



California Coalition on
22ND Workers' Compensation
ANNUAL CONFERENCE
LEGISLATIVE & EDUCATIONAL FORUM

**THE TOP 4 PROVIDER
MISTAKES THAT
SABOTAGE RETURN-
TO-WORK SUCCESS**

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DISCLOSURES

Conflict of Interest Statement

We have no actual or potential conflicts of interest in relation to this presentation.

LEARNING OBJECTIVES

01



Identify Roles & Responsibilities

Identify the key roles and responsibilities of physicians and providers in the return-to-work process and how their actions impact the worker's recovery journey.

02



Analyze Common Mistakes

Analyze common communication and assessment mistakes that physicians and providers make in the return-to-work process and understand their potential consequences.

03



Implement Effective Strategies

Implement effective strategies to avoid common pitfalls and enhance collaboration with workers and employers, ensuring a successful return-to-work outcome.

CASE STUDY EXAMPLE

Umbilical Hernia Repair



INJURY

Employee experienced sharp pain in the lower abdomen and left groin after slipping while handling cases of water.



DIAGNOSIS

Diagnosed with a 1 cm umbilical hernia. Ultrasound ruled out bilateral inguinal hernias.



TREATMENT

Umbilical hernia repair performed on 6/11/2024.



RETURN-TO-WORK MILESTONE

7/24/2024: PTP notes the Surgeon released employee to return to work.



DEVIATION

Employee requested 1–2 more weeks of recovery time to PTP. Temporary disability continued despite surgical release.

FINANCIAL IMPACT



Paid on Claim

\$19,000



Reserve Costs

\$31,000



TOTAL CLAIM EXPOSURE

\$50,000

MISTAKE

#1

EVIDENCE-BASED DURATION (UMBILICAL HERNIA REPAIR)

Expected Duration (EDD): 46 days

Maximum Duration: 51 days

Actual Duration:

+3 Months Beyond Guideline

IGNORING EVIDENCE-BASED RECOVERY TIMELINES

WHY THIS MATTERS



Unnecessary
disability
extensions



Delayed
return-to-work



Increased
indemnity
exposure



Higher
claim costs

COMMON PROVIDER PITFALLS

- ❌ Failing to manage the case according to evidence-based recovery timelines
- ❌ Not recognizing when disability duration exceeds expected benchmarks
- ❌ Allowing deviations from recovery timelines to derail return-to-work plans
- ❌ Continuing disability without objective findings supporting restrictions
- ❌ Failing to adjust work status and treatment based on patient progress



KEY TAKEAWAY: Work restrictions and disability duration must align with evidence-based recovery timelines.

BEST PRACTICE

Align Treatment and Disability Duration with Recovery Milestones

- ✓ Review ODG / MTUS / ACOEM guidelines early in the claim
- ✓ Establish expected recovery and return-to-work milestones. Functional capabilities. Look at restrictions as level of function.
- ✓ Compare patient progress against expected timelines at each visit
- ✓ Require objective findings to support ongoing work restrictions
- ✓ Transition from modified duty to full duty as milestones are achieved
- ✓ Declare MMI and discharge when objective recovery is complete



IN THIS CASE

At approximately 6 weeks post-surgery:

- ✓ Surgeon released employee to return to work
- ✓ Functional recovery milestone achieved
- ✓ Employee should have returned to full duty, declared at MMI, and discharged



BEST PRACTICE PRINCIPLE: Return-to-work decisions should be driven by functional recovery and objective findings—not solely by subjective requests.



EMPLOYER, CLAIMS & CASE MANAGEMENT STRATEGIES

Preventing Recovery Timeline Drift



PHYSICIAN COMMUNICATION- BEFORE THE FIRST APPOINTMENT

- Provide job description and physical demands analysis
- Communicate modified-duty availability
- Establish return-to-work expectations



PHYSICIAN COMMUNICATION- DURING TREATMENT

- Share ODG/MTUS disability duration benchmarks
- Discuss anticipated recovery milestones
- Monitor claims that exceed expected recovery timelines
- Consider nurse case management or peer review when delays occur



EMPLOYEE COMMUNICATION

- Reinforce that return to work is part of recovery
- Discuss modified-duty opportunities early
- Maintain regular RTW-focused conversations



SUCCESS FORMULA: Evidence-Based Guidelines + Recovery Milestones + Employer RTW Program = Faster Recovery and Lower Claim Costs



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CASE STUDY EXAMPLE

Low Back Strain



INJURY

63-year-old sonographer developed low back pain while moving a patient bed on 5/31/24.



