

DISTRICT OF COLUMBIA WORKERS' COMPENSATION BASICS

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1. History of the Act:

- a. Derived from the Longshore Act.
- b. The District of Columbia Act as undergone four major amendments since original enactment, most recently in 1999.
- c. The Act is also routinely interpreted by the District of Columbia Court of Appeals, whose Decisions often have the impact of changing the interpretation of the law.

2. Claim Investigation:

a. Injury:

- i. It must arise out of and in course of employment.
- ii. What is considered an injury in DC is very broad.
- iii. An Occupational Disease must be a medical condition that is an expected result of working under the conditions inherent in the employment.
 - 1. The claims are handled in the same fashion.
 - 2. There are no separate notice or limitations provisions.
- iv. Most injuries are compensable. There are defenses to certain types of injuries, including: self-inflicted injuries, horseplay, and drugs/alcohol (sole cause of injury).

b. Jurisdiction: (32-1503(a))

- i. Has the Claimant received benefits pursuant to an order in another jurisdiction (32-1503(a-1))? If the Claimant files a claim in DC after receiving payment pursuant to an Order in a sister jurisdiction, the claim can now be brought in DC, but the employer/insurer has a credit for any benefits paid in the other jurisdiction.
 - 1. The employer/insurer may not direct the claimant to file in a given jurisdiction. If they do so, the claimant may still be able to file in DC, even if there is an order in a sister jurisdiction.
- ii. If hurt in an alternate jurisdiction, but regularly employed in DC the claim is likely covered (32-1503(a-2)).
- iii. Intermittent Employee: not residents of DC, contract of hire is entered in another state, if Claimant is only temporarily or intermittently within DC, if there is insurance coverage in alternate jurisdiction, then jurisdiction can be contested (a-3).

3. Notice: (32-1513)

- i. 30 days to notify the employer of the injury and its relationship to employment. It is critical that the Claimant provide both, not simply that he/she/they were hurt.
- ii. 30 days begins running from the date the Claimant is aware of the relationship.
- iii. Notice shall be in writing, BUT, lack of writing is not actually necessary.
- iv. If the employer (supervisor) witnesses the accident and injury, notice will be deemed to have been given.
- v. Indemnity benefits vs. Medical benefits - Notice only bars indemnity Benefits, medical benefits must still be paid if the claim is otherwise compensable.

4. Statute of Limitations: (32-1514)

- i. 1 year
- ii. However, period does not begin to run until employer files a first report and sends the report and the rights form to the Claimant certified return receipt requested.
- iii. Period does not begin running if the employer makes payments in the interim or otherwise induces the claimant to take an adverse action, such as not filing. An Estoppel will extend the limitations period.
- iv. Limitations MUST be raised at the first hearing or is deemed waived.
 - 1. It is uncertain whether the reference to a hearing refers to the Formal Hearing or also refers to an Informal Conference. Good practice is to raise it when the matter is first adjudicated, whether that be at an OWC Informal Conference or AHD Formal Hearing.
- v. The issue of Statute of Limitations is currently pending before the Court of Appeals involving reopening. The community expects to receive a decision in the coming year.

5. Intoxication:

- i. If the Claimant's injury was caused SOLELY by his intoxication or willful intention to injure him/her or another, then the claim will be barred. (32-1503(d))

- ii. There is no bar if it is not the sole cause.

6. Presumptions: (32-1521)

- a. The following ARE presumed:
 - i. Claim falls within the Act;
 - ii. Notice given;
 - iii. Injury was NOT as a result of Intoxication of the Claimant;
 - iv. Injury was not as a result of the willful intention of the Claimant.
- b. NOTE: The following common issues are NOT presumed:
 - i. Nature and Extent of Disability;
 - ii. Necessity of medical care;
 - iii. Average Weekly Wage
 - iv. This is not an exhaustive list. Good practice is to assume that unless the statute states that it is presumed, it is not and to prepare accordingly.

