I have spent years reading adjuster notes, deposing claims handlers, and sitting across conference tables with risk managers who trust their process more than their instincts. The most common surprises in a workers' compensation case rarely come from the medicine or the law. They come from small, fixable mistakes on the claims side that snowball into delayed care, burned trust, and swollen costs for everyone involved. If you are an injured worker, an employer, or a new adjuster trying to do it right, knowing where claims usually drift off course can spare you months of frustration.

What the adjuster is up against

https://smb.thepostsearchlight.com/article/Law-Offices-of-Humberto-Izquierdo-Jr-PC-Highlights-Critical-30-Day-Workers-Compensation-Reporting-Rule-for-Atlanta-Employees/6a67826b928d990002e6cd81

Most adjusters are not villains. They are overworked case managers who juggle 120 to 180 open files, sometimes more during peak seasons. They answer to supervisors, vendors, and state deadlines. Many learned the craft by shadowing a senior adjuster for a few months, then inheriting a stack of live cases. They rely on templates and rules of thumb because they do not have time to reinvent the wheel for each file. None of that excuses bad claims handling, but it explains how routine missteps happen even to decent people.

The challenge, as I see it from my side of the table as a workers compensation lawyer, is that small delays and imprecise decisions land hardest on injured people who do not have a safety net. A missed authorization can mean two unpaid weeks. A sloppy wage calculation can mean a mortgage payment. So while some adjuster errors look technical, they have real weight in a worker's daily life.

Early delay on a simple question

The first 30 days of a claim make or break everything that follows. Adjusters often lose time confirming basic facts: who witnessed the incident, what exact body parts were affected, where the worker first treated, whether there was a prior injury, and whether modified duty exists. When those answers sit unresolved, medical authorizations stall. I have watched cases where a primary care doctor refers a worker for an MRI within a week of injury, but the scan does not happen for six weeks because the claim has not been accepted for that body part yet. By the time the image is taken, muscle guarding and inflammation have masked the initial pathology, which gives the defense doctor room to argue nothing serious ever occurred. That lag started with a single unanswered phone call.

A better path exists. Early recorded statements, same week employer questionnaires, and prompt first fill pharmacy cards prevent a lot of friction. Good adjusters front load the fact gathering, then give a short-term green light to reasonable conservative care while the deeper investigation unfolds. It saves money over the life of the claim.

Mislabeling the injury, and why words matter

A strain or sprain has a very different lifespan than a tear, a herniation, or a complex regional pain syndrome diagnosis. I frequently encounter claim notes that default to "lumbar strain" or "knee contusion" even after a radiologist flags a meniscal tear or a disc protrusion. The problem is not just semantics. Utilization review guidelines screen care based on the documented injury. If the claim only recognizes a strain, the request for arthroscopic surgery gets bounced as not related or not indicated. Weeks pass while the worker's lawyer files to add a body part, the authorization team asks for more detail, and the treating physician fights a paper war.

The cure is clarity. When a higher level diagnosis appears, update the accepted conditions immediately or grant an interim authorization tied to the pending addendum. A good adjuster tracks evolving diagnoses like a living list, not a one time label.

Average weekly wage mistakes

I have yet to depose an adjuster who enjoyed calculating average weekly wage. Still, it is where I see some of the most harmful errors. Many states require inclusion of bonuses, shift differentials, overtime that is regular, and concurrent employment. Leaving out any of those can underpay temporary disability by 10 to 30 percent. For a line cook making 20 dollars per hour with steady overtime, that shortfall can be 150 to 250 dollars per week.

Another common oversight involves variable schedules or seasonal workers. Claims teams sometimes take a four week snapshot from a slow period and ignore the twelve week or fifty two week look back that state law prefers. I have also seen claims where a second job driving for a delivery app was left out because the adjuster never asked about it. In most states, concurrent earned income counts.

If your checks feel light, ask for the wage statement and the math. A fair adjuster will share the calculation. When I bring it up in mediation, nine times out of ten we find a fixable discrepancy in the base period used, a missing bonus, or an outdated hourly rate.

