Medical treatment is the heartbeat of any workers' compensation claim. Without it, pain lingers, injuries worsen, and people lose ground at work and at home. When a carrier denies treatment, the disruption is more than administrative. It is physical, emotional, and often financial. As a workers compensation lawyer, I think in two directions at once, immediate care and long game. You need relief now, but you also need a record strong enough to carry your case through reviews, hearings, and negotiations.

The way forward is part triage, part strategy, and part patience. Every state has its own rules, but denials follow familiar patterns. With the right steps, many of them can be reversed, narrowed, or worked around.

Why treatment gets denied in the first place

Few denials are about malice. They are usually about paperwork, timing, and medical guidelines. Carriers lean on utilization review and state treatment schedules to keep costs predictable. That can help weed out unproven care, but it also sweeps up legitimate treatment that does not fit neatly in a template.

I see the same reasons again and again. A reviewer says the injury is not work-related because the initial visit mentioned "prior soreness." Another flags treatment as "not medically necessary" because the request lacked specific functional deficits or failed to show tried-and-failed conservative care. Network rules trip people up too. If you saw a non-approved physician, even by mistake, some carriers use that to block referrals and imaging. Some denials come after a doctor declares maximum medical improvement too early, closing the door on further care unless a new event or new objective findings appear.

Behind each reason is a way to respond. Understanding the rationale tells you which lever to pull: evidence, process, or leverage.

First steps when treatment is denied

Speed matters because appeal windows tend to be short. Some states allow only a few business days for urgent care and a couple of weeks for standard disputes. Others give 30 days, measured from the date on the letter, not when you receive it. Missing a deadline can lock in the denial until new evidence emerges.

Here is a tight approach I use when a client calls during that first week:

- Ask for the denial in writing, including the specific guideline or rule relied upon.
- Continue medically necessary care through group health insurance if possible, and keep receipts for co-pays and prescriptions.
- Book a follow-up visit with the treating doctor to add missing detail to the request, then re-submit promptly.
- Put the carrier on notice, in writing, that we will appeal through the designated process, whether that is internal review, independent medical review, or a hearing.
- Track dates. Create a simple timeline with injury date, first treatment, testing, and every request and denial.

Those steps preserve options. Meanwhile, I set up the file like it will be tried. If we never need a hearing, great. If we do, nothing beats a clean record.

Strengthening the medical record so the next reviewer says yes

The most persuasive thing in a treatment dispute is not a lawyer's letter. It is a doctor's detailed narrative that tracks the guidelines while staying true to clinical judgment. I work closely with treating physicians because their

language decides most fights.

A helpful report includes the mechanism of injury, your job tasks with weights and distances, the onset and progression of symptoms, and objective findings. Objective does not always mean a dramatic MRI. It can be restricted range of motion measured with a goniometer, swelling documented in photos, grip strength testing, or a positive Spurling’s sign. Pain scales alone rarely carry the day.

If a guideline says to try six weeks of physical therapy before approving an injection, then the note should list the actual sessions, home exercise compliance, and the percentage improvement that plateaued. If a prior authorization is for an MRI of the shoulder, the doctor should connect it to red flag symptoms like night pain, weakness with abduction, or apprehension test results. Vague language invites an easy no.

When denials cite preexisting conditions, I ask the physician to address apportionment head-on. A brief paragraph outlining baseline function before the work event, and the step change afterward, can be enough. A spine surgeon once resolved a yearlong fight for his patient with two sentences: “Degenerative changes preexisted. There was no radicular pain or neurologic deficit before the injury. Both are present now.” The injection was approved within a week.

Working inside the utilization review machinery

Utilization review can feel faceless, but it runs on specific protocols. Most carriers lean on nationally recognized treatment guidelines. You will hear references to ACOEM, ODG, and state-specific medical treatment schedules. These are not ironclad. They allow exceptions where documented clinical factors justify deviation.

Timing is the first tactical point. Emergency requests often require a decision within a few days. Routine requests might have a window close to a week for the initial decision, then another short window for appeal. Independent medical review, where available, often has a 30-day turnaround once accepted. I calendar every deadline with a two-day cushion, then build the appeal around the exact reason stated in the denial. If the reviewer says, “no failed course of conservative care,” the appeal shows the dates and outcomes of those sessions and provides therapy notes, not just a summary.

Some denials hinge on identity rather than content. If the physician who requested treatment is outside the employer’s network or medical provider roster, a carrier might deny on that basis alone. Fixing this can be as simple as transferring care properly and having the in-network doctor reissue the same request with the same documentation. It feels bureaucratic because it is, but the second time around often succeeds.

Preparing for the independent medical exam

Independent medical exams are not really independent, but they are important. The report will likely be quoted at hearings and in negotiation. I do not coach clients to “win” the exam. I prepare them to give accurate, consistent information so the report does not undercut real symptoms.