INITIAL TREATMENT

- Ibuprofen
- Flexeril
- Physical Therapy
- Work Restrictions



CLINICAL COURSE

- Within a week the employee called the PTP to complain of significant back pain-went to ED.
- MRI showed primarily degenerative findings.
- Complaints expanded to hip and knee.
- Restrictions were never meaningfully advanced.
- Multiple specialist referrals pursued.
- Surgical recommendations ultimately denied by UR.



DEVIATION

- Focus shifted toward imaging abnormalities rather than functional recovery.
- Restrictions remained in place despite lack of objective progression.

FINANCIAL IMPACT



Paid on Claim

\$22,351



Reserve Costs

\$24,690



TOTAL CLAIM EXPOSURE

\$47,041



MISTAKE

#2

EVIDENCE-BASED RECOVERY
EXPECTATIONS (LOW BACK STRAIN)

EDD (Typical): 21 Days

EDD (Maximum): 27 Days

Actual Duration:

+60 Days Beyond Guideline

FAILING TO EFFECTIVELY MANAGE WORK RESTRICTIONS

WHY THIS MATTERS



Employees
remain unnecessarily
disabled



Restrictions
become
stagnant



Providers focus
on symptoms
instead of function



Return-to-work
progression
stalls



Claim costs
escalate

COMMON PROVIDER PITFALLS

- ❌ Restrictions that don't align with actual job demands
- ❌ Restrictions that are never advanced as recovery progresses
- ❌ Failure to establish a graduated RTW plan
- ❌ Treating imaging findings instead of functional limitations
- ❌ Allowing work restrictions to become permanent without objective justification



KEY TAKEAWAY: Work restrictions should evolve as function improves—not remain static throughout the claim.

BEST PRACTICE

Progress Restrictions Based on Function, Not Fear

- ✓ Set return-to-work expectations at the first visit.
- ✓ Match restrictions to actual job demands. Avoid accommodation statements. i.e., no sweeping, no driving, no costume headdress
- ✓ Review PT progress at every follow-up
- ✓ Advance restrictions incrementally as function improves
- ✓ Obtain objective testing (EMG/NCS) when diagnosis remains unclear
- ✓ Focus on activity progression rather than symptom elimination



IN THIS CASE

What should have happened?

- ✓ Continue conservative treatment
- ✓ Increase functional activity at each visit
- ✓ Progress restrictions toward full duty
- ✓ Use objective testing before escalating specialty referrals
- ✓ Reinforce expected recovery trajectory



BEST PRACTICE PRINCIPLE: Work restrictions should be based on demonstrated functional capacity—not imaging findings alone.



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EMPLOYER, CLAIMS & CASE MANAGEMENT STRATEGIES

Preventing Restriction Creep



PHYSICIAN COMMUNICATION- BEFORE THE FIRST APPOINTMENT

- Provide job description
- Provide physical demands analysis
- Explain transitional-duty program



PHYSICIAN COMMUNICATION- DURING TREATMENT

- Review PT progress notes
- Compare restrictions against actual job demands
- Question restrictions that never advance
- Discuss estimated RTW timeline with provider
- Monitor claims exceeding EDD



EMPLOYEE COMMUNICATION

- Reinforce that activity promotes recovery
- Encourage participation in modified duty
- Discuss recovery milestones
- Focus on function, not pain scores



SUCCESS FORMULA: Appropriate Restrictions + Functional Progression + Transitional Duty = Faster Return-to-Work and Lower Claim Costs



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CASE STUDY EXAMPLE

Left Anterior Cruciate Ligament (ACL) Strain



INJURY

Elevating the head of a patient bed. While unlocking and pulling it out, employee's left knee buckled back, causing pain.