Premature maximum medical improvement

Declaring maximum medical improvement turns off temporary disability and points the case toward settlement or permanent disability rating. Some adjusters push MMI too soon based on a paper review or a brief visit with a panel physician. I had a client, a warehouse picker in his 40s, who had back surgery recommended at week ten by a spine specialist. The insurer sent him to an independent medical exam, and the IME doctor wrote that he was at MMI with a 3 percent whole person impairment. The adjuster cut off his checks and denied the surgery request. Three months later, a neutral evaluator retained by the judge reviewed the film and sided with the surgeon. The policy ended up paying for the fusion plus back due benefits. What could have been a straightforward prehab and short-term TTD became a yearlong fight.

A thoughtful approach is to weigh the treating doctor’s long-term plan, not just the latest note. If surgery is on the table and the worker is still in conservative care, MMI can wait. Pushing for closure before the care curve plays out often backfires.

Authorization drift and “not my file anymore”

One silent killer of momentum is adjuster turnover. When a claim changes hands, authorizations vanish into email limbo. Providers fax a request to a number that no longer forwards. The new adjuster assumes the old approvals still apply, but the third party utilization review vendor wants a fresh packet. While everyone means well, the worker loses time. I once saw an abductor tendon repair take 80 days to schedule because the legacy approvals did not migrate when the file moved from one desk to another the week before Thanksgiving.

Simple fixes help. Centralized intake for authorizations, standard subject lines, and a shared task list visible to the nurse case manager prevent drift. If you are the injured person, when you hear that your file changed hands, call and ask what authorizations are open, expired, or pending and confirm the correct fax and email for your provider.

The IME trap

Independent medical exams are not evil. I have used them on both sides of the aisle when a treating plan needs a sober second look. Where adjusters go wrong is treating the IME as a veto instead of a consult. Not all IME doctors read the entire record, and some rely on one physical exam with limited testing. If an adjuster treats a single IME report as definitive proof that surgery is unnecessary, the claim can spin into petitions, hearings, and needless acrimony.

Better practice is to send a clean, balanced IME letter that frames the medical questions precisely, then invite the treating physician to comment on the report. When adjusters compare reasoning rather than signatures, they get closer to the medical truth. Judges notice the difference.

Surveillance without context

Surveillance footage can be useful when fraud exists, but it can also mislead. A 15 minute clip of a roofer lifting a toddler does not reveal the four hours he spent flat on his back afterward. I have seen adjusters deny care based on a single surveillance day, only to retract the denial once we produced weeks of pain journals and co worker statements. Good claims work avoids snap judgments. If surveillance raises a question, ask the treating provider to reconcile the activity with the restrictions. Often, the explanation is simple. People do their best to live their lives even when they are hurting.

Ignoring mental health components

Physical injuries carry psychological effects. A shoulder tear that ends a carpenter’s career brings grief, anxiety, and sometimes depression. Many states recognize compensable mental health conditions that flow from a physical injury, but adjusters often treat them as separate, optional, or suspect. The result is incomplete care and slower functional recovery.

Timely referrals to counseling, pain psychology, or even an evaluation for sleep disturbance can shorten disability. The cost is modest compared to prolonged TTD. When I suggest this in mediation, seasoned adjusters nod. They have watched the worker who gets help for anxiety return to work weeks earlier than the one who does not.

Utilization review used as a wall instead of a filter

Utilization review exists to check that care is appropriate, not to block it at every turn. In practice, I see UR used reflexively. Every request, even a first MRI or an extra six sessions of PT that fit the guideline, gets sent to UR with little context. Providers grow tired and reduce their requests. The worker’s recovery flattens.

High functioning claims shops pre authorize routine conservative care for a short window, then pivot to UR if the plan goes outside the guardrails. They call the doctor’s office and ask for clarification before denying a request. That simple human conversation saves months.

Lost in translation

Language access continues to trip up claims. I represented a housekeeper who spoke limited English. She signed a medical release and a light duty offer she did not fully understand. The adjusted assumed refusal when she did not appear for the modified job, and temporary disability stopped. Only after a hearing with an interpreter did we straighten it out. She was willing to work, but the offered job conflicted with her physician’s restrictions and the bus route she used. A 20 minute phone call with an interpreter could have avoided a three month detour.

If the worker's preferred language is not English, assume that translated notices and live interpretation will be necessary at key points: recorded statements, work offers, surgeries, and settlement talks. It is not just humane. It protects the integrity of the file.