Bring a simple packet. It should include imaging reports, a medication list with dosages, a timeline of key events, and a short list of job duties. Practice the mechanism of injury in two or three sentences. Avoid superlatives and avoid minimizing. If you can lift a gallon of milk but not a 30-pound box, say so. Demonstrate limits carefully and consistently. If a test causes pain, say where and how it feels. If standing more than 15 minutes triggers symptoms, note the time, do not guess.

One client, a grocery stocker, struggled with a shoulder injury. The IME physician wrote, “Patient reports near-constant pain, but lifts arm overhead during exam effortlessly.” What the report left out was context. She reached overhead momentarily, then winced. Before her hearing, we obtained a short addendum from the treating doctor

describing the difference between active and repetitive motion and tying that physiologic concept to her job. The judge ordered a second opinion, and therapy plus an injection were approved.

Using the rules to your advantage

Procedure can seem dull until you discover leverage hidden in it. Several states allow expedited hearings for medical disputes. If a carrier knows you are ready to calendar a fast-track appearance where a judge can order treatment, the tone of negotiation changes. In some jurisdictions, unreasonable denial or delay of medical care opens the door to penalties and attorney's fees. Those are not automatic, and every state sets its own definitions of unreasonable. Still, the possibility nudges adjusters toward compromise.

Another underused tool is the subpoena for treatment criteria. Carriers sometimes rely on internal algorithms or proprietary edits. When a denial cites a guideline, I ask for the exact page, the edition, and any internal policy layered on top. It is surprising how often a reviewer quotes outdated language. Catching that is not about being clever. It is about showing your client is entitled to decisions based on current standards.

Finally, depositions of treating physicians can carry real impact when used sparingly. I rarely schedule them for routine therapy disputes. I do use them for higher-cost items like surgery or long-term pain management. A 45-minute deposition, with the right foundation questions and case-specific hypotheticals, can flip a position that seemed stuck.

Negotiating partial approvals and step care

Perfect can be the enemy of progress. If a surgeon requests a three-level fusion and the carrier balks, there is often room to approve staged interventions that relieve suffering and build proof. Agreeing to a diagnostic injection, then a radiofrequency ablation if relief is temporary, may turn an absolute no into a conditional yes. The same approach works with therapy. An initial eight-visit block, followed by an outcomes check, sometimes unlocks what a flat request for 24 visits did not.

I also push for practical add-ons that keep people moving: home TENS units, ergonomic adjustments, or work hardening when therapy alone is not enough. These are modest costs in the scheme of a claim and often improve function quickly.

Documentation that matters when appealing

If there is one place where injured workers can powerfully help their case, it is in the quality of personal records. Adjusters and judges prefer contemporaneous notes to hindsight summaries. A small investment of daily attention can pay off months later.

Here is a focused set of documents that helps nearly every appeal:

- A pain and activity journal that notes time of day, activity, and duration before symptoms start.
- A medication log showing doses taken, side effects, and whether it allowed certain activities.
- Work restrictions from doctors, saved in order, with any modified duty offers from the employer.
- Proof of out-of-pocket costs for care during the denial period, including receipts and mileage.
- Photos or short videos demonstrating swelling, range of motion, or adaptive devices in use.

I have walked into hearings where a client's four pages of neat, dated notes outweighed a reviewer's generic form letter. Specifics persuade.

Special challenges: repetitive trauma, mental health, and preexisting conditions

Some injuries do not look dramatic. A one-time fall leaving fractures and visible bruising takes a straight path to approval. Carpal tunnel, lumbar strain with degenerative findings, and stress-related conditions wind through more gates.

Repetitive trauma claims benefit from careful job analysis. I ask clients to describe exact grips, weight of tools, cycle times, and breaks. If assembly requires 400 pinches per hour, measuring that matters. A hand specialist can connect those facts to the medical literature more persuasively than a generalist.

Mental health claims after a workplace assault or severe accident are legitimate, yet they draw heightened scrutiny. Documents from early counseling, records showing sleep disruption and panic symptoms, and consistent discussion of triggers create a through-line that makes authorizations for therapy and medication more likely. Avoid gaps. If finances force a pause in counseling, note that. An unexplained six-week gap invites skepticism.

Preexisting conditions are the thorniest. The law in many states recognizes aggravation of a prior condition as compensable. The pivot is showing the delta. What could you do before? What changed after? Objective anchors help here, like increased dosage of anti-inflammatories, added neuropathic medications, or new radicular findings. I once represented a forklift operator with a ragged lumbar MRI before the injury and a somewhat worse scan after. The carrier said nothing changed. We had his supervisor testify that the man missed only two days of work in the year before the incident, then missed 29 full days and returned on restrictions afterward. That testimony, plus nerve conduction studies, moved the needle.

Coordinating care while the fight continues

Denied treatment does not always mean no treatment. Many clients can run care through group health insurance temporarily. Doing so prevents deconditioning and shows good faith. Keep tight records. Health plans often assert reimbursement rights if the workers’ comp carrier later accepts responsibility. That is a solvable accounting issue, not a reason to stop getting better.

