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IN THIS ISSUE

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Issues with “How to Help Injured Workers Return to Work”

Catch – 22: Issues with “How to Help Injured Workers Return to Work”

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Left to Right: James B. Talmage, MD; Robert B. Snyder, MD; J. Wills Oglesby, MD

This literature review will attempt to clarify what physicians can, and cannot do, to help injured workers return to work. Returning to work after an injury is usually in the worker's long-term best interest (Talmage 2011).

Recently published scientific review articles highlight the problems physicians encounter in helping their employees return to work (RTW) after a workplace injury or a work-related illness.

The American College of Occupational and Environmental Medicine (ACOEM) publishes evidence-based treatment guidelines that are presumptively correct for treatment of injured workers in California, Nevada, and New York. Their revised "Workplace Disability Prevention and Management" guidelines are summarized in a recently published article (Kertay 2025). Their methodology was to search seven electronic databases for studies on this topic. Sixteen authors reviewed 4,249 published studies, and they list 275 articles as references.

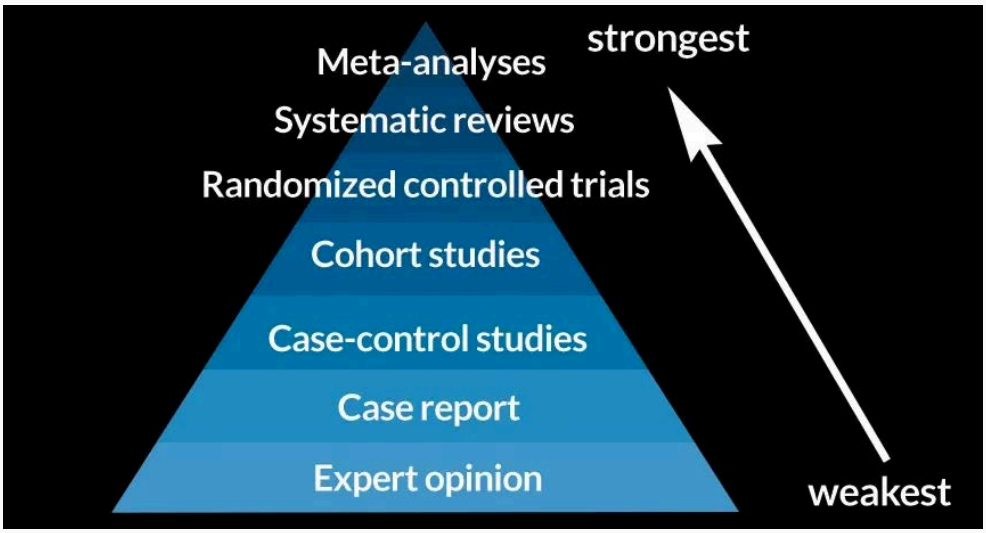
They "recommend" a number of medical interventions to improve return to work, even though they classified these as "Recommended, **Insufficient** Evidence" (*i.e. "Recommended" by consensus, even though there is **not** scientific evidence of the intervention being effective*). This category included Screening Questionnaires to predict which claimants will have prolonged time off and/or fail to return to work (*evidence consistently failed to show predictive ability*), Education, Exercise, Nurse Case Management, and Vocational Rehabilitation.

They noted the use of two medications -- opioids or benzodiazepines -- appear to increase disability-the opposite of facilitating RTW. [*see for example Hunt, 2019*]

Their category of "**NO** recommendation, **Insufficient** Evidence" included Medical and Psychological Treatments for Symptom Reduction (*symptoms includes **pain***).

They noted "passive" treatments of Electrical Therapies, Heat or Cold therapies, Massage, Manipulation, Acupuncture, Injections, and some surgeries have little value for return to work and may inadvertently increase work disability by "externalization" (*relying on others for treatment while avoiding active patient-involved rehabilitation strategies*).

The ACOEM Guidelines' authors concluded that psychologists delivering cognitive behavioral therapy evinces Return to Work efficacy (despite pain), and surgery for some specific diagnoses may be helpful when RTW is the outcome studied.


strongest
Meta-analyses
Systematic reviews
Randomized controlled trials
Cohort studies
Case-control studies
Case report
Expert opinion
weakest

Examples of the surgical Return to Work literature are Cheriyan 2015, Daniels 2017, Halicka 2022, and Saltychev 2025.