7. Treating Physician:

- i. Selected by the Claimant, however, the claimant must be aware of his/her right to select a doctor (rights form);
- ii. If the claim is completely contested, the claimant may change doctors without permission.
- iii. If any voluntary/ordered payments have been made, the claimant may only be change doctors if agreed by the employer or if authorized by OWC;
- iv. Change in Treating Physician is an issue before OWC only;
- v. The employer cannot request the doctor be changed.
- vi. Treating Physician's opinion is afforded great weight and usually followed.

8. Payment of Compensation: (32-1515)

- a. DC is a voluntary pay jurisdiction
 - i. Can pay without prejudice.
- b. Waiting Period: 3 days. However, if the Claimant is out for more than 14 days he/she is paid those three days.

9. Employer's First Report:(32-1532)

- i. Due within 10 days from the employer's knowledge of the injury.
- ii. Limitations does not begin running until the Employer's First Report and the Claimant's Rights Form are BOTH filed with the OWC and sent certified mail, return receipt requested to the last known address of the Claimant.
 - 1. Limitations period for filing a claim is 1 year in DC.
 - 2. The Employer's First Report and the Rights Form must be sent to the Claimant, even if represented by counsel.
- iii. Penalty for failure to file timely: Up to \$1,000.00.

10. Notice of Controversion:

- i. Pay or controvert within 14 days.
- ii. You must have a good faith basis for Controversion.
- iii. Penalties.
 - 1. Failure to pay or controvert timely, then a 10% on unpaid benefits is imposed. (32-1515e)
- iv. If in doubt, good practice is for the employer to file a Controversion.
- v. Request a date stamped copy of the Controversion.

11. Notice of Payment of Benefits (Form 15; 32-1515g):

- i. OWC must be notified upon making of the FIRST and LAST payment of benefits.
- ii. Must be filed within 16 days after the final payment of benefits.
- iii. Applies to each TYPE of benefit as well, temporary total disability, permanent partial disability, etc.
- iv. Failure to file results in a \$100 civil fine.

12. Dispute Resolution:

a. Informal Conference/Mediation: (DCMR 219.xxx)

- i. Testimony is NOT under oath.
- ii. The IC can be handled by a claims adjuster.
- iii. Claimant Attorney Fees:

1. If the claim is contested in the entirety and the Claimant meets with success, fees may be imposed.
 2. However, if it is a subsequent denial, so long as the employer pays consistent with the Memorandum, imposition of Claimant's attorney's fees will be avoided.
 3. Fees are customarily up to 20% of all benefits secured, including medical benefits. Claimant's counsel must file a fee petition itemizing the effort expended and justifying the fee.
 4. Agreements can be converted to a binding Final Order. However, it is currently unclear whether a "Final Order" is a "Compensation Order" for purpose of starting the statute of limitations clock. (*Levy*, see also, *Darryl Kelly v. DOES*). Be aware that the Court of Appeals in *Riley* referred to a Final Order is a Final Compensation Order, thus apparently indicating that OWC can issue a binding Compensation Order. The law is somewhat unclear on this issue.
- iv. Stipulations cannot be converted to a binding Final Order.
 - v. IC are usually conducted by telephone.
 - vi. No Subpoena Power available to the employer at the OWC level – maybe.
 - vii. No one other than Claimant can testify. The employer is not permitted to present witnesses to testify, however, the employer representative can be present.
 - viii. There are no rules of evidence; almost any document can be submitted.
 - ix. Mediation aspect. The OWC makes an effort to resolve pending disputes by way of mediation.
 - x. The parties will likely be called by the Examiner before the Informal Conference to verify the issues and determine if they can be resolved.
 - xi. Paper copies of the exhibits must be mailed to OWC to be received prior to the Informal Conference. There is no electronic filing at OWC.
 - xii. The Memorandum of Informal Conference (decision) is not admissible at the Formal Hearing level.

b. Memorandum of Informal Conference.

