based on the claimant's loss of wage-earning capacity pursuant to D.C. Official Code § 1-623.15. A claimant has the burden to establish entitlement to continuing wage-loss benefits and extent of any loss in wage earning capacity.

- (3) *Award of Benefits.* The ID accepting a claim should detail the nature of compensation benefits awarded. The amount of compensation awarded and calculation of any benefits shall not be included in the ID, but rather in a separate Notice of Benefits (NOB) to the employee, with appeal rights to the Chief Risk Officer pursuant to 7 DCMR § 156.
- (a) Medical benefits. An ID accepting a claim should contain a statement indicating that the claimant is entitled to medical treatment for the accepted conditions.
 - (b) COP eligibility. An initial acceptance should include a statement of whether COP was payable or paid. An injured employee is entitled to COP for traumatic injury claims only and only for the period that the claim for compensation has not been accepted by the Program. For more information pertaining to COP, see Chapter 3 of this manual.
 - (c) Wage-loss indemnity benefits. Wage-loss benefits may be total or partial. An award of wage-loss indemnity benefits should be based upon the medical evidence and may be awarded for a closed period, if appropriate. An award of partial wage-loss benefits shall include a determination of such benefits made with reference to the factors provided at D.C. Official Code § 1-623.15.
 - (d) Schedule award for permanent disability. A schedule award for permanent disability may be made in lieu of temporary disability benefits upon filing a claim if a claimant has loss of use of both hands, both arms, both feet, or both legs or the loss of sight of both eyes. However, even under these extreme circumstances, because maximum medical improvement is not likely to have been reached at the initial stage of the claim, the better practice is likely to issue an award of TTD, pending stabilization and an accurate assessment of permanent impairment.

- C. Denials. If a claimant fails to establish, by a preponderance of the evidence, one or more of the five basic elements of a claim under the Act (timeliness, employee status, fact of injury, performance of duty, and causal relationship), or if a statutory exclusion applies, the CE should issue an Initial Determination denying the claim. Any denial based on statutory exclusion must be supported by substantial evidence in the claim file. A claim for compensation may also be denied if an injured worker fails to accept a modified duty assignment that accommodates medically recommended work restrictions or fails to appear for an Additional Medical Examination pursuant to D.C. Code § 1-623.23.

An ID denying a claim should include the following information: date of injury, name of employing agency, finding of facts, alleged work-related injury, diagnosis and condition claimed, reason for the denial, information regarding eligibility for COP, attachment of documents supporting the decision, and appeal rights.

- (1) Claim development and requests for information. Before denying a claim, the CE should adequately develop the claim and advise the claimant in writing of his or her burden to establish entitlement to benefits. Prior to issuing an ID denying a claim or taking other adverse action, a claimant should be given at least thirty (30) days to reply to any Program requests for additional information necessary to adjudicate the claim.

When requesting information from a claimant, the CE should state what evidence is already in the case record and why it is not sufficient to make a decision. The claimant should be informed of the time allotted for a response, and that action may be taken based on the information contained in the file following the expiration of the response period

- (2) Information in Notice. The ID denying a claim should: (1) describe the nature of the injury; (2) summarize the evidence initially submitted with the claim and provide an explanation as to why it was deficient; (3) summarize what additional information was requested upon development; (4) describe all evidence received after development; and (5) explain why the evidence is insufficient to support the claim.
- (3) COP eligibility. An injured worker is not eligible for COP if a claim for compensation benefits has been denied. Any COP paid may be charged to sick or annual leave or be deemed a debt to the District and subject to collection pursuant to D.C. Official Code §1-629.03. For more information pertaining to COP, see Chapter 3 of this Manual.

- D. Appeal Rights. All Initial Determinations issued on or after December 1, 2016 shall be subject to appeal to the Office of Administrative Hearings (OAH). Initial Determinations issued prior to December 1, 2016 shall be subject to appeal to the Department of Employment Services, Office of Hearings and Adjudications (OHA). See D.C. Official Code §1-623.24(b)(1), D.C. Official Code §2-1831.03(b)(1), and 7 DCMR 155. A claimant not satisfied with an Initial

Determination may request a hearing within 30 days of the issuance of the decision.

- E. Amending Initial Determinations. The PSWCP may modify an initial award for compensation if it is determined that the original decision was made in error. *See* D.C. Official Code §1-623.24(d)(4)(E). Where supported by *strong compelling evidence*, the Program may set aside or modify an initial decision and issue a new decision. To justify recession of acceptance, the Program must establish that its prior acceptance was erroneous based on new or different evidence or through new legal argument.
- F. Notice of Benefits. A Notice of Benefits should issue within fourteen (14) days following a Notice of Determination accepting a claim that provides information regarding the benefits awarded. *See* 7 DCMR §120.10.