IMAGING & DIAGNOSIS

- MRI without contrast: Mild ACL sprain (no tear), mild tricompartmental osteoarthritis, and mild prepatellar edema.
- MRI arthrogram: Questionable partial ACL tear or sprain.



TREATMENT COURSE

- Steroid injection – no sustained relief
- PTP deemed chronic; released with permanent restrictions
- Synvisc and PRP injections – no relief
- Arthroscopic partial lateral meniscectomy, patellar and lateral tibial chondroplasty on 3/16/24
- Post-op improvement of pain but remained with permanent restrictions



DEVIATION

- Focus shifted to non-industrial degenerative changes
- Permanent restrictions were maintained
- Claim exceeded evidence-based duration by 1 year, 2 months

FINANCIAL IMPACT



Paid on Claim

\$27,000



Reserve Costs

\$20,000



TOTAL CLAIM EXPOSURE

\$47,000



MISTAKE

#3

EVIDENCE-BASED DURATION
(ACL STRAIN)

EDD (Typical): 169 Days

EDD (Maximum): 208 Days

Actual Disability Duration:

**+1 Year, 2 Months
Beyond Guideline**

ASSUMING RESPONSIBILITY FOR NON-INDUSTRIAL PATHOLOGY

WHY THIS MATTERS



Treating
non-industrial
conditions



Extends
disability
unnecessarily



Increases
claim costs



Creates risk of
poor medical
management



Blurs scope of
professional
responsibility

COMMON PITFALLS

- ❌ Failing to distinguish between industrial and non-industrial conditions
- ❌ Not applying work-relatedness guidelines
- ❌ Overstepping scope and managing non-industrial pathology
- ❌ Allowing non-industrial conditions to drive treatment and restrictions
- ❌ Risking inappropriate permanent work restrictions and MMI decisions



KEY TAKEAWAY: Providers should only treat and place restrictions for limitations directly related to the accepted work injury.

BEST PRACTICE

Focus on the Accepted Work Injury – Not Underlying Conditions

- ✓ Define scope of responsibility using ACOEM Causation Guideline and Work-Relatedness article
- ✓ Distinguish limitations caused by the work injury vs. non-industrial conditions
- ✓ Treat and restrict only for accepted industrial injury
- ✓ Once the industrial injury resolves, d/c to PCP for non-industrial conditions
- ✓ Declare MMI without permanent restrictions related to non-industrial pathology
- ✓ Collaborate with other healthcare providers



IN THIS CASE

What should have happened?

- ✓ Treat the ACL strain and allow recovery
- ✓ Progress work restrictions as knee function improves
- ✓ At MMI, d/c with no permanent restrictions related to the industrial injury
- ✓ Refer to PCP for non-industrial osteoarthritis and ongoing pain management
- ✓ Focus on functional improvement and return-to-work progression



BEST PRACTICE PRINCIPLE: Limit treatment and work restrictions to limitations directly related to the accepted work injury.



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EMPLOYER, CLAIMS & CASE MANAGEMENT STRATEGIES

Preventing Overreach and Managing Non-Industrial Conditions

 PHYSICIAN COMMUNICATION - DEFINE SCOPE EARLY	 PHYSICIAN COMMUNICATION – DURING TREATMENT	 PHYSICIAN COMMUNICATION – AT MMI	 EMPLOYEE COMMUNICATION
● Identify accepted body part(s) and accepted conditions ● Communicate scope of responsibility to provider ● Reference ACOEM Causation Guideline and Work-Relatedness article	● Monitor for development of non-industrial issues ● Ask for clinical rationale linking limitations to the industrial injury ● Prevent non-industrial conditions from driving treatment or restrictions	● Identify remaining limitations caused by the work injury ● D/c to PCP for non-industrial conditions ● Avoid permanent restrictions for non-industrial issues	● Explain the difference between the work injury and underlying conditions ● Set realistic expectations for recovery ● Encourage focus on function and return to work



SUCCESS FORMULA: Treat the Work Injury + Manage Non-Industrial Conditions Separately = Appropriate Outcomes, Lower Costs, and Better Medical Care



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CASE STUDY EXAMPLE

Left Wrist Strain



INJURY

While sitting with a patient on observation for suicidal ideation, bed cords were left on the bed. The patient grabbed the cords and wrapped them around the employee's neck. During the struggle, the patient grabbed and hyperextended the left wrist.



