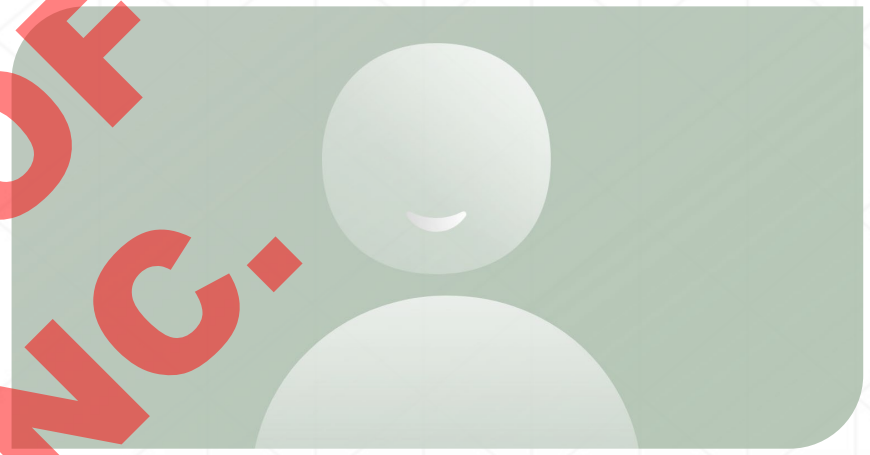
FRASCO® training

Rethinking Recurrence

What Every Professional Should Know

Objectives

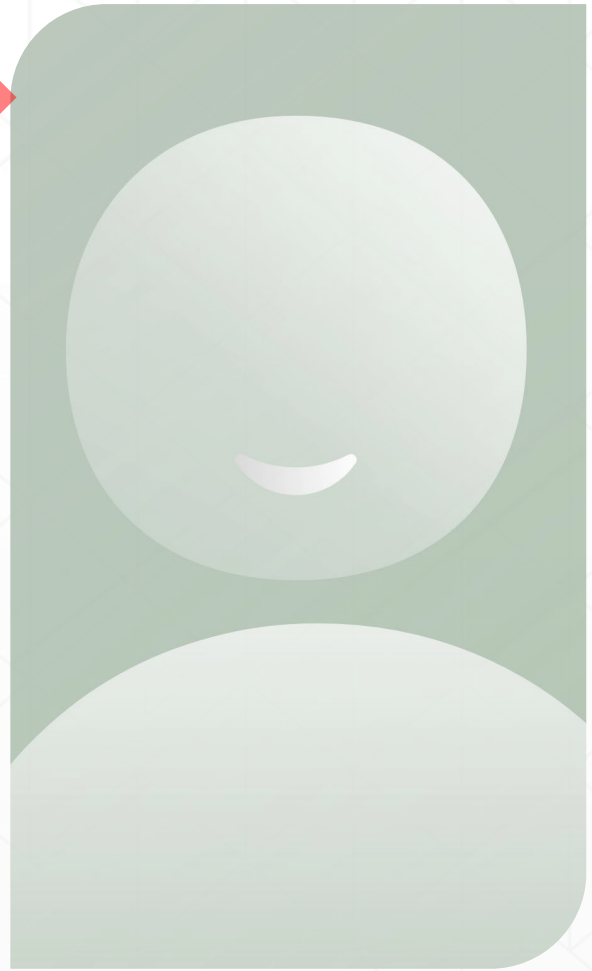


1. Define recurrence and explore its types
2. Understand the recurrence claim filing process
3. Identify key documentation needed to support recurrence claims
4. Review documentation best practices after medical release or return to work
5. Examine how agency actions, like withdrawing light duty, impact recurrence claims

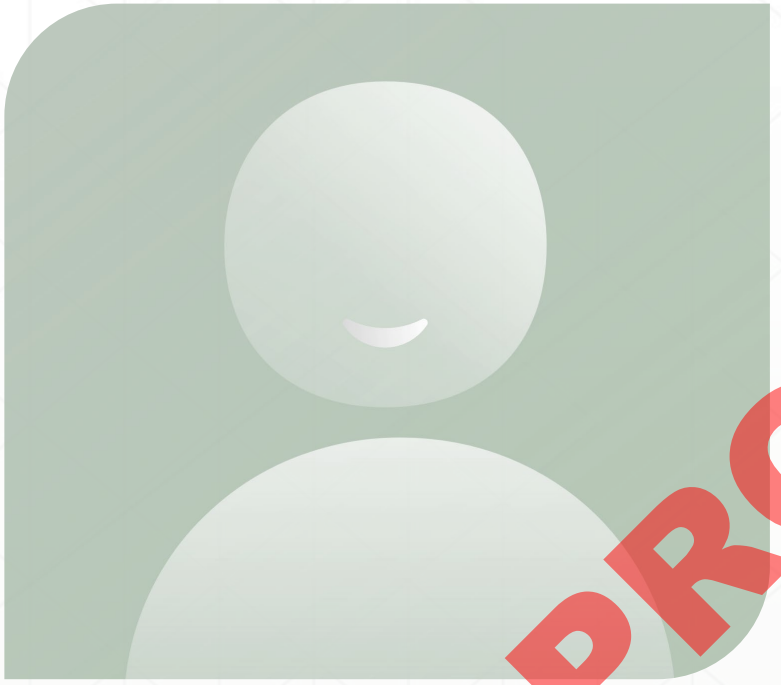
What is a Recurrence?

A recurrence is when an employee:

- Experiences a return of symptoms from a prior injury
- Has increased disability linked to the original condition
- Needs additional treatment after release from care
- Loses light duty with no other assignment available



Larson's Definition of Recurrence



A recurrence is compensable when:

- The original, work-related injury worsens over time
- There's **no independent, non-work-related cause**
- The **true cause** of the worsening is the original injury

Arthur Larson, former U.S. Under Secretary of Labor, helped define key principles in workers' compensation law.