4-7 DEATH CLAIMS

- A. Eligibility. To be eligible for death benefits, a claimant must be the spouse or domestic partner, child, or other eligible dependent of an individual who died as a direct result of an injury sustained in the performance of duty as a District of Columbia government employee.

(1) Benefits.

- (a) Monthly compensation. Monthly compensation is payable to eligible individuals enumerated at D.C. Official Code §1-623.33 and further defined within D.C. Official Code §1-623.01. Those not specified are not eligible.

Spouses and domestic partners may also be entitled to lump sum settlements pursuant to D.C. Official Code §1-623.35.

Eligibility for compensation begins the day after death and is calculated in accordance with D.C. Official Code §1-623.33. A beneficiary's failure to notify the Program of a change in eligibility for death benefits may result in the Program initiating overpayment proceedings pursuant to 7 DCMR §133.

- (b) Funeral expenses and transportation of the body. The personal representative of the deceased employee shall be entitled to an amount to be determined by the Chief Risk Officer, not to exceed \$5,000.00, for funeral and burial expenses. If an employee dies away from his or her home, official station, or outside of the United States, the reasonable costs to return the body to the decedent's home or place of last residence shall be payable from the Employees' Compensation Fund. *See* D.C. Official Code §1-623.34.

- (c) Notwithstanding any funeral and burial expenses paid under D.C. Official Code § 1-623.34, \$200 shall be payable to the personal representative of the Estate upon termination of the decedent's status as an employee of the District of Columbia government. *See* D.C. Official Code §1-623.33(f).
- (2) Relationship to the deceased and dependent status. The relationship of the claimant to the deceased, eligibility and dependent status are determined as of the date the death occurred.
- (3) Applicable Forms.
 - (a) Death claim only (no payment of indemnity). Form CA7, Form 1, Form 2, Form 4, death certificate, and other documentation to establish the relationship of the claimant to the deceased employee, such as a certified copy of a marriage license or birth certificate, should be provided. If the cause of death is unknown or is not clearly related to the work injury, Form 3A must be submitted along with a coroner's report, if any.
- (4) Election of Benefits. Pursuant to D.C. Official Code §1-623.16(b) and 7 DCMR 134.3, an election must be made between death benefits and any other benefit the claimant may be eligible to receive as a result of the employee's death from the same injury, excluding life insurance proceeds.
 - (a) A surviving spouse or domestic partner who is entitled to benefits under Chapter 23 of the CMPA derived from more than one husband or wife shall elect one entitlement. D.C. Official Code §1-623.33(b)(2).
 - (b) A beneficiary, who is eligible to receive benefits upon the employee's death under the Civil Service Retirement System (CSRS), who elects to receive workers' compensation death benefits under D.C. Official Code § 1-623.01 *et seq.*, is not a death beneficiary annuitant under the CSRS and is therefore not eligible to receive Federal Employee Health Benefits.
 - (c) Where a claimant begins accepting CSRS death benefit annuity payments prior to acceptance of a claim for compensation, any election of PSWCP death benefits in lieu of a CSRS death benefit annuity shall take effect prospectively and payment of compensation payments will be made prospectively, after the death benefit annuity from the CSRS discontinues.
- (5) Limitations.

- (a) Monthly compensation payable pursuant to D.C. Official Code § 1-623.33 is paid from the time of the employee's death until:
 - (i) A surviving spouse or domestic partner dies, marries, remarries, or enters into a domestic partnership;
 - (ii) A child or other eligible dependent, dies, marries or enters into a domestic partnership, becomes 18 years of age, or if over age 18 and incapable of self-support, becomes capable of self-support; or
 - (iii) A parent or grandparent dies, marries or enters into a domestic partnership, or ceases to be dependent.
- (b) A claimant who ceases to be eligible for death benefits because of the foregoing restrictions is required to notify the Program upon the effective date of any event that affects his or her eligibility.
 - (i) A claimant who receives death benefit compensation is required to notify the Program when the claimant marries, remarries or enters into a domestic partnership.
 - (ii) A claimant who receives death benefit compensation, who is also the decedent's parent or grandparent, is required to notify the Program when the claimant ceases to be a dependent.
 - (iii) A claimant who receives death benefits as the decedent's child, brother, sister, or grandchild, who is over 18 and incapable of self-support, must notify the Program when the claimant becomes capable of self-support
- (c) A claimant, who is eligible for another benefit pursuant to D.C. Official Code § 1-623.16, shall make an election of benefits. *See* Section 4-7(A)(4).
- (6) Eligibility.
 - (a) Spouse or Domestic partner. To be eligible for monthly compensation, a surviving spouse or domestic partner must have been living with or dependent upon the decedent at the time of death or living apart for reasonable cause or because of desertion by the decedent. *See* D.C. Official Code §1-623.01(21).
 - (i) *Evidence of marriage or domestic partnership.* If neither the decedent nor the surviving spouse was previously married, a certified copy of the marriage certificate will be sufficient. If either the decedent or surviving spouse was