- i. Payments recommended pursuant to a Memorandum must be made within 14 days of receipt of the Memorandum, if not controverted.
- ii. The parties must agree or controvert within 14 days. However, the application for Formal Hearing can be filed up to 34 working days following the Memorandum.
- iii. If controverted and an Application for Formal hearing is filed at AHD, the Memorandum becomes a nullity.
- iv. If no controversion or Application for Formal Hearing is filed within 34 working days, the Memorandum will become a Final Order.
- v. If not automatically issued, you can request the Memorandum be converted to a Final Order.

c. Formal Hearing:

- i. Notice of Controversion must be filed within 14 days and the Application for Formal Hearing must be filed within 34 WORKING days from the (receipt) date of the Memorandum of Informal Conference.
- ii. There is currently uncertainty whether the parties must proceed to an Informal Conference first. See, *Riley*. If the employer files an Application for Formal Hearing while issues are pending for an Informal Conference, the claimant can object to the Formal Hearing and have the matter remanded to OWC for an Informal Conference.
- iii. All issues are ripe for adjudication at a Formal Hearing with limited exceptions, for example: change in treating doctor; attorney's fees at OWC.
- iv. The Formal Hearing is the only opportunity to introduce evidence into the record.
- v. The parties have subpoena power.
- vi. Compensation Order:
 - 1. Payment must be received by the Claimant within ten (10) days of the date of the employer's receipt of the Compensation Order.
 - 2. Failure to pay an order timely results in an automatic 20% penalty. (32-1515(f))
 - 3. An appeal from a Compensation Order is NOT a stay. Payments must continue pending any subsequent appeal.

vii. Reopening/Worsening:

1. This area of law is in flux. See, *Crutchfield*, which is currently pending decision from the Court of Appeals.
2. It appears that the one year timeframe to reopen an Order for Worsening (32-1524) applies to all categories of benefit. However, the Court of Appeals may indicate otherwise. For example, a wage loss PPD award may carry a three year (see 32-1508(a)(3)(V)).

d. Compensation Review Board (CRB): (32-1522 as amended)

- i. The Petition and supporting brief (along with a copy of the Order being appealed) must be filed within thirty (30) days from the date of receipt of the Compensation Order.
- ii. The Respondent may file the reply brief within 15 days. It is good practice to immediately file a motion with the CRB requesting additional time to file your reply brief if there is a concern it will not be submitted within 15 days.
- iii. The CRB is the appellate body for any Compensation Order, whether issued by OWC or AHD.
- iv. The appeal is solely on the record created at the Formal Hearing. The CRB will not accept additional evidence, even if unavailable at the time of the Formal Hearing.
- v. The CRB may schedule oral argument, but that is very rare.
- vi. Three judge panel
- vii. Decisions are issued solely in writing.

e. Court of Appeals:

- i. The Petition for Review must be filed within thirty (30) days from the date of the CRB decision.
 1. There is a mechanism to skip the CRB but that is not recommended as the District of Columbia Court of Appeals looks to guidance from the Agency (CRB) and strongly favors the exhaustion of remedies at the Agency before asking the DCCA for review.
- ii. The appeal is solely on the record, but also has the discretion to require oral argument by counsel.
- iii. The Court of Appeals will look to see if there is an error of law or misinterpretation of the facts.
- iv. The Court of Appeals will look to Agency to interpret the Act.

- v. This is the final appeal available. However, often the Court of Appeals decision may not be the final ruling in a matter as it is common that claim be remanded back to the Agency for further findings.

13. AWW: (32-1511)

- a. Wage stack is available in the District of Columbia. The earnings of alternate job are included in the calculation. However, the claimant must be employed at the other job of the date of injury.
- b. In most instances the AWW is based upon 26 weeks of gross earnings prior to the week of the injury, but not including the week of the injury.
- c. Wages include non-monetary benefits such as room, board, and gratuities declared for tax purposes, but not health insurance premiums. Overhead costs are not included in the AWW calculations.

14. BENEFITS AVAILABLE: (32-1508)

a. Temporary Total Disability.

- i. $66 \frac{2}{3}$ of AWW up to the statutory maximum for that calendar year.
- ii. No Statutory Minimum despite what the statute states. The statutory minimum only applies to PTD cases. *Hiligh.*
- iii. A Claimant cannot receive more than 500 weeks of TTD and non-scheduled PPD benefits. The 500 weeks does not include TPD, scheduled loss PPD and PTD benefits. It is cumulative. However, if the Claimant can demonstrate at least a 20% disability, he/she/they may be entitled to up to an additional 167 weeks of benefits, for a total of 667 weeks.