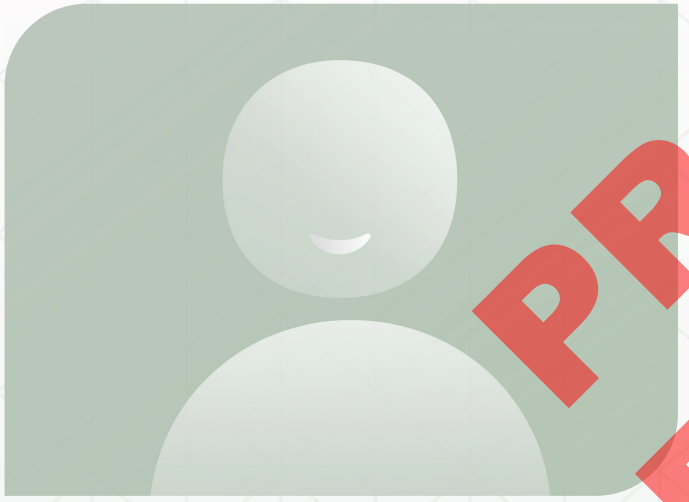
Types of Recurrence

A recurrence of the medical condition

A recurrence of disability

A new injury must be reported on a new Form CA-1 or Form CA-2, even if it is to the same body part as the prior injury.

What is Not a Recurrence of Disability?



End of a **temporary appointment**

Loss of special funding (e.g., grants)

Reduction in force (RIF) affecting all employees

Facility closure (e.g., base shutdown)

A **new injury or exposure**, even if it affects the same area

Termination of Employment

A recurrence **is not compensable** if the job loss was due to:

Misconduct

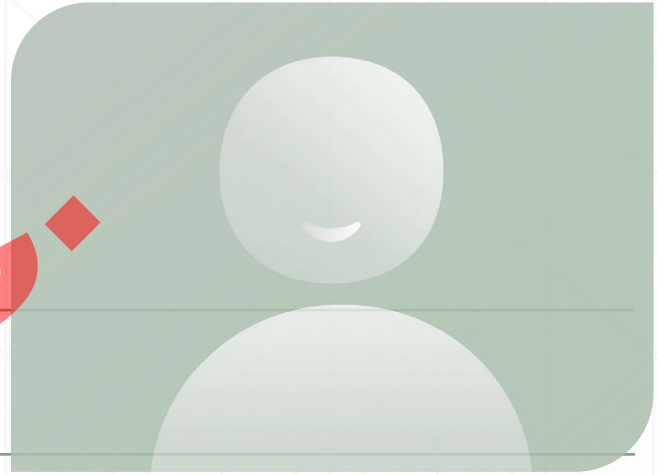
Poor or non-performance of duties

Consequential Injury

A **consequential injury** occurs off the job but is a direct result of a prior work-related condition.

Example:
An employee recovering from knee surgery falls at home when the knee gives out, resulting in a concussion.

Filing for a Recurrence



IW completes Part A (or someone on their behalf if incapacitated)

Supervisor completes Part B only if IW is still federally employed

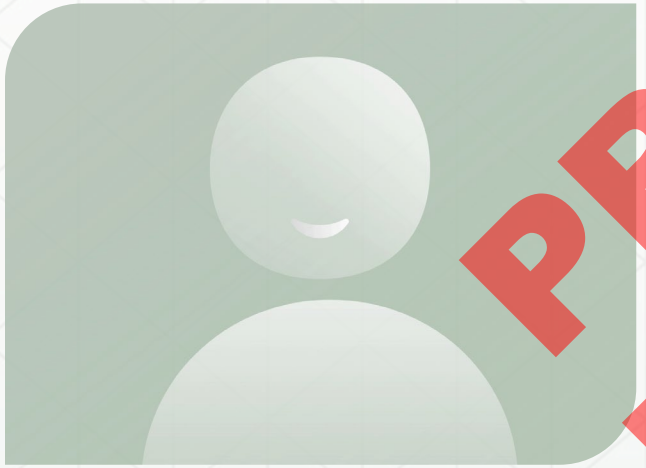
If **still federally employed:** agency submits completed form to OWCP

If **no longer federally employed:** IW completes Parts A & C and submits directly to OWCP

Claimant must provide supporting factual and medical evidence

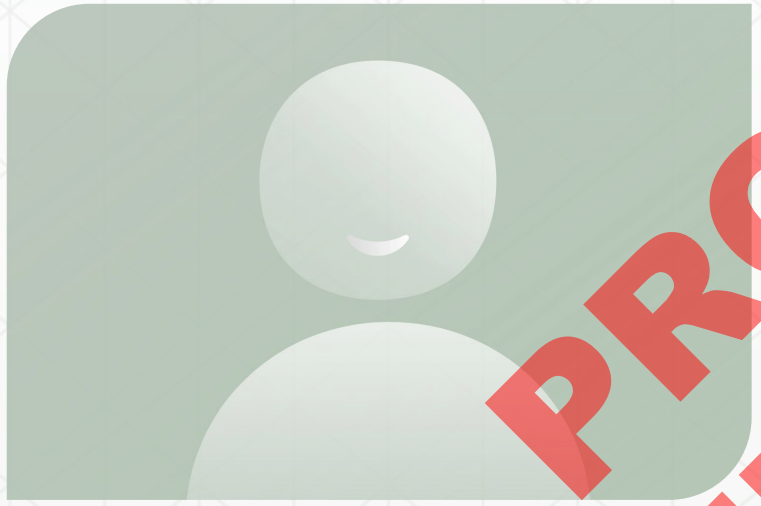
Agency is not required to complete form if claimant is no longer employed

Agency Processing of Claims for Recurrence



- Ensure IW completes **Sections 1-24 (Part A)** and **Sections 1-7 (Part C)**
- Complete **Part B** and submit form to **OWCP District Office**
- Do **not** delay submission waiting for medical evidence
- If IW can't provide narrative (Part B, Sections 38-40) immediately, submit form with note that statements will follow
- Send completed form directly to **OWCP District Office** (not to Central Mail Room, London, KY)

Recurrence Adjudication



If claim is under Agency Review (AR), DOL must first accept it before adjudicating recurrence