married previously, the surviving spouse must also submit copies of the divorce or annulment decree showing dissolution of the prior marriage(s), or death certificate of the former spouse(s), as the case may be.

- (ii) For domestic partnerships, the claimant must establish the criteria of the state or District where the parties reside. For residents of the District of Columbia, a certified copy of a Domestic Partnership Certificate must be provided.
 - (iii) If common law marriage is at issue, the claimant must provide documentation satisfactory to the Chief Risk Officer to establish the marriage according to the law of the legal jurisdiction in which the participants satisfied the applicable elements of common law marriage.
 - (iv) *Remarriage.* Upon remarriage or entry into a domestic partnership **before reaching age 60**, a surviving spouse or domestic partner shall be entitled to a lump-sum equal to 24 times the monthly compensation payment (excluding compensation on account of another individual) to which he or she was entitled immediately before the remarriage or entry into a domestic partnership. See D.C. Official Code §1-623.35(c).
 - (iv) *Termination.* To terminate a death benefit based on remarriage or entry into a domestic partnership, the Program has the burden of establishing that the subsequent marriage or domestic partnership took place. Cohabitation in and of itself is not sufficient to establish the existence of a bona fide common law marriage or domestic partnership, unless it is accepted by the legal jurisdiction in which the beneficiary resides.
- (b) Children (and other eligible dependent minors). D.C. Official Code § 1-623.01(9) defines a “child” as one who, at the time of death of the employee, is under 18 years of age or over that age and incapable of self-support. Stepchildren, adopted children, and posthumous children (born after the death of the employee) are included, but children who are married or in a domestic partnership are not.
- (i) *Evidence required.* Proof of parentage or other familial relationship must be provided. Examples include birth certificates, adoption records and marriage certificates.
 - (ii) *Limitations.* Compensation benefits continue until a child (or other eligible dependent minor) dies, marries or enters

into a domestic partnership, becomes 18 years of age, or if over age 18 and incapable of self-support, becomes capable of self-support.

- (iii) *Termination.* Compensation benefits shall terminate at the end of the month during which an eligible child attains age 18.
- (iv) *Student status.* D.C. Official Code § 1-623.01(13) defines a “student” as an individual under 23 years of age who has not completed four (4) years of education beyond the high school level and who is regularly pursuing a full-time course of study or training at a qualifying institution.
 - (a) *Where a child has reached age 18 and has indicated no intention to attend school after high school,* compensation should cease at the end of the month in which the child graduated from high school.
 - (b) *Where a child is a student at the time he or she reaches age 18 and has indicated an intention to continue full-time study at a school or qualifying institution during the next regular session,* benefits may continue for up to four (4) years of eligible education beyond high school, or until the beneficiary reaches age 23, whichever comes first. D.C. Official Code §§ 1-623.33(b)(2) and 1-623.01(13). A student whose 23rd birthday occurs during a semester or other enrollment period is deemed a student until the end of the semester or other enrollment period.
 - (c) *Eligible education.* Entitlement to compensation based on eligible education are counted in annual increments. Thus, if a beneficiary should decide for any reason not to attend school for part of a year during which benefits were paid on account of student status, that beneficiary would be charged with having used an entire year of eligibility out of the allotted four years, even though compensation terminates when the beneficiary leaves school.

Eligible education begins the month after the child graduates from high school, if the child has indicated an intention to continue a full-time course of study or training during the next regular session,

and each successive 12-month period, provided that full-time attendance continues. If, however, the child did not attend during the next regular session following high school graduation due to factors beyond his or her control, eligible education begins on the date the child actually begins a full-time course of study at a school or qualifying institution.