Prescription management deserves similar attention. If the workers’ comp pharmacy vendor refuses to fill a medication, ask your treating doctor about lower-cost generics or short-term alternatives. Use discount programs if needed, but save every receipt. Mileage to appointments, sometimes overlooked, is often reimbursable at set cents per mile in many states. Track it.

Transportation, childcare, and time off work complicate attendance. Communicate early with providers and your employer about scheduling constraints. Adjusters and judges look kindly on patients who keep appointments and tell the truth about barriers.

Hearings, leverage, and when to push

Not every denial should be marched to a judge. Some need a phone call between counsel to reframe a request. Others need a tweaked diagnosis code and resubmission. But when delay becomes the tactic, a hearing date becomes the remedy.

I file for expedited relief when three things line up. First, the **workers compensation attorney** medical basis is clear and well documented. Second, the harm from delay is obvious, such as a time-sensitive surgery or progressive nerve symptoms. Third, efforts to resolve informally have stalled. I make sure the doctor is available, either live or by telephone, and I bring copies of the guideline sections the defense has cited. Being ready often

prompts resolution a day or two before the hearing. If not, a short, focused presentation beats a long speech. Judges want clarity on necessity and causation. Give them both.

Some jurisdictions allow penalties when denials are unreasonable. You do not get those by accusing the carrier of bad faith. You get them by showing a timeline where requests were complete, deadlines were ignored, and rationales shifted without new facts. A small penalty now can prevent bigger fights later. It tells the other side that process matters.

Settlements, medical set-asides, and the long tail

A settlement can be tempting after months of conflict. Money on the table feels like closure. Before agreeing to close medical rights for a lump sum, think long-term. Calculate realistic annual costs for ongoing medications, therapy bursts during flares, and likely procedures. Multiply by years to Medicare age or by the expected life of the condition. The number surprises people, often higher than the offer.

If you are a Medicare beneficiary or likely to become one soon, a Medicare set-aside analysis may be necessary. This is a carve-out of settlement funds reserved for future medical care related to the injury. Spending must follow specific rules so Medicare will cover non-injury care. It is bureaucratic, but it protects your access to treatment later.

Not every claim should close medical rights. In shoulder and knee cases, keeping medical open and settling indemnity can make sense when employers remain stable and carriers pay reasonably. In cases where trust has eroded and utilization review is chronic, a well-funded closeout might serve you better. It is a math and risk exercise. A good workers compensation lawyer will run scenarios with conservative, moderate, and aggressive assumptions, then let you choose based on your tolerance for uncertainty.

How a seasoned lawyer moves the needle day to day

A strong case is built in the ordinary days, not the hearing days. The small habits matter. I return doctors’ calls the same day. I send short case summaries to specialists so their notes are focused. I ask adjusters, in writing, which guideline section they relied on and why the exception criteria did not apply. I set reminders to refile when a denial is procedurally defective rather than medically grounded. And I tell clients what to expect, even when the news is mixed.

Two examples, anonymized but true, show the range. A warehouse picker in her 40s had a denied MRI. The reviewer said no red flags and inadequate conservative care. Within two weeks we obtained therapy notes documenting six sessions, a positive drop arm test, and night pain. We added a one-page narrative from the treating doctor tying those findings to cuff pathology. The MRI was approved on reconsideration. It showed a high-grade partial thickness tear, and surgery followed.

In a different case, a delivery driver with a low back injury faced serial denials for injections and therapy. The carrier leaned on preexisting degeneration. We pursued an expedited hearing. Ahead of time, I deposed the pain specialist for 30 minutes, narrowing the issue to functional improvement after a diagnostic block. We brought time-stamped videos from the client’s spouse showing walking tolerance before and after the block. The judge ordered treatment. The carrier did not appeal.

What you can do right now

Most clients feel better when they have a plan they can execute. You do not need to know every statute to move your case forward. You do need to protect your record, your health, and your deadlines.

Start with the basics. Ask for every denial in writing. Keep your appointments. Be honest about what hurts and what helps. Keep a simple log. If you have a union, involve your steward early. If your employer offers modified duty, consider it seriously, but do not exceed medical restrictions to be a hero. Short-term pride can mean long-term setbacks.

And if you feel stuck, consult a lawyer who handles these cases routinely. The best time to call is not when the denial arrives, but the first time your doctor mentions preapproval. A brief strategy session then can prevent months of delay. When you do hire counsel, ask how they approach medical disputes specifically. Look for someone who talks about timing, documentation, and guidelines, not just hearings and settlements.

The human side of a denial

Behind every file is a person who wants a normal day back. I remember a machinist who measured life in millimeters, then found he could not unscrew a jar at home without pain. Denials broke his patience faster than his body. We won approvals in stages, a few visits at a time. Each green light was a small dignity returned, the kind you only notice when you lose it.

That is what this work is about at ground level. Strategy matters, rules matter, and persistence matters. But the point is simpler. Care restores capacity. When a system says no, the job is to find the path to yes, using every honest tool the law allows.