OWCP will not authorize medical treatment until recurrence claim is accepted

If entitled to Continuation of Pay (COP) and days remain, IW may elect to use remaining COP if within 45 days of return to work

IW may use sick leave or annual leave while recurrence claim is adjudicated

Filing a Claim for Recurrence CA-2a

Notice of Recurrence Reset Print

U.S. Department of Labor
Office of Workers' Compensation Programs

Employee: Complete Part A below if you experienced a recurrence as defined by OWCP on page 4 of this form.
Employing Agency (Supervisor or Compensation Specialist): Complete Part B.
Note: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

OMB No. 1240-0009
Expires: 01/31/2027

Part A - Employee

1. Name of employee (Last, First, Middle Initial)
2. Social Security Number
3. OWCP file number for original injury
4. Date of Birth Mo./Day/Yr.
5. Sex ☐ Male ☐ Female
6. Home telephone
7. Home mailing address (include street address, city, state, and ZIP code). See instructions for address requirement.
City State Zip Code
8. Dependents
☐ Spouse
☐ Child/Children under 18 years
☐ Other, e.g., qualifying student under age 23
9. Name and Address of Employing Agency at time of original injury (number, street, city, state, ZIP code)
10. Name and Address of Employing Agency at time of recurrence, if other than shown in 9. If you are no longer employed with the Federal Government, complete Part C also.
11. Date and Hour of original injury (Mo./Day/Yr.)
12. Date and Hour of recurrence (Mo./Day/Yr.)
13. Date and Hour stopped work after recurrence (Mo./Day/Yr.)
14. Date and Hour pay stopped after recurrence (Mo./Day/Yr.)
15. Date and Hour returned to work (Mo./Day/Yr.)
16. Are you claiming? Check both if applicable.
☐ Medical Treatment
☐ Time Loss From Work
17. Date of first medical treatment following recurrence (Mo./Day/Yr.)
18. Name and address of treating physician
19. After returning to work following the original injury, were you in any way limited in performing your usual duties? (If so, explain. Also state how long these limitations continued.) ◯ Yes ◯ No
20. Describe your condition since you returned to work, including the nature and frequency of all medical treatment received.
21. Describe how and when the recurrence happened. Explain why you believe your current condition is related to the original injury.
22. Describe all injuries and illnesses which you suffered between the date you returned to work after the original injury, and the date of recurrence. Arrange for the submission of all relevant medical records.

I hereby claim medical treatment if needed and up to 45 days Continuation of Pay if disabled from work.

I certify that the information provided above is true and accurate to the best of my knowledge and belief. Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud, to obtain compensation as provided by the FECA, or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment, or both. In addition, a state or federal criminal conviction for FECA fraud will result in termination of all current and future FECA benefits. I understand that by signing this form, I authorize any physician or hospital (or any other person, institution, corporation, or government agency) to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs (or to its official representative).This authorization also permits any official representative of the Office to examine and to copy any records concerning me.

23. Signature of employee
24. Date (Mo./Day/Yr.)

If you have a disability and are in need of communication assistance (such as alternate formats or sign language interpretation), accommodations and/or modifications, please contact OWCP. See form instructions for REQUESTS FOR ACCOMMODATIONS OR AUXILIARY AIDS AND SERVICES.

CA-2a (01/2024)

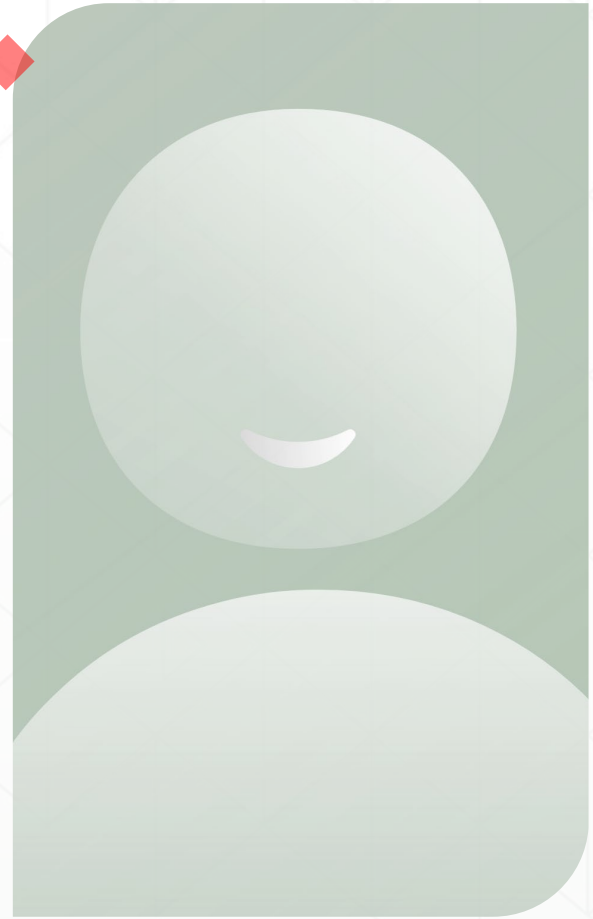
Part B - Federal Employing Agency

25. Name and address of reporting office (include street address, city, state and ZIP Code)
OWCP Agency Code
City State Zip
OSHA Site Code
26. Employee's duty station (include street address, city, state, and ZIP Code)
27. Date of first return to FULL-TIME REGULAR duty following original injury Mo./Day/Yr.
City State Zip
28. Regular work hours From: To:
29. Regular work days ☐ Sun. ☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ Sat.
30. Date of Injury Mo./Day/Yr.
31. Date of recurrence Mo./Day/Yr.
32. Date stopped work after recurrence Mo./Day/Yr. Time:
33. Date pay stopped after recurrence Mo./Day/Yr.
34. Dates COP paid for recurrence Mo./Day/Yr. From: To:
35. Date returned to work after recurrence Mo./Day/Yr. Time:
36. Did the employee receive medical care at an agency facility due to the recurrence? If so, please attach all relevant medical records. ◯ Yes ◯ No
37. At the time of the injury did your agency authorize medical treatment on Form CA-16? ◯ Yes ◯ No
38. After the original injury, did you make any accommodations or adjustments in the employee's regular duties due to injury-related limitation? ◯ Yes ◯ No If so, provide full details.
39. After return to work, did the employee sustain any other injury or illness which affected performance of his or her duties? If so, provide full details.
40. Please review the statements made by the employee in Part A of this form and provide any relevant comments and additional information.