- (d) *Interim periods between courses of study.* An individual is not deemed to have ceased being a student during an interim between school years if the interim is not more than 4 months *and* if he or she shows a bona fide intention of continuing a full-time course of study or training during the following enrollment period or during periods of reasonable duration during which, in the discretion of the Chief Risk Officer, the beneficiary is prevented by factors beyond his or her control (such as a period of incapacitating illness) from pursuing his or her education. “Factors beyond the control” and “reasonable duration” will be decided by the Program on a case by case basis based on evidence submitted by the beneficiary.
- (e) *Proof of enrollment and bona fide intention of continued enrollment.* Upon graduation from high school and during the interim between school years, the beneficiary bears the burden of proof to establish his or her bona fide intention of continuing a full-time course of study to be eligible for continuing benefits. Examples include completed enrollment applications, letter of acceptance from a school or qualifying institution, commitment letter, or course enrollment documentation. A beneficiary must produce evidence sufficient to establish actual full-time enrollment at the beginning of each term or enrollment period. Examples include a letter of enrollment from the school or qualifying institution, class schedule, or proof of tuition payment.

Example 4-7A(6)(a):

A beneficiary’s date of birth is January 13, 1990. He is receiving death benefit compensation and will graduate from high school in June 2008. Steve has indicated that he will not attend college or another qualifying institution following high school. He will be entitled to compensation through the end of June 2008, as he will be age 18 at the time of graduation.

Example 4-7A(6)(b):

A beneficiary's birth date is February 10, 1977. She is receiving death benefit compensation and will graduate high school in May 1994. She has provided documentation indicating that she will attend college on a full-time basis starting in the fall of 1994. Her first year of education beyond high school will begin in June 1994. This is true even though she is still entitled to benefits by being under 18 until February 1995. The beneficiary would be entitled to continued compensation benefits for the period between high school graduation and the start of the fall college term, provided that the period is not more than 4 months.

Example 4-7A(6)(c):

A beneficiary's date of birth is April 15, 1994. She is receiving death benefit compensation and will graduate high school in May 2012. The beneficiary has provided documentation indicating that she will attend college on a full-time basis starting in the fall of 2012. Based on this representation, she would be entitled to continued compensation benefits in the interim between high school graduation and the start of the fall college term. In September, she advises PSWCP that she has reconsidered and decided to work instead of attending school.

Compensation would terminate on October 1, 2012 without declaring an overpayment as the beneficiary has previously established a bona fide intent to continue in school the following semester.

To be eligible for a resumption of compensation benefits based on student status, the beneficiary must establish that her failure to continue school enrollment following high school graduation was due to "factors beyond her control." Since she received compensation following high school graduation based on school attendance, the period for which she was paid represents one full year of eligibility out of her 4-year allotment.

- (v) Marriage. A dependent child's eligibility for benefits terminates on the date of the child's marriage. A child whose marriage ended prior to the employee's death or whose marriage is annulled will not be barred from receiving death benefits if otherwise entitled, but a child who is divorced or widowed after the employee's death is not eligible for benefits.
- (vi) Over 18 and Incapable of self-support. To be entitled to benefits, a child over 18 at the time of the employee's death must have been incapable of self-support at the time of death by reason of a mental, developmental, or physical disability. A child who becomes incapable of self-support after the employee's death, but before reaching age 18, is eligible for benefits under the same provision.

- (a) *Representation.* A beneficiary incapable of self-support by reason of mental or developmental disability must be represented by a guardian *ad-litem* or other court-appointed legal guardian and must submit documentation in support of said relationship at the time the claim is filed.
 - (b) *Incapable of self-support.* A beneficiary is incapable of self-support if his or her medically established mental, developmental, or physical condition is such that he or she is unable to obtain and retain a job or engage in self-employment that would provide a sustained living wage pursuant to D.C. Official Code § 2-220.01 *et seq.*
 - (c) *Burden of Proof.* A beneficiary claiming benefits in this capacity bears the burden of proof to establish the beneficiary's incapability of self-support based on medical evidence. A determination on eligibility for compensation must be based on medical evidence that demonstrates a lack of capability for self-support. The beneficiary must provide medical evidence and records in support of his or her claim at the Program's request. A physician's opinion must be based on sufficient findings and rationale to establish unemployability. When medical evidence demonstrates incapacity for self-support, this determination will stand unless refuted by sustained work performance.
 - (d) *Compensation Payment.* Compensation payment for beneficiaries over 18, who are incapable of self-support by reason of mental or developmental disability, shall be distributed to a conservator, a person appointed by the court to take care of someone who is incapacitated, other court-appointed legal representative, or custodial parent.
- (c) Dependent Siblings, Parents and grandparents. The decedent's parent(s) (by birth or adoption), step-parent(s), grandparent(s), or sibling(s) may be eligible for compensation benefits if he or she was wholly or partially dependent on the deceased for support.
- (i) *Proof of kinship,* such as a birth certificate or adoption records, must be submitted. Additional kinship records and proof of marriage must be submitted if the claimant is a grandparent, step-parent, or sibling.