Vocational rehabilitation by autopilot

Return to work succeeds when it is specific. Adjusters sometimes mail a packet of generic rehab resources and consider the duty discharged. Workers check boxes, attend a resume class, then stall. Where I see success is with hands on coordination between the VR counselor, the employer, and the physician to identify concrete light duty tasks. A hardware store clerk with a 15 pound limit can still handle returns, reorder labels, or paint mixing with a cart. Vague letters about "accommodations as available" often lead nowhere.

As for job search expectations, setting a quota of applications without supporting transportation or childcare often leads to noncompliance findings that are more punitive than practical. Thoughtful VR considers those barriers upfront.

Settlements that ignore future care, including Medicare's interests

Some adjusters focus on the indemnity number and gloss over medical closure. If the worker is a Medicare beneficiary, a Medicare set aside analysis may be necessary. Skipping that step risks denial of future Medicare payments for related care. Even for non beneficiaries, a poor estimate of future medical can turn a fair cash payment into a short term bandage. I have seen a case resolve for what sounded like a healthy sum, only for the worker to discover that two years of injections and radiofrequency ablation would eat it up.

Sound practice includes a line item projection for likely future care based on the treating physician's plan, the worker's age, and the benefit usage so far. Some adjusters involve a nurse case manager to model probable costs. That level of rigor gets both sides closer to a sustainable resolution.

The human cost of bad communication

Most injured workers are scared of being abandoned. Adjusters who do not return calls for a week add to that fear. Silence causes more friction than almost any other mistake I encounter. A 24 to 48 hour callback norm, even if the message is simply that the answer is coming, reduces attorney involvement and keeps trust intact. When I get retained primarily because the adjuster will not call back, I can almost always trace wasted expense back to that early breakdown.

I remember a construction framer who had not heard from his adjuster in three weeks. He assumed his checks were stopping, hired my firm, and we spent weeks fixing misunderstandings that would have taken two phone calls. The insurer paid additional attorney fees and penalties for late payments. Everyone lost.

Red flags that a claim is going off track

- You are waiting more than 10 business days for approval of a first MRI, PT, or specialist visit after your claim has been reported.
- Your temporary disability checks arrive inconsistently or the amount changes without explanation.
- The adjuster labels your condition a strain after imaging shows a tear or herniation.
- You are asked to sign documents you cannot read or do not understand, including a return to work offer.
- You are told you reached MMI while your treating doctor is still recommending significant care.

What to do when care is denied or delayed

- Ask, in writing, for the specific reason for denial and the guideline or statute used.
- Request a copy of the utilization review decision and the medical notes it relied on.
- Schedule a quick visit with your treating provider to submit a clarified, detailed request for the denied care.
- Keep a simple daily log of pain levels, medications, and functional limits to support medical necessity.
- If delays persist beyond statutory deadlines, consult a workers compensation lawyer who knows your state’s timelines and penalties.

Employers have a stake too

When employers partner with adjusters instead of checking out, claims resolve faster. The most successful employers I work with do a few things consistently. They document the incident with photos and witness names right away, designate a contact who answers the adjuster’s calls, and prepare a short list of real modified duty jobs with written restrictions. They also talk to the injured worker like a person, not a problem. That last part matters. When employees feel supported, they return sooner and litigate less.

I once represented a line cook in a family owned restaurant. The owner called him the day after surgery and offered to have him sit at the hostess stand answering phones for two weeks at full pay while he healed. That tiny bit of care broke the usual cycle of mistrust. The adjuster authorized PT without a fight. Total cost of the claim was a fraction of what I expected.

Documentation that helps both sides

Good documentation is boring and powerful. For injured workers, save pay stubs, note any second job, and keep a calendar of medical appointments and missed days. For adjusters, create a short chronology of medical events and authorizations with dates and decisions. When I walk into a mediation and both sides have clean timelines, we solve problems. When no one can find the UR decision from two months ago, we chase ghosts.

I tell clients to photograph swelling or bruising at its worst, then again after treatment. Images can corroborate the trajectory of recovery in a way words do not. Providers appreciate that data too.

When preexisting conditions become an excuse

Preexisting conditions are part of most adult lives. Degenerative disc disease shows up on almost every MRI after age 40. Adjusters sometimes latch onto degeneration as proof that work did not cause the problem. That is rarely how medicine sees it. Aggravation of a preexisting condition is compensable in many jurisdictions. The legal test usually asks whether work activities caused a material worsening, not whether the spine was pristine before.