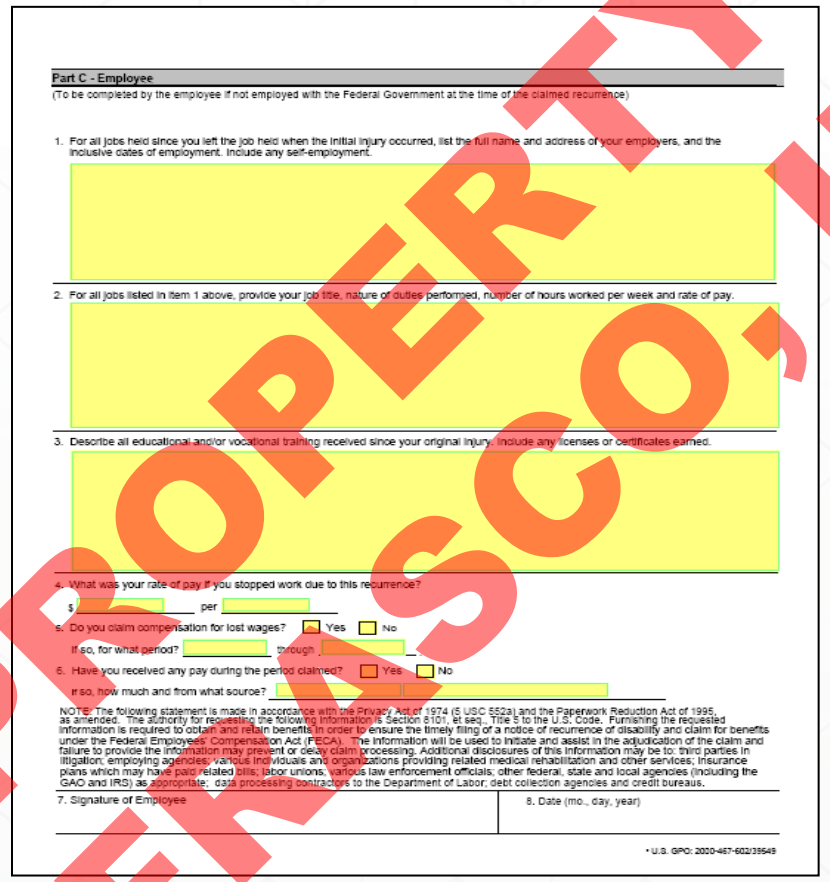
A supervisor or compensation specialist who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect to this claim may also be subject to appropriate criminal prosecution.

41. Signature of Supervisor or Compensation Specialist (at time of recurrence)
42. Title
43. Work phone
44. Date (Mo./Day/Yr.)

CA-2a (Rev. 01/2024)



Form CA-2a Notice of Recurrence



Part C - Employee

(To be completed by the employee if not employed with the Federal Government at the time of the claimed recurrence)

1. For all jobs held since you left the job held when the initial injury occurred, list the full name and address of your employers, and the inclusive dates of employment. Include any self-employment.

2. For all jobs listed in item 1 above, provide your job title, nature of duties performed, number of hours worked per week and rate of pay.

3. Describe all educational and/or vocational training received since your original injury. Include any licenses or certificates earned.

4. What was your rate of pay if you stopped work due to this recurrence?

$ _____ per _____

5. Do you claim compensation for lost wages? ☐ Yes ☐ No

If so, for what period? _____ through _____

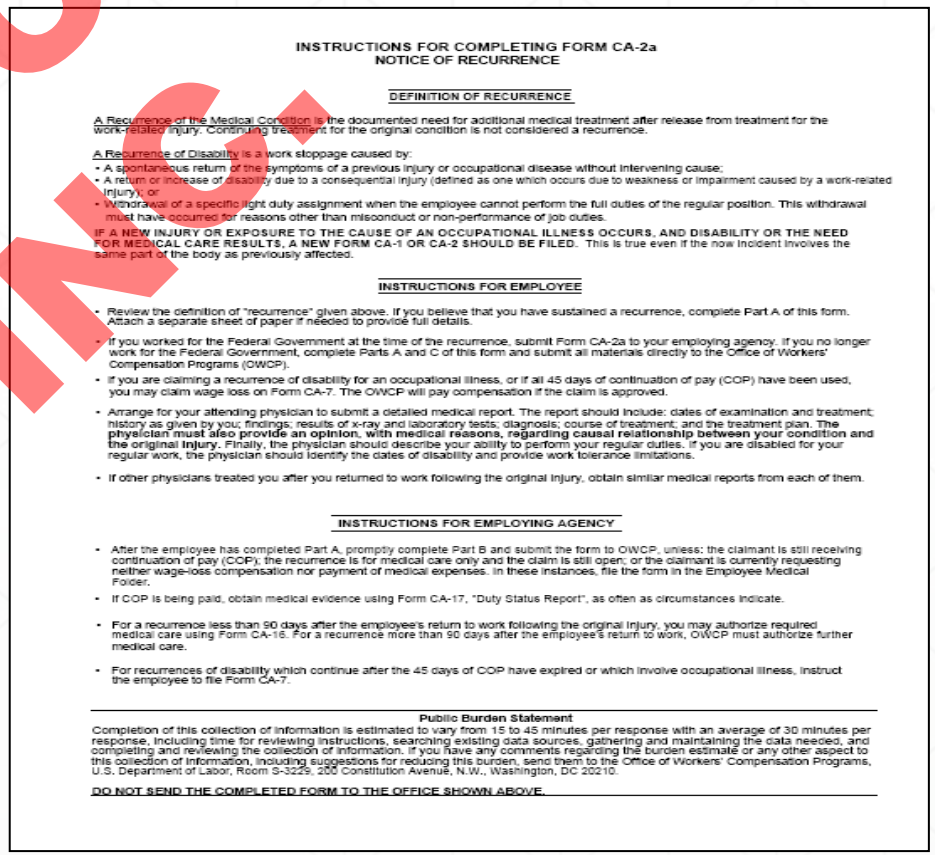
6. Have you received any pay during the period claimed? ☐ Yes ☐ No