Cheriyan 2015 is a US meta-analysis of 31 published studies on spine surgery.

> A total of nine studies, four prospective (n=1193) and five retrospective (n=548), reported on number of patients who returned to work in the compensated and non-compensated groups. Out of 491 patients, 282 (57.4%) returned to work at the last follow-up in the compensated cohort, whereas out of 1250, 1036 (82.9%) in the non-compensated cohort.

Daniels 2017 Narrative Review had similar conclusions.

> Numerous investigations have revealed that workers' compensation status is a negative risk factor for outcomes after spine injuries and spine surgery. However, positive patient outcomes and return to work are possible in spine-related workers' compensation cases with proper patient selection, appropriate surgical indications, and realistic postoperative expectations.

Halicka 2022 is a British systematic review of RTW after spinal surgery. They screened 2,622 publications and found only eight were relevant (only five were low risk of bias).

> Narrative synthesis and meta-analysis where possible found that individuals less likely to RTW were older (odds ratio [OR] = .58; 95% confidence interval [CI]: 0.46–0.72), not working before surgery, had longer sick leave (OR = .95; 95% CI: 0.93–0.97), higher physical workload, legal representation (OR = .61; 95% CI: 0.53 –0.71), psychiatric comorbidities and depression (moderate quality-of-evidence, QoE), and longer CLBP duration and opioid use (low QoE), independent of potential confounders.

Saltychev 2025 is a systematic review from Finland of Return to Work after Lumbar Discectomy. They screened 2,285 articles and included 31 in their meta-analysis.

> Conclusion. The results of this review suggest that ~70% to 80% of patients who undergo a microsurgical procedure for disc herniation return to work within the first month and a half (6 weeks). It also seems that returning to work after this period is quite unlikely. The duration of preoperative symptoms did not affect significantly the prevalence of RTW. Information about these trends should be taken into account both in the planning phase of the procedure and in setting goals for postoperative rehabilitation.

Many surgeons do not see the patient for the first one to three post-op visits, preferring to have a mid-level provider deal with these “routine” office visits. Seeing the patient for the first time several months after the spinal surgery means the surgeon misses the opportunity to influence the RTW.

Pain is most frequently the factor keeping injured workers from returning to work. Injured workers who could return safely (*acceptable risk of reinjury – no need for restrictions*) and who could do

work tasks (*have the motion, strength, etc. to function – no limitations*) would appear to be fit to work.

What they frequently lack is the **tolerance** to do work tasks despite pain. While acute injury related pain may be a valid reason for physician certification of time away from work, many patients with chronic pain go to work every day, and pain is not scientifically measurable.

The statement, "This patient has too much chronic pain to return to work," is really a poor paraphrase of, "This patient says he/she has too much pain to want to return to work."

Pain is common. The U.S. Centers for Disease Control 2023 survey [Lucas 2024] indicates 24% of US adults have chronic pain, and 8.5% have high-impact chronic pain. Many of these individuals go to work every day. A 2022 Systematic Review of published studies on the prevalence of chronic pain [Zimmer 2022] found significant variation in the prevalence of chronic pain in 52 countries, varying from 9.9% to 50.3%. In the "Americas" (*North and South American continents*) the surveyed countries had on average 26% of the adult population with chronic pain. Both articles noted the older individuals had an increased prevalence of chronic pain.

Shaw 2021 studied helping workers with chronic pain stay at work and cited studies stating 40% of U.S. workers report persistent or recurrent musculoskeletal pain or other chronic physical conditions limit their work performance.

An Australian review [Wegrzynek 2020] of interventions for chronic pain patients to improve return to work searched eight electronic medical databases for studies and concurred with the subsequent ACOEM 2025 review, concluding,

> "There is no conclusive evidence to support any specific tertiary RTW intervention for workers with chronic pain…".

Again, pain most frequently hinders RTW, and a different 2025 a systematic review of interventional procedures for chronic, non-cancer pain [Wang 2025] found **no** evidence doctors could reduce chronic pain.

A Canadian review of the role of Healthcare Providers in RTW [Kosny 2018] points out that the population of injured workers can be subdivided. Those with "visible, acute, physical injuries" are not generally a problem for employers, or health care providers.

However, Healthcare Providers (HCPs)...