DIAGNOSTIC FINDINGS

MRI and EMG/NCS normal.



CLINICAL COURSE

- Pain continued unchanged over the next 5 months
- Referred to orthopedics for steroid injection to the first dorsal compartment (De Quervain's)
- Did not complete occupational therapy
- Provided modified work assignment
- Pain therapy workshop



DEVIATION

- Communication breakdown with employee
- Lack of active listening and rapport building
- Incomplete understanding of full clinical and psychosocial context
- Employee remained symptomatic with delayed recovery

FINANCIAL IMPACT



Paid on Claim

\$20,201



Reserve Costs

\$7,493



TOTAL CLAIM EXPOSURE

\$27,694



MISTAKE

#4

EVIDENCE-BASED DURATION (LEFT WRIST STRAIN)

EDD (Typical): 38 Days

EDD (Maximum): 53 Days

Actual Duration:

+130 Days Beyond Guideline

POOR COMMUNICATION TECHNIQUES

WHY THIS MATTERS

				
Breaks trust and rapport	Leads to incomplete information	Impacts accuracy of diagnosis	Delays recovery and RTW	Increases claim costs

COMMUNICATION BREAKDOWN ISSUES

- ✗ Not actively listening – no trust building
- ✗ Not asking the right questions – no rapport building
- ✗ Not explaining – no respect, trust, or rapport building
- ✗ Miscommunication leads to incorrect diagnoses and delayed recovery
- ✗ Employees become frustrated and disengaged, delaying RTW



KEY TAKEAWAY: Effective communication builds trust, uncovers the full clinical picture, and drives better outcomes.

BEST PRACTICES

Build Trust, Ask the Right Questions, Explain, and Listen

- ✓ Set clear expectations for the RTW timeline early
- ✓ Use active listening: nodding, body language, and reflecting back what you hear
- ✓ Ask open-ended, clarifying questions
- ✓ Explain diagnosis, treatment plan, and expectations in plain language
- ✓ Read the room: be aware of non-verbal cues and psychosocial factors
- ✓ Build trust and rapport to improve engagement and outcomes



IN THIS CASE: WHAT SHOULD HAVE HAPPENED?

- ✓ Establish rapport and listen to employee's full story
- ✓ Ask the right questions to understand the injury and psychosocial context
- ✓ Explain the diagnosis and treatment plan clearly
- ✓ Set expectations for recovery and RTW
- ✓ Encourage and support adherence to OT
- ✓ Communicate regularly and adjust plan as needed



BEST PRACTICE PRINCIPLE: Great communication leads to better engagement, accurate diagnoses, faster recovery, and lower claim costs.



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EMPLOYER, CLAIMS & CASE MANAGEMENT STRATEGIES

Improve Communication, Build Trust, and Drive Recovery



PHYSICIAN COMMUNICATION - BEFORE THE FIRST APPT.

- Share job description and demands
- Prepare employee for what to expect at the visit
- Encourage employee to share complete medical and work history



PHYSICIAN COMMUNICATION – DURING TREATMENT

- Use active listening techniques
- Ask open-ended and clarifying questions
- Explain in plain language
- Confirm understanding
- Set clear expectations for recovery and RTW



PHYSICIAN COMMUNICATION – ONGOING MANAGEMENT

- Communicate regularly with employee and provider
- Address psychosocial factors that impact recovery
- Reinforce positive progress and engagement
- Monitor claims exceeding EDD



EMPLOYEE COMMUNICATION

- Show empathy and respect
- Listen to concerns
- Explain the plan and why
- Reinforce the importance of active participation
- Encourage return to modified duty as appropriate



SUCCESS FORMULA: Effective Communication + Trust + Clear Expectations + Active Participation = Faster Return-to-Work and Lower Claim Costs



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QUESTIONS



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