If so, how much and from what source? _____

NOTE: The following statement is made in accordance with the Privacy Act of 1974 (5 USC 552a) and the Paperwork Reduction Act of 1995, as amended. The authority for requesting the following information is Section 8101, et seq., Title 5 to the U.S. Code. Furnishing the requested information is required to obtain and retain benefits in order to ensure the timely filing of a notice of recurrence of disability and claim for benefits under the Federal Employees' Compensation Act (FECA). The information will be used to initiate and assist in the adjudication of the claim and failure to provide the information may prevent or delay claim processing. Additional disclosures of this information may be to: third parties in litigation; employing agencies; various individuals and organizations providing related medical rehabilitation and other services; insurance plans which may have paid related bills; labor unions; various law enforcement officials; other federal, state and local agencies (including the GAO and IRS) as appropriate; data processing contractors to the Department of Labor; debt collection agencies and credit bureaus.

7. Signature of Employee | 8. Date (mo., day, year)

• U.S. GPO: 2000-467-602/39549



INSTRUCTIONS FOR COMPLETING FORM CA-2a
NOTICE OF RECURRENCE

DEFINITION OF RECURRENCE

A Recurrence of the Medical Condition is the documented need for additional medical treatment after release from treatment for the work-related injury. Continuing treatment for the original condition is not considered a recurrence.

A Recurrence of Disability is a work stoppage caused by:

- A spontaneous return of the symptoms of a previous injury or occupational disease without intervening cause;
- A return or increase of disability due to a consequential injury (defined as one which occurs due to weakness or impairment caused by a work-related injury); or
- Withdrawal of a specific light duty assignment when the employee cannot perform the full duties of the regular position. This withdrawal must have occurred for reasons other than misconduct or non-performance of job duties.

IF A NEW INJURY OR EXPOSURE TO THE CAUSE OF AN OCCUPATIONAL ILLNESS OCCURS, AND DISABILITY OR THE NEED FOR MEDICAL CARE RESULTS, A NEW FORM CA-1 OR CA-2 SHOULD BE FILED. This is true even if the new incident involves the same part of the body as previously affected.

INSTRUCTIONS FOR EMPLOYEE

- Review the definition of "recurrence" given above. If you believe that you have sustained a recurrence, complete Part A of this form. Attach a separate sheet of paper if needed to provide full details.
- If you worked for the Federal Government at the time of the recurrence, submit Form CA-2a to your employing agency. If you no longer work for the Federal Government, complete Parts A and C of this form and submit all materials directly to the Office of Workers' Compensation Programs (OWCP).
- If you are claiming a recurrence of disability for an occupational illness, or if all 45 days of continuation of pay (COP) have been used, you may claim wage loss on Form CA-7. The OWCP will pay compensation if the claim is approved.
- Arrange for your attending physician to submit a detailed medical report. The report should include: dates of examination and treatment; history as given by you; findings; results of x-ray and laboratory tests; diagnosis; course of treatment; and the treatment plan. The **physician must also provide an opinion, with medical reasons, regarding causal relationship between your condition and the original injury.** Finally, the physician should describe your ability to perform your regular duties. If you are disabled for your regular work, the physician should identify the dates of disability and provide work tolerance limitations.
- If other physicians treated you after you returned to work following the original injury, obtain similar medical reports from each of them.

INSTRUCTIONS FOR EMPLOYING AGENCY

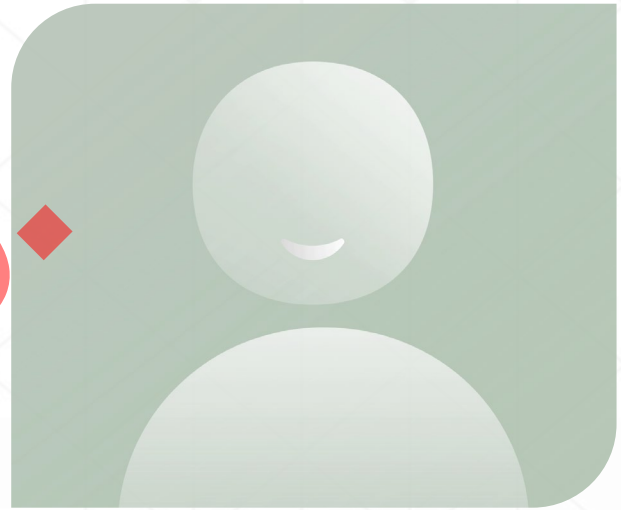
- After the employee has completed Part A, promptly complete Part B and submit the form to OWCP, unless: the claimant is still receiving continuation of pay (COP); the recurrence is for medical care only and the claim is still open; or the claimant is currently requesting neither wage-loss compensation nor payment of medical expenses. In these instances, file the form in the Employee Medical Folder.
- If COP is being paid, obtain medical evidence using Form CA-17, "Duty Status Report", as often as circumstances indicate.
- For a recurrence less than 90 days after the employee's return to work following the original injury, you may authorize required medical care using Form CA-16. For a recurrence more than 90 days after the employee's return to work, OWCP must authorize further medical care.
- For recurrences of disability which continue after the 45 days of COP have expired or which involve occupational illness, instruct the employee to file Form CA-7.

Public Burden Statement

Completion of this collection of information is estimated to vary from 15 to 45 minutes per response with an average of 30 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding the burden estimate or any other aspect to this collection of information, including suggestions for reducing this burden, send them to the Office of Workers' Compensation Programs, U.S. Department of Labor, Room S-3229, 200 Constitution Avenue, N.W., Washington, DC 20210.