15. Temporary Partial Disability:

- a. $66 \frac{2}{3}$ of the actual wage loss up to the statutory maximum for that calendar year.
- b. Temporary partial benefits are limited to 5 years.
- c. Please be aware when calculating the wage loss that the AWW is based upon the possible stacked wages.
- d. The 5 years of temporary partial disability benefits do NOT count towards the 500/667 maximum number of weeks. TPD carries a separate 5 year maximum benefit structure.

16. Permanent Partial Disability:

a. Scheduled Loss Disability:

- i. Scheduled Loss Body Parts: Fingers, hands, arms, toes, feet, legs, eyes, ears.
- ii. Paid at 2/3 AWW up to the statutory maximum for the year of the injury.
- iii. Site of manifestation of disability. For example a neck injury often leads to a scheduled loss PPD to the upper extremity(ies) and a back injury leads to lower extremity(ies) scheduled loss PPD. However, the disability must be separate and distinct.
- iv. There is no apportionment in the District of Columbia. However, the employer does receive a credit for PPD paid to the same body part under a prior Order.
- v. Economic Loss component in scheduled loss cases. The District of Columbia is a wage loss statute. The issue of wage loss is a consideration and may act to increase or decrease a PPD Award.
- vi. An Examiner/ ALJ can pick a mid-point percentage figure. The Examiner (OWC) / ALJ (AHD) had broad discretion in making the PPD finding. *Negussie*.
- vii. The Agency follows the AMA Guides, which is currently in its 6th Ed. However, ratings rendered pursuant to an earlier edition will be considered. In addition, the Agency considers the "Maryland Five Factors" of pain, weakness, atrophy, loss of endurance, and loss of function. Please note, the AMA 6th does rate pain.
- viii. When presenting to a Formal Hearing, you must include in your exhibits the AMA Guides tables and charts that the physician you are relying upon. Make certain the physician notes the tables and charts that are being utilized to render the impairment rating.
- ix. Post Mortem PPD benefits are available to survivors, if the PPD was not paid during the life of the claimant. If the claimant was PTD, no scheduled loss benefit remains available.

b. Non-Scheduled Disability:

- i. Any body part that is not specifically scheduled is non-scheduled "other cases".
- ii. The benefit paid is $66 \frac{2}{3}$ wage loss up to the statutory maximum for the calendar year for the date of the injury.
- iii. Election: The Claimant is entitled to compare what he/she/they would have made had he/she/they remained in the pre-injury job to current earnings; OR can compare what the current job would have paid on the date of the injury. The Claimant receives whichever provides the greatest wage loss.
- iv. Post 4/16/1999 injury: 500 week cap on permanent partial disability benefits with a possible 167 additional weeks if at least 20% disabled. No cap exists for injuries occurring prior to 4/16/1999.
- v. The 500/667 week cap applies to temporary total disability and non-scheduled permanent partial wage loss benefits only, not scheduled loss permanency, temporary partial disability or permanent total disability. A claimant can receive scheduled loss PPD in addition to 500/667 weeks of wage loss benefits. Further, it does not apply to permanent total disability.

c. Permanent Total Disability:

- i. Once a finding of PTD is made, the Claimant receives the Supplemental Allowance each year.
- ii. There is a 5% cap on increases from year to year. However, there is no cap in the first year. The 5% maximum applies for year 2 forward.
- iii. Date of annual adjustment, January 1.
- iv. The calculation is done by comparing the compensation rate to the maximum compensation rate for the year of the injury. That percentage is then applied to the maximum rate for the year the claimant is deemed permanently and totally disabled, up the maximum benefit for that year. The effect is to essentially recoup the prior increase.

d. Death Benefits: (32-1509)

- i. Due to the complexity of the statute, it is recommended that the Statute be reviewed in each instance.
- ii. Check actual financial dependency.