- (ii) *Proof of Dependency.* A beneficiary filing the claim as a dependent, other than minor children, must establish proof of dependency to be eligible for compensation benefits. The test for dependency is not whether the claimant is capable of self-support without the amount which was previously provided by the deceased. The person claiming dependency must show that he or she looked to and relied upon the contributions, in whole or in part, as a means of maintaining or helping to maintain a customary standard of living.
 - (iii) *Termination.* Compensation benefits continue until death, marriage or entry into a domestic partnership, or end of dependency. Compensation should terminate when the beneficiary's current income received, less compensation, equals or exceeds the total income from all sources, to include contribution from the decedent, at the time of death.
- B. Initial Development of Death Claims. A person claiming death benefits under D.C. Official Code §1-623.33 bears the burden of proving a qualifying familial relationship and dependency, if necessary. Additionally, the claimant must establish the 5 basic elements of a claim (time, employee status, fact of injury, performance of duty, and causal relationship) as discussed in Section 4-5 above. All requirements must be established by a preponderance of the evidence. *See* 7 DCMR 119.1. The evidence submitted must be reliable, probative and substantial.
 - (1) *Time.*
 - (a) Notice. Notice must be given to the employee's immediate supervisor within thirty (30) days of the injury or death. *See* D.C. Official Code § 1-623.19(a)(1) and 7 DCMR 104. Notice is effective upon the immediate supervisor's receipt of completed Form 1, Form 4, and Form 5.
 - (b) Death Claims. A claim for death benefits must be filed within two (2) years of the employee's death. The timely filing of a disability claim will satisfy the time requirements for a death benefits claim based on the same injury. *See* D.C. Official Code § 1-623.22(a) and (c).
 - (i) The filing of a compensation claim beyond the 2-year filing requirement **may** be allowed if: (1) the immediate supervisor had *actual knowledge* of the injury or death within 30 days; or (2) written notice of the injury or death

was given within 30 days. *See* D.C. Official Code § 1-623.22(a).

- (ii) The 2-year statutory time limitation does not apply:
 - (1) To a minor until he or she reaches 21 years of age or has had a legal representative appointed;
 - (2) To an incompetent individual while he or she is incompetent and has no duly appointed legal representative; or
 - (3) Against any individual whose failure to comply is excused by the Chief Risk Officer due to exceptional circumstances. *See* D.C. Official Code § 1-623.22(d).
 - (2) *Employee Status.* The deceased worker must be a District of Columbia government employee as defined by D.C. Official Code § 1-623.01(1).
 - (3) *Fact of Injury.* The claimant must establish that the accident, untoward event, or employment factors alleged actually occurred, and that a medical condition has been diagnosed in connection with the event or employment factors.
 - (4) *Performance of Duty.* A claimant must establish that the employee was performing official duties (or an activity incidental to employment) at the time of the injury or death. The injury or death must arise out of and in the course of District government employment for the performance of duty element to be met.
 - (5) *Causal Relationship.* The claimant must establish a causal relationship between the death and work environment by presenting medical evidence relating the death to the work injury, unless the relationship between the death and employment is obvious.
- C. Initial Determinations. The Program **shall issue, within 30 days** of the filing of a claim for death benefits, an Initial Determination (ID) to accept, deny, or place the claim in abeyance. *See* D.C. Official Code § 1-623.24(a) and 7 DCMR 120.1. If the Program fails to issue an ID within 30 days of filing, the claim for death benefits shall be deemed accepted and compensation benefits shall be payable on the 31st day. *See* D.C. Official Code § 1-623.24(a-3)(1). Payment of compensation benefits shall continue until such time as the Program issues an ID denying compensation benefits pursuant to D.C. Official Code § 1-623.24(a-3)(2). All IDs shall include findings of fact and appeal rights.