DO NOT SEND THE COMPLETED FORM TO THE OFFICE SHOWN ABOVE.

Evidence Required



Factual Evidence

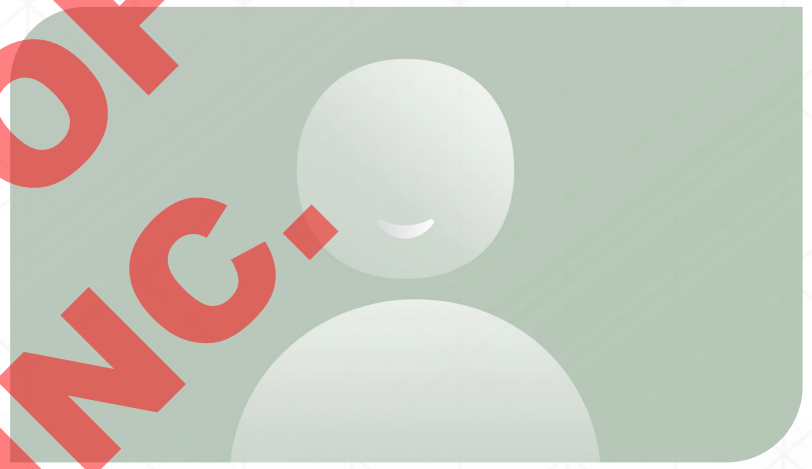
- Description of changes in accepted condition(s)
- Description of any changes in work duties during the period

Medical Evidence

Report from treating physician including:

- Current exam & diagnostic findings
- Current diagnosis
- Medical opinion linking the condition to work injury
- Discussion of changes in findings & their relation to recurrence
- Any pre-existing or intervening conditions affecting the same body part
- Work duties claimant cannot perform as of the recurrence date

Time Lost for Follow-up Medical Care



Follow-up care causing time loss is **not a recurrence**, but part of the **original injury**

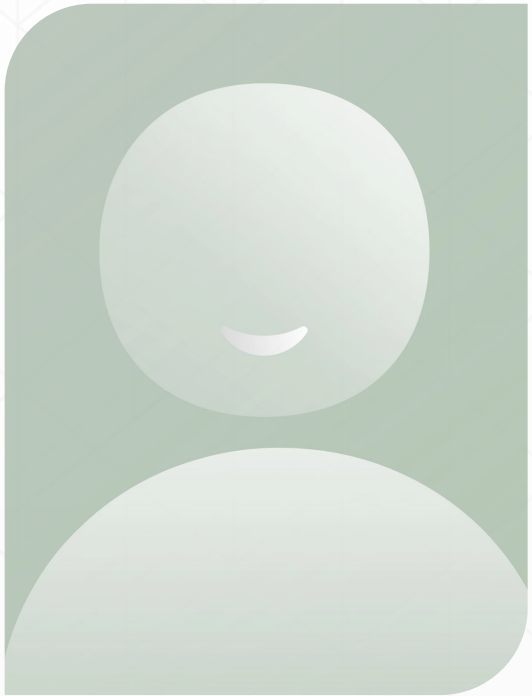
Time loss is attributed to the original injury **unless the injured worker has been released from treatment**

Recurrence in First 90 Days

The claimant must submit a physician's statement supporting a causal link between the current and accepted condition.

The statement **does not require a detailed medical rationale unless**:

- Intervening injury evidence exists (request bridging info)
- The original case was for the temporary aggravation of a pre-existing condition
- Recurrence involves a different diagnosis from the accepted condition



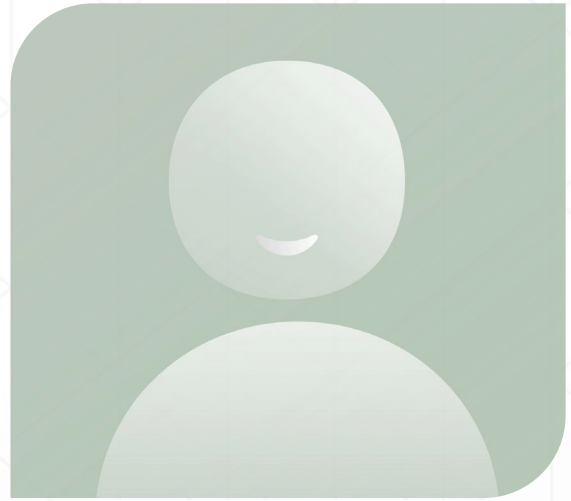
Recurrence Post 90 Days

The claimant must submit an attending physician's report with:

- Current objective findings
- Medical rationale linking current condition(s) to accepted condition(s)

Medical evidence must be **as detailed and conclusive** as for the original claim

Recurrent Disability: First 90 Days



Burden of Proof

- Claimant must provide evidence showing disability is related to accepted condition(s)
- Within 90 days of return, the focus is on **disability**, not causal relationship

Disability for Work

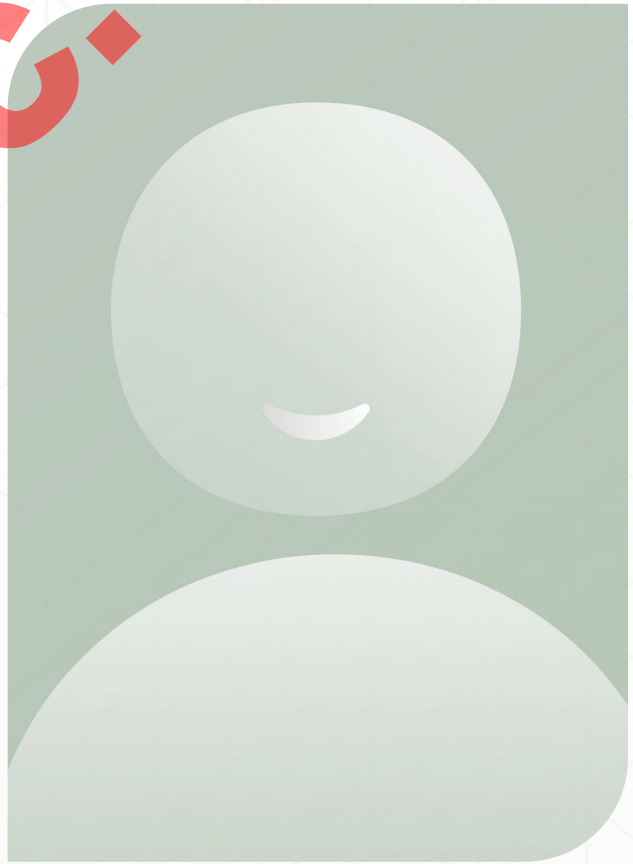
- Submit the attending physician's narrative describing:
- Duties claimant **cannot perform**
- Objective medical findings supporting renewed disability