- iii. In order to qualify for death benefits, it only needs to be demonstrated that financial support was provided by the decedent that provided for their pre injury lifestyle. If the decedent provided such a contribution, the individual can be considered financially dependent under the Act.
- iv. Death Benefits are paid at 50% of the AWW if there exists only one surviving dependent. However, if there exists more than one dependent, such as a child, the benefit is increased to the collective total of 66 2/3 % (compensation rate) for the collective group and benefits are proportioned among the dependents.
- v. Benefits are subject to the Supplement Allowance increases.
- vi. Funeral expenses are granted up to \$5,000.00.
- vii. If there are no surviving dependents, the employer is obligated to pay the \$5,000 assessment specified in 32-1540(d)(1).

e. Disfigurement:

- i. Disfigurement is available in DC.
- ii. It is limited to \$7,500.00 and decided by an OWC Examiner.
- iii. The determination is discretionary on the part of the Examiner.

17. SETTLEMENT/AGREEMENT IN WRITING

a. Agreement in Writing:

- i. A “stipulation” is a voluntary payment and will not begin the running of the statute of limitations.
- ii. However, an Agreement in Writing between the parties can be converted to a Final Order if an application for Informal Conference is pending. DCMR 219.17.

b. Settlement:

- i. All Settlements must be submitted to OWC for approval.
- ii. The Regulations indicate that when the Claimant and employer are represented by counsel, a submitted settlement *shall* be approved.
- iii. Payment is due to be received by the Claimant within 10 days from the date of the Approval Order or a 20%

automatic penalty will be imposed. There is no discretion; the penalty will be imposed, if requested.

- iv. Be aware, under *Levy* an open medical settlement may not be considered a “full and final settlement” and the Claimant may be able to reopen indemnity benefits at a later date.
- v. In light of Medicare issues, open medical benefits may be evaluated when appropriate.
- vi. Medicare: The parties are not permitted to impose on Medicare the cost of medical care related to the injury. The parties must reasonably consider Medicare’s rights and provide for a Medicare Set Aside Trust, if future medical care is needed.
 - 1. Approval by CMS for an MSA will be considered if:
 - a. The total value of the settlement is \$25,000 or greater and the claimant is a current Medicare recipient; or
 - b. The total value of the settlement is \$250,000 or greater and the claimant has a reasonable expectation of becoming a Medicare recipient within the next 30 months.
 - 2. Medicare will not review MSA’s that are submitted for CMS approval if the petition falls outside of the two above parameters.
 - 3. CMS approval is not required, but the parties have no safe harbor if they fail to secure CMS approval.
 - 4. If you have CMS approval, be certain to follow all requirements including sending the approval order back to CMS/Medicare. If you fail to follow all the requirements, approval is not finalized and the parties do not have safe harbor protection against future conditional payments.

18. Vocational Rehabilitation: (32-1507)

- a. Vocational Rehabilitation is provided in the Act.
- b. The employer is free to select the counselor.
- c. There is no maximum timeframe to provide benefits.
- d. The goal should be to return the Claimant to “suitable alternative employment” at as close to the same wage as possible.
- e. Suitable alternative employment is not any employment and must take into consideration the claimant age, education, work history and prior earnings.

- f. Temporary total, or temporary partial, disability benefits are paid while the Claimant is participating with vocational rehabilitation, as appropriate.
- g. If the Claimant fails to cooperate with vocational rehabilitation, benefits are suspended until he/she/they cooperates again. Benefits are not terminated for non-cooperation.
- h. If suitable alternative employment is offered to the claimant and declined, the voluntary limitation of income can form the basis for a termination or reduction of benefits.

