What the Insurance Company Won't Tell You After a Work Injury

This page is general information about how California workers' compensation claims are commonly handled. It is not legal advice about your case, and reading it or contacting us does not create an attorney client relationship. Every claim and every claims administrator is different.

The adjuster handling your claim does not work for you. Insurance companies and claims administrators are in the business of paying out as little as the law allows, and the system gives them many ways to do it. The tactics below are common, legal or close to it, and most injured workers never see them coming.

The friendly first phone call

Soon after you report the injury, someone calls to “get your side of the story.” The tone is warm and helpful. The call is often recorded, and the questions are chosen carefully: prior injuries, hobbies, weekend activities, whether it “really” happened at work, whether it hurt “that much.”

The fallout: Anything you say can be compared later to your medical records and testimony. An offhand remark about an old sports injury, or minimizing your pain to sound tough, can be used to deny the claim, blame a prior condition, or attack your credibility.

“Your claim is under investigation”

The claims administrator has up to 90 days after the claim form is filed to accept or deny the claim (Labor Code section 5402(b)). Many use every one of those days. While a claim is pending, the law limits the employer's liability for treatment to $10,000 (section 5402(c)), and temporary disability checks often do not arrive at all.

The fallout: You may go months with no paycheck and limited treatment while bills pile up. Some workers give up, go back to work hurt, or use their own health insurance, which can create liens and confusion later.

The company doctor

Most employers use a Medical Provider Network, and the first appointment is usually at an occupational clinic chosen by the employer or the insurer. Many of these clinics see high volumes of insurer referred patients and depend on that business.

The fallout: Quick exams, a diagnosis of “sprain” or “strain,” early release to full duty, and reports that later become the insurer's evidence that you are not seriously hurt.

Treatment denied by a doctor who never met you

When your doctor requests surgery, an MRI, therapy or medication, the request goes to utilization review. A reviewing doctor, paid by or through the insurer, reads the paperwork and decides whether the treatment is “medically necessary.” They never examine you. The decision is due within 5 working days in most cases, and the only appeal is Independent Medical Review, which must be requested within 30 days.

The fallout: Needed care is delayed for months or denied outright. If the IMR deadline passes, the denial generally stands for 12 months unless your condition or circumstances change.

Declaring you “permanent and stationary” too early

Once a doctor reports that you have reached maximum medical improvement, the insurer can stop temporary disability and switch you to permanent disability payments, which are often paid at a lower weekly rate. Insurers frequently push for that report as early as possible, sometimes while body parts are still untreated or not yet accepted.

The fallout: Your income drops overnight. Treatment can be wound down. The permanent disability rating may be based on an incomplete picture, and conditions that never got treated can be left out of the case entirely.

Late checks and sudden stoppages

The first temporary disability payment is due within 14 days after the employer learns of the injury and the disability, and payments are due every two weeks after that. Late payments carry an automatic 10 percent increase, and unreasonable delay can lead to a penalty of up to 25 percent (Labor Code sections 4650 and 5814). For many insurers, those costs are simply part of doing business.

The fallout: Missed rent, missed car payments, and pressure to settle cheap or return to work before you are ready.

Running out the clock

For most injuries, temporary disability is capped at 104 weeks within five years of the date of injury (Labor Code section 4656). Disputes, delayed authorizations and slow medical legal evaluations all eat into that time.

The fallout: A worker who is still unable to work can reach the cap with the case unresolved and no income coming in.

Surveillance and social media

Insurers hire investigators to film injured workers in public: carrying groceries, playing with children, working in the yard. They also review public social media posts and photos.

The fallout: A few minutes of video on a good day, shown without context, can be used to accuse a worker of exaggerating or of fraud, damage credibility with the doctors and the judge, and cut a case's value.

The nurse case manager in the exam room

Some insurers assign a nurse case manager who offers to “help coordinate your care” and asks to attend your medical appointments and speak privately with your doctor.

The fallout: The nurse works for the insurer. Their presence and their conversations with your doctor can shape treatment decisions and work restrictions in the insurer's favor.

Blaming your age, your past, or “degeneration”

California law requires permanent disability to be apportioned based on causation (Labor Code section 4663). Insurers routinely argue that part of your disability comes from aging, arthritis, “degenerative” changes on an MRI, an old injury, or your weight.

The fallout: Your permanent disability award can be cut by a large percentage, even when you had no symptoms and no limitations before the work injury.

Paperwork with hidden deadlines

Injured workers receive a steady stream of letters and forms: benefit notices, utilization review decisions, QME panel lists, records logs. Many contain short deadlines, some as short as 10 days, buried in dense language.

The fallout: Miss a deadline and you can lose the right to pick your QME, to object to records, to challenge a treatment denial, or to dispute a rating. The worker who does not understand the notice pays for it.

Losing the job after the injury

Firing or punishing a worker for having a work injury is illegal (Labor Code section 132a). Even so, modified duty offers can disappear, positions get “eliminated,” and workers are let go once restrictions become inconvenient.

The fallout: Loss of income, loss of employer health insurance, and a harder road back to work.

The quick settlement

Once the insurer has the numbers it wants, it may offer to settle, often with a lump sum that buys out your right to future medical care for the injury. The offer is usually presented as a good deal and as a way to be done with the system.

The fallout: If future surgery, medication or treatment is needed, the worker pays for it, or goes without. Liens for state disability or other benefits

can come out of the settlement, and a settlement that looked large up front can leave little behind.

Waiting out the deadlines

An employee must give notice of the injury within 30 days (Labor Code section 5400), and a claim generally must be filed within one year from the date of injury or the last benefit provided (section 5405). Long delays, vague promises and slow answers can carry a worker right past those dates.

The fallout: A valid claim can be lost entirely, not on the merits, but on the calendar.

The bottom line

None of this means every adjuster acts in bad faith. It means the system is built around the insurer's interests, and the insurer knows the rules far better than the worker does.