A careful adjuster asks the right question: what changed after the incident? New radicular symptoms, loss of function, or the need for treatment beyond prior baseline are the guideposts. A denial rooted only in the word degenerative rarely holds up when scrutinized.

Penalties and interest are not free money, they signal a process failure

States impose penalties and interest for late wage payments, delayed authorizations, or noncompliance with orders. From the insurer’s view, that is leakage. From the worker’s view, it is the only lever to enforce the rules. As a workers compensation lawyer, I prefer not to spend six months chasing penalties. I would rather see the claim

handled on time, with an open line to fix mistakes as they arise. When penalties stack up, they usually reflect chronic understaffing, not malice. That does not soften their bite. A mature claims program invests in staffing and technology to meet deadlines. It is cheaper in the long run.

A word on attorney involvement

People often ask when to hire a lawyer. My honest answer is this. If your checks are on time, your care is moving, and the adjuster returns calls, you may not need one yet. If care stalls, if your wage calculation seems off, if you are being sent to an IME that feels like ***Georgia Workers' Compensation*** a foregone conclusion, or if you are pressured to settle before your condition stabilizes, talk to counsel. A brief consult can prevent avoidable errors. Sometimes, a letter from an attorney gets the claim back on track without a drawn out fight.

From my side, the best cases are the ones where the adjuster does solid work and I can help my client understand the process, keep expectations realistic, and push for clarity without theatrics. Good lawyering and good claims handling do not have to be adversarial.

Practical examples and small course corrections

A grocery stocker in her 50s tore her rotator cuff lifting a crate. Early imaging confirmed a full thickness tear. The adjuster initially listed the injury as a shoulder strain and sent every request to UR. Four denials later, surgery finally cleared, but the delay had stiffened the shoulder to the point that manipulation under anesthesia was needed too. The claim paid more in TTD and surgery than it would have with a prompt label change and early PT. One accurate update to the accepted condition at week two would have saved months.

A delivery driver had two jobs. The adjuster never asked about concurrent employment and paid TTD on the warehouse wage only. We flagged the omission, supplied pay records, and the insurer recalculated AWW, issuing a lump sum catch up. The driver avoided eviction. The adjuster learned to add one line to her recorded statement script: Do you have any other jobs or income sources?

A hotel housekeeper with limited English signed a light duty offer that required repetitive overhead reaching, which violated her restrictions. When she could not do the tasks, the employer accused her of refusal and TTD stopped. Once an interpreter bridged the gap and the employer saw the restrictions, they shifted her to folding and inventory. Checks resumed. It took a day to fix, but it could have been avoided altogether with translated offers from the start.

If you are the injured worker, hold on to the basics

You do not need to know every statute. Focus on the levers you control. Report the injury promptly, even if you think it will get better on its own. Tell every provider the same story about how it happened and what hurts. Keep your appointments and follow restrictions, even when you feel restless. Call the adjuster calmly, ask for timelines, and write down the answers. Save every envelope and check stub. If you lose a week waiting for a callback on a critical authorization, escalate politely and consider calling a workers compensation lawyer in your state to learn your options.

If you are the adjuster, what matters most

Return calls. Update accepted body parts when the diagnosis changes. Calculate wages with care and ask about second jobs. Use UR as a scalpel, not a wall. Send thoughtful IME letters and read the reports critically. When in

doubt, ask the treating provider for context. Most doctors want their patients to get well and back to work. They will talk to you if you ask the right questions.

I have deposed many of your colleagues. The ones judges trust sound the same. They know the file cold, can explain the timeline without searching, and admit when they made a mistake and fixed it. That authenticity carries weight.

The quiet truth behind most disputes

So much of workers' compensation comes down to timing, listening, and precision. An extra day here, a missing note there, and suddenly a routine knee scope turns into a litigated mess. The opposite is also true. A clear call, a correct wage sheet, a correctly labeled diagnosis, and a translated return to work offer can bring a claim home smoothly.

The system will always have sharp edges. People get hurt in messy ways, and the law tries to fit those stories into structured boxes. But I have learned that if everyone involved attends to the boring details and treats each other with a little patience, the outcomes improve. Not perfectly, not every time, but enough to matter.