19. **Medical Benefits** (32-1507)

- a. A Claimant is entitled to lifetime medical benefits for care that is reasonable, necessary and causally related to the occupational injury.
- b. Any party can challenge the reasonableness and necessity, medical appropriateness, of medical care only by instituting Utilization Review.
- c. An employer can challenge the causal relationship of ongoing care to the occupational injury by securing an IME.
- d. **Utilization Review:**
 - i. Utilization Review is essentially a peer review.
 - ii. Utilization Review is required to challenge medical reasonableness and necessity of medical care.
 - iii. The reviewer must be a URAC certified.
 - iv. The opinion of the UR is given the same weight as that of the treating physician.
 - v. Must give the UR report to the challenged doctor, who has the right to comment.
 - vi. The issue of Utilization Review can be litigated at the Informal Conference or Formal Hearing.
- e. Medical Bills are paid “pursuant to the Act”, not the full billing submitted by the provider. Currently it is the Medicare Allowance plus a percentage.

20. **Subrogation:** (32-1535)

- a. An employer has an *automatic* lien against any third party recovery a Claimant may make related to the same incident. Claimant’s counsel must protect the lien.
- b. The lien is automatic, no notice is required. However, placing Claimant’s counsel on notice is good practice.

- c. The employer must pay a reasonable attorney fees, likely the same respective percentage as claimant's counsel charges the claimant to protect the lien plus shared costs.
- d. The right to pursue the third party is exclusive to the claimant for the first six (6) months following an Award under a Compensation Order. It then becomes the right of the employer to file an action within the next within 90 days or the assignment or the claim reverts back to the claimant. If the claimant does not pursue the third party, and the employer wants to do so, the employer must secure the assignment of the claim from the claimant. (DC Code §32-1535).
- e. If the claimant settled the third party claim without the consent of the employer, the claimant cannot seek additional compensation under the worker's compensation claim.
- f. If the claimant declines to pursue the third party action after the 90 day window, the employer should secure an assignment of the claim from the claimant if it wishes to pursue the action on its own.

21. Mental Health Claims:

- a. Mental Physical claims are available in D.C.
- b. Mental Mental claims area also available. The legal standard is no longer an objective person test. Instead, the standard is the same as a physical injury, i.e., an aggravation is compensable, no matter how minor.

22. Miscellaneous

- a. Special Fund no longer available for relief for employers/insurers for claims arising on or after 4/16/1999.
 - i. Special Fund relief may still be available for claims arising prior to 4/16/1999. A Petition must be filed outlining the entitlement to Special Fund relief.
 - ii. Special Fund relief will limit the employer's exposure to 104 weeks of permanent disability benefits and medicals.
- b. Benefits may not be attached or assigned (32-1517)
 - i. However, in practice the exception is for child support.
- c. Exclusive Remedy: (32-1504)
 - i. Workers' Compensation is the exclusive remedy against the employer.

- ii. Exclusivity extends to co-employees, who are protected from a third party action.
- d. Bad Faith: (32-1528)
 - i. Bad faith does not require animus.
 - ii. Bad faith is the absence of good faith.
 - iii. Bad faith benefits are paid at the AWW rate, rather than the compensation rate.
- e. Attorney Fees: (32-1530)
 - i. A Claimant can seek to have his/her attorney fees paid by the employer by filing a Petition at OWC/ AHD.
 - ii. A Claimant can seek to impose an attorney fee upon the employer if the case is challenged in the entirety and ultimately secures benefits.
 - iii. If the parties proceed to an Informal Conference on subsequent issues and the employer pays consistent with the Memorandum of Informal Conference, then the employer will not be responsible for the claimant's attorney fee, even if the Claimant receives more benefits at the formal hearing level.
 - iv. The Agency currently recognizes a reasonable rate of up to \$350 per hour for Claimant's counsel who has been practicing for 20 years or more. Counsel with less experience are entitled to a lower rate. The Fee Petition must itemize the time spent.
- f. Medical Case Management:
 - i. NCM is not provided in the Act.
- g. Forms:
 - i. The District Of Columbia has limited forms, however they are available on line at: <http://does.dc.gov/page/workers-compensation-does>.

These materials are not intended, and do not provide, legal advice, or create a lawyer-client relationship. Every case is different and the law is constantly changing. Legal advice should be tailored to each individual matter. You are urged to seek the advice of competent counsel should concerns or questions arise in a given matter. (Rev5; 6/2026; © Kiernan Trebach LLP – David M. Schoenfeld, Esq.)