> "... faced challenges when they encountered patients with multiple injuries, gradual-onset or complex illnesses, chronic pain and mental health conditions. In these circumstances, many (HCPs) experienced the workers compensation system as opaque and confusing. A number of systemic, process, and administrative hurdles, disagreements about medical decisions, and lack of role clarity impeded the meaningful engagement of HCPs in RTW. In turn, this has resulted in challenges for injured workers (IWs), as well as inefficiencies in the workers compensation system." [Kosny 2018]

So, the conclusions of the "medical" review can be stated as:

- One group of injured workers recover at the same rate as those with similar non-work-related injuries. RTW is not an issue for these workers.
- The other group has a low risk of reinjury, the capacity for work, chronic pain, and their pain tolerance is **THE** factor preventing RTW. Doctors will generally not solve this group's pain problem or improve RTW rate.

The Catch 22: employers may expect the physician to solve the RTW issue for these workers, and yet physicians **can't** do that.

What should physicians and employers do with the second group of injured workers?

First, "Ask the patient." Likely the first study to document the usefulness of this was in Sweden and was published in 2006

[Heijbel]. 508 off-work patients were asked how likely it was they would RTW. Only six out of the 135 who predicted they would not return to work actually did return to work (odds ratio of correct prediction = 8.28). A later systematic review [Carrière 2023] of 30 published studies of 28,741 patients found single question surveys "Do you think you'll RTW?" had strong evidence of predictive value.

For those workers interested in RTW, a recent systematic review has documented published evidence that employers **can** do what doctors can't do [Jansen 2021].

> "On supervisor level, strong evidence was found for an association between work accommodations and continued employment and return to work. Moderate evidence was found for an association between social support and return to work."

Physicians as a group have not been trained in assigning work abilities/restrictions, and many are uncomfortable with that role, especially when the patient resists RTW overtures.

Jason Parker taught the October 2024 Tennessee Bureau of Workers' Compensation REWARD Employer session. His method is likely to be both the most efficient and the most effective for those injured workers who express interest in RTW but who appear to be lagging behind the expected recovery curve. Rather than take physician "restrictions" and try to figure out a transitional duty job, he suggests employers and employees jointly discuss and agree on a RTW plan and then present the plan to the treating physician to review for safety concerns.

The conversation should involve the employer's Return to Work Coordinator, the injured worker, and the worker's supervisor. The place to start is by asking, "In your pre-injury job, what work tasks can you do today?" This will help determine if the worker's original job can be modified by temporarily reassigning the challenging tasks to other workers, or if an entirely different "transitional duty" job is needed.

Once the employer (return to work coordinator), the worker, and the supervisor have agreed on a transitional job, the RTW coordinator can draft a letter to the treating physician asking him/her to "sign off"

that the worker at this stage of recovery can safely do the job in question. When phrased this way, physicians think reinjury risk at this stage of recovery, and rarely do they fail to certify RTW in the job agreed to by the worker and the employer.