Recurrent Disability: After 90 Days

The claimant must demonstrate:

- A **change in medical condition**, or
- A **change to a limited-duty position**

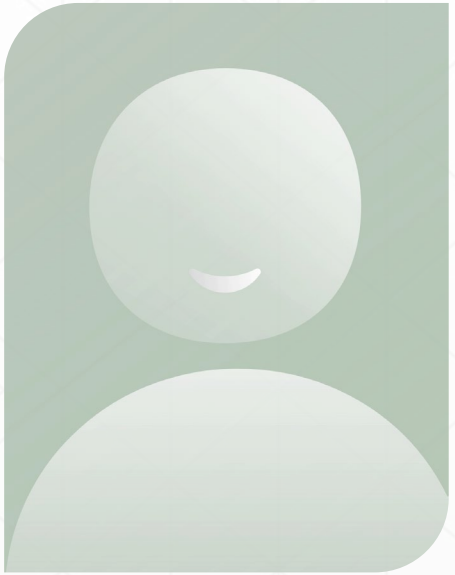
If the limited-duty job no longer accommodates medical restrictions, OWCP may accept recurrence and begin disability management.



Hedman ECAB Decision

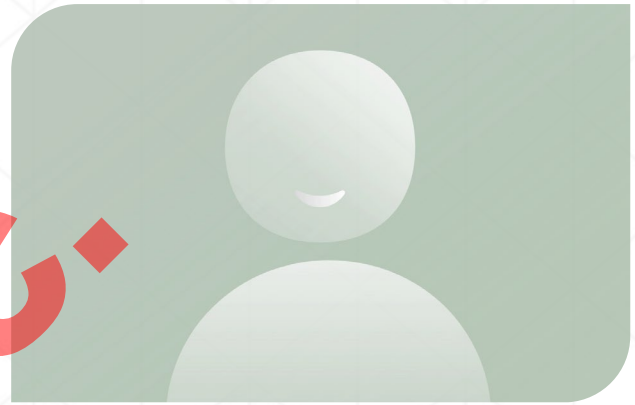
When the employee returns to or can perform limited duty, the burden is to prove by reliable, probative, substantial evidence:

- Recurrence of total disability
- Inability to perform limited duty
- Change in nature/extent of injury-related condition or limited duty requirements



Note: An Increase in pain alone is **not** objective evidence of disability

Recurrence and Withdrawal of Limited Duty



When limited duty position accommodating restrictions is withdrawn and a formal LWEC decision exists, **LWEC remains in place**

Recurrence claims after withdrawal should be treated as **requests to modify LWEC, not recurrence of disability**

If the claimant returned to full duty >90 days, **well-rationalized evidence must link recurrence to the original injury**

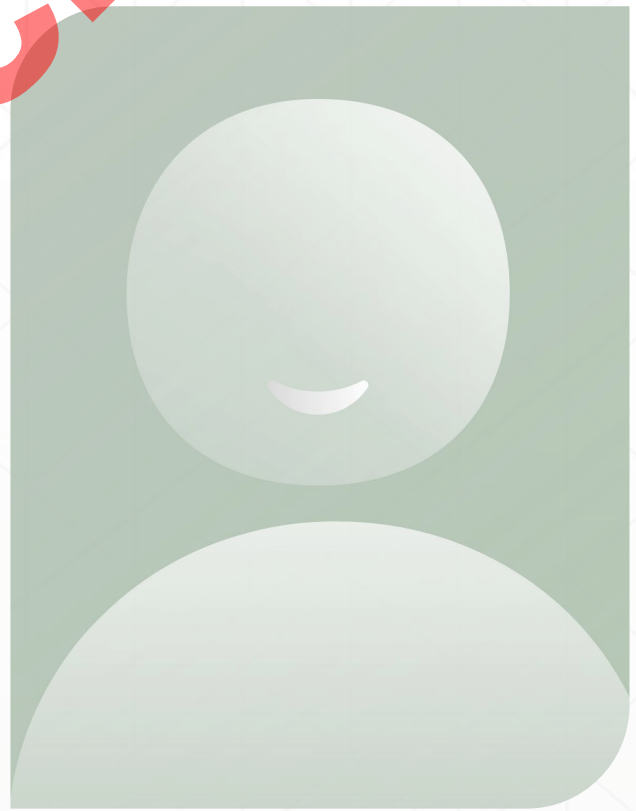
Claimant bears burden to submit **factual and medical evidence** supporting recurrence

Recurrence & LWEC Modification

A claimant on limited duty must show:

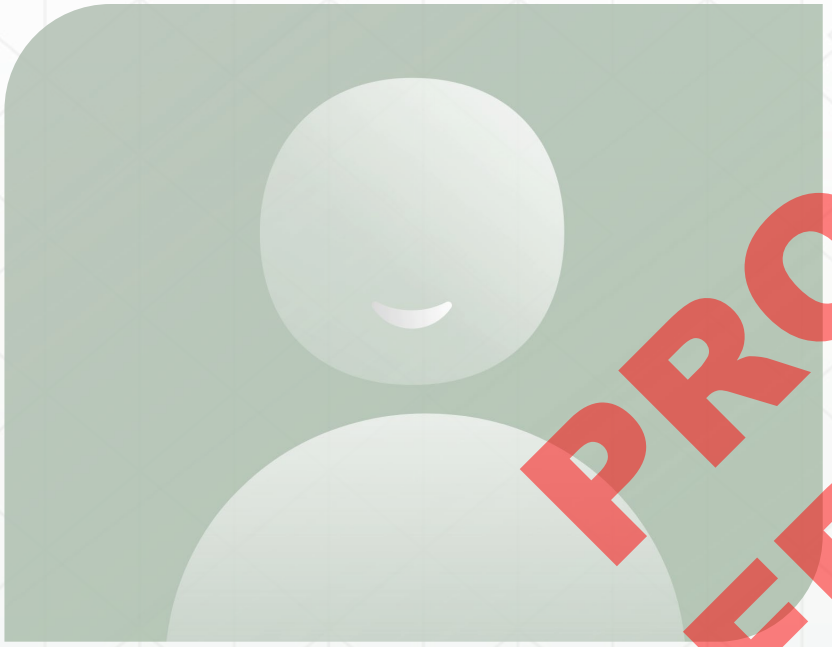
- **Change in medical condition**
- **Change in job duties that no longer fit the restrictions**

If the job no longer matches medical limits, OWCP may accept the recurrence and start disability management.



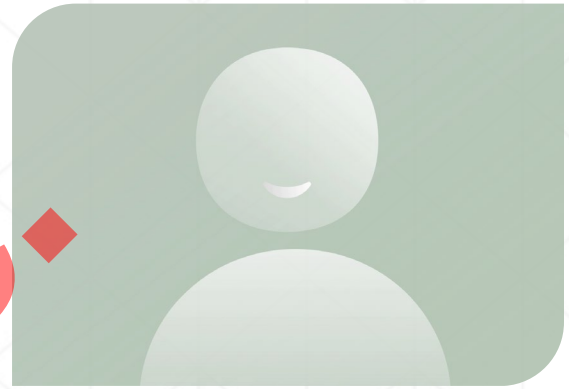
Terminations

Including for Cause



- Employing agency offered light duty
- Claimant was working in the light duty position
- Light duty would have remained available if not terminated for cause
- No evidence claimant was unable to perform light duty

For Normand to Apply

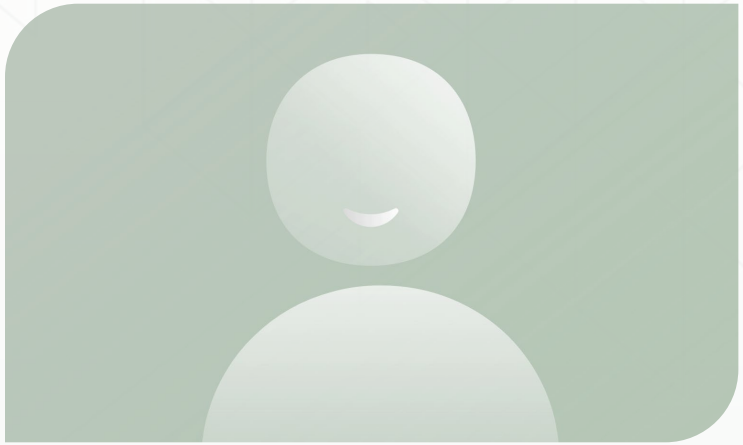


- Case: John W. Normand, 39 ECAB 1378 (1988)
- Claimant removed from light-duty position for disciplinary reasons
- ECAB affirmed denial of compensation

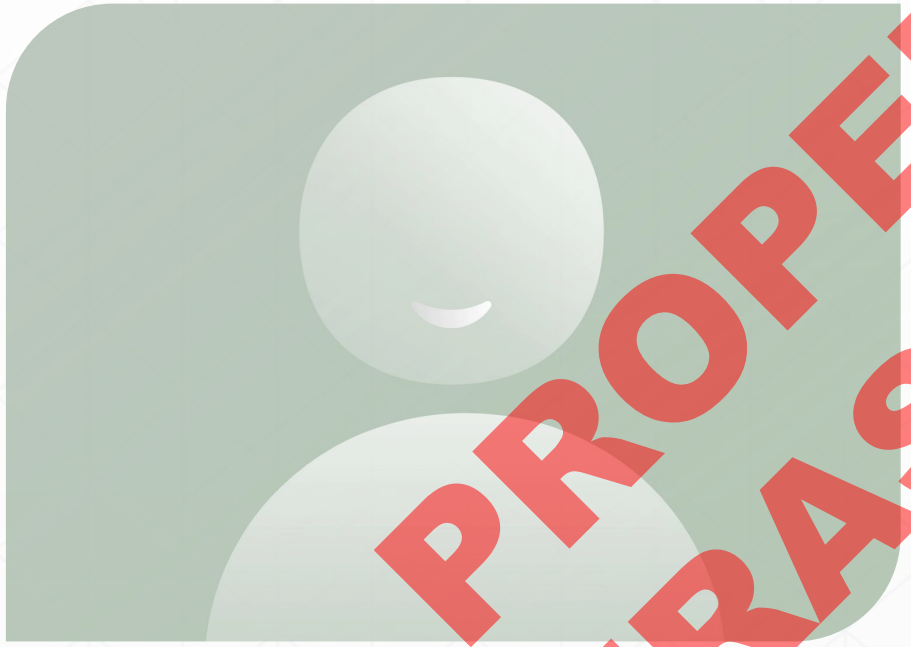
Recurrent Pay Rate

For recurrences occurring 6+ months after first return to full-time duty:

- Effective pay rate date = Date of Recurrence (DOR)
- Applies only if the DOR pay rate is higher than the Date of Injury (DOI) and the DDB pay rates



Recurrence and Occupational Disease Claims



Form CA-2a may be used **instead of filing a new claim** if:

- Diagnosis remains the same
- Disability increases due to continued exposure to the same work factors

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Example:
A claimant with carpal tunnel syndrome who returns to work and experiences worsened symptoms from repetitive tasks, leading to surgery, does not need to file a new claim.

Exceptions – New Claim Required:

- Emotional stress cases
- Hearing loss cases