- (1) *Notice of Abeyance.* If “extenuating circumstances” exist that prevent the Program from accepting or denying a claim within 30 days of filing, the Program shall issue a Notice of Abeyance.
 - (a) Extenuating circumstances exist where:
 - (i) The Program does not have sufficient medical evidence to make a determination;
 - (ii) The employee or his representative has failed to cooperate with the Program in the assessment of the claim; or
 - (iii) There is a delay in receiving information from the Employing Agency that is beyond the reasonable control of the Employing Agency. *See* 7 DCMR 121.3.
 - (b) A Notice of Abeyance shall include detailed reasons for the abeyance, to include what information has been submitted and why it is not sufficient to adjudicate the claim. If the abeyance results from insufficient medical evidence, the notice shall inform the claimant that the claimant has 30 days to provide the necessary medical records and/or submit for additional medical examinations as requested by the Program. The notice should also inform the claimant that a decision to accept or deny a claim may issue following the expiration of the submission period and provide a right for review before the Chief Risk Officer pursuant to 7 DCMR 156.
- (2) *Acceptance.* Unless a claimant is eligible for another benefit as a result of the employee’s death that requires the claimant to make an election pursuant to D.C. Official Code § 1-623.16, an Initial Determination accepting a death claim should include the following information:
 - (a) Name of deceased employee;
 - (b) Date of injury and death;
 - (c) Name of employing agency;
 - (d) Findings of fact;
 - (e) Eligible beneficiaries,
 - (f) Conditions(s) under which death benefits may cease, and
 - (g) Appeal rights.

- (3) *Notice of Eligibility.* In lieu of an Initial Determination accepting and awarding a claimant death benefits, a claimant, who is eligible for another benefit as a result of the employee's death that requires the claimant to make an election pursuant to D.C. Official Code § 1-623.16, shall be issued a Notice of Eligibility and Election of Compensation Form.
- (a) The Notice of Eligibility shall include all information provided in the Initial Determination accepting the claim, as provided at Section 4-7(C)(2) of the chapter and
- (i) The amount of benefits the claimant is eligible to receive;
- (ii) Notification that he or she is determined to be eligible for another benefit that requires the claimant to make an election pursuant to D.C. Official Code § 1-623.16; and
- (iii) The Election of Compensation Form, which the Claimant is obligated to sign and return to the Program, so benefits may commence.
- (b) When a claimant elects to receive workers' compensation death benefits provided under D.C. Official Code § 1-623.33 while already receiving a death benefit annuity under the CSRS, the Program shall notify the United States Office of Personnel of the claimant's election and receive written confirmation of the date that the death benefit annuity will cease prior to the Program issuing workers' compensation death benefit payments.
- (4) *Denial.* If a claimant fails to establish, by preponderance of the evidence, a qualifying familial relationship, dependency (if necessary), and the 5 basic elements of a claim under the CMPA (timeliness, employee status, fact of injury, performance of duty, and causal relationship), the CE should issue an Initial Determination denying the claim.
- (a) An ID denying a claim should include the following information:
- (i) Name of deceased employee;
- (ii) Date of injury and death;
- (iii) Name of employing agency;
- (iv) Finding of facts;
- (v) Reason for the denial; and
- (vi) Appeal rights.

- (5) *Appeal Rights.* All Initial Determinations issued on or after December 1, 2016 shall be subject to appeal to the Office of Administrative Hearings (OAH). Initial Determinations issued prior to December 1, 2016 shall be subject to appeal to the Department of Employment Services, Office of Hearings and Adjudications (OHA). *See* D.C. Official Code §1-623.24(b)(1), D.C. Official Code § 2-1831.03(b)(1), and 7 DCMR 155. A claimant not satisfied with an Initial Determination may request a hearing by filing the request within 30 days of the issuance of the decision.

Any party adversely affected or aggrieved by a compensation order or final decision issued by OHA or OAH may appeal said compensation order to the Compensation Review Board (the Board) by filing an application for review with the Board within 30 calendar days from the date shown on the certificate of service of the compensation order or final decision. *See* 7 DCMR 163.2

- D. Notice of Benefits. A Notice of Benefits (NOB) should issue within fourteen (14) days following a Notice of Determination accepting a claim that provides information regarding the benefits awarded. The NOB should include eligible beneficiaries, conditions(s) under which death benefits may cease, benefit(s) granted (monthly compensation, funeral expenses, \$200 administrative fee), amount of benefit award(s), and right of appeal to the Chief Risk Officer as provided at 7 DCMR 156.
- E. Claims Management. On a regular basis the Program may require a beneficiary to confirm his or her continuing eligibility for benefits, such as marital or domestic partnership status, age, school enrollment, or dependency, and may conduct any investigation necessary to confirm this information. 7 DCMR 152.5.