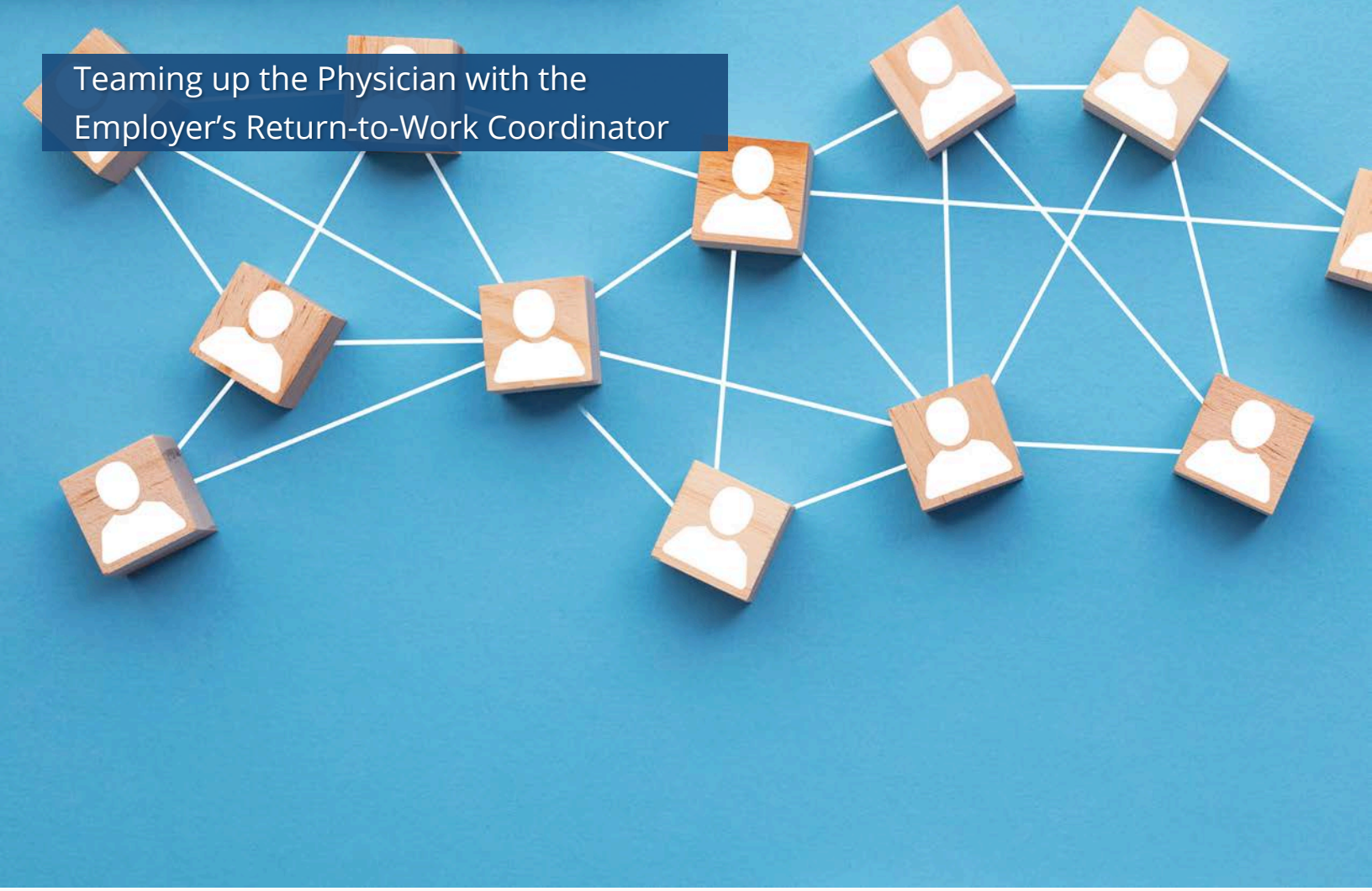
Rather than physicians guessing and filling out a form on RTW "restrictions" (*that frequently is equivalent to "this person needs a full-time live-in attendant" (e.g. "no lifting > 2 pounds")* physicians can state:

> "The employee and employer should meet, agree on a transitional-duty program that starts with job tasks the employee can do now, and present that to me at the employee's next office visit."

Hopefully this literature review has clarified what physicians and other health care providers can, and cannot do, to help injured workers return to work.

*Jump to **references** for this article.*

Teaming up the Physician with the Employer's Return-to-Work Coordinator



Optimizing Return-to-Work Outcomes: Teaming up the Physician with the Employer's Return-to-Work Coordinator

Brian Holmes

INTRODUCTION

The Tennessee Bureau of Workers' Compensation's R.E.W.A.R.D. Program (Return Employees to Work And Reduce Disability) emphasizes timely, safe return-to-work (RTW) as a critical component of recovery following occupational injury. Physicians are central to this process, particularly when integrated into an employer's RTW infrastructure. This essay aims to guide physicians on how to help employers improve the workers' compensation claim experience by aligning with the R.E.W.A.R.D. framework. It will explore the physician's role in effectively communicating with the injured worker, documentation that includes initial causation, medical necessity determinations, return-to-work decision-making, and collaboration with employers and their return-to-work coordinators.

I. THE RETURN-TO-WORK COORDINATOR

The R.E.W.A.R.D. program encourages employers to identify a return-to-work (RTW) coordinator to spearhead the post-accident recovery, improve the claim experience, and reduce the impact of a claim on both the injured worker and the employer. "Employees who are satisfied with their employer's response to injury or illness returned to work 50% faster with 54% lower cost." (Mitchell, 2012).

RTW coordinators improve the claim experience by complying with the statutes and rules, setting expectations for injured workers, and solving problems. They create a culture of returning to work, train employees to expect to return-to-work post-accident and use employees to identify light duty tasks pre-injury.

Physicians support the coordinator's efforts through clinical decisions and communication strategies that normalize and prioritize return-to-work in their communication with the injured worker. Physicians may help develop the initial RTW Program (Bosma, 2022). They can better understand the workplace and work being performed by touring an employer's facilities, or meeting with the RTW coordinator at the onset of a claim. R.E.W.A.R.D. encourages coordinators to schedule and pay for an appointment for the sole purpose of communication between the employer and the physician (Talmage, 2024).

II. CERTIFIED PHYSICIANS PROGRAM (CPP): A KEY RESOURCE FOR CLAIM OPTIMIZATION

Physicians participating in the Bureau's Certified Physicians Program (CPP) receive specialized training in causation, impairment, medical necessity, maximum medical improvement (MMI), and best practices in workers' compensation care. These physicians are listed on a public registry to help employers assemble compliant and capable medical panels (Tennessee Bureau of Workers' Compensation, n.d.). Properly executing the panel provisions with certified physicians will significantly improve the claims experience and resolution.

In fact, a common dispute driver in the mediation and ombudsman programs for the Tennessee Bureau of Workers' Compensation is the panel. "When a panel of physicians has one who is not willing and able to treat an injured worker, it has a significant negative impact on that injured worker's claim experience," says Jeannie Henderson, the lead mediator for middle Tennessee. She adds: "The injured worker often becomes suspicious of the claim experience and blames their employer."

When panels contain physicians not trained or aware of their responsibilities to the workers' compensation system, it harms the claim experience. Frequently, injured workers contact the Bureau's ombudsman program to incredulously ask why they were given an authorized treating physician who can't address causation or render an opinion on impairment, even though they were willing and able to treat the condition. Sandy Cannon, the program coordinator for the Bureau's ombudsmen, says: "Injured workers often fear their workers' compensation claim is going downhill when their treating physician, can't, or won't, do all the work they are expected to do to help everyone conclude the claim."

This problem may be compounded when an injured worker is forced to attend an independent medical evaluation, further adding to the injured worker's feelings of suspicion and may delay their treatment or settlement of their claim. RTW coordinators, their employers and carriers will improve the claim experience when they correctly provide a competent and knowledgeable panel and by using certified physicians appropriately.

III. THE PHYSICIAN'S INFLUENCE ON PATIENT MINDSET, WORK REENTRY, AND MEANINGFUL WORK

The R.E.W.A.R.D. program teaches return-to-work coordinators to talk to their workers about return-to-work before an injury occurs and immediately after the work injury. The Bureau's return-to-work highlights the physical, financial, and emotional consequences of staying out of work (Tennessee Bureau of Workers' Compensation, n.d.). Additionally, a conversation about the negative impact of non-meaningful work on recovery is an opportunity that some physicians might be able to use to help improve the claim experience. When the RTW coordinators and physicians have effective and consistent return-to-work messaging in the exam room, it resonates much better with injured workers.

Social proof—a concept taught by persuasion expert Robert Cialdini—can be a powerful clinical tool. When patients learn what others with similar injuries have successfully done to return to work, they are more likely to follow suit (Cialdini Institute, n.d.). Physicians who share anonymized patient recovery stories and emphasize the therapeutic benefits of meaningful work can positively shape patient behavior and expectations.

The RTW coordinator and the physician need to be aware of how meaningful work is viewed by the injured worker. The Bureau's dispute resolution program frequently receives complaints from injured workers who view what was recommended as non-meaningful work, or modified work that lacks apparent purpose, is perceived to be retaliatory or may seem punitive. Sandy Cannon adds: "The impact on the claim experience is detrimental. False assignments of motivation, such as 'They just want me to quit' are frequently stated, and negative feelings of self-worth are readily apparent."

R.E.W.A.R.D. encourages employers to follow these steps to identify meaningful work:

1. Consider modified jobs and tasks before a work injury occurs. Receive input from your front-line workers in addition to

supervisors and managers.

2. Measure your jobs and tasks to understand the force and weight requirements.
3. Both employer and employee independently review the authorized treating physician's work ability recommendations and consider what work can be done.
4. Meet, discuss, and develop a modified work plan.
5. Submit the plan to the authorized treating physician to determine it is safe
6. If yes, implement the plan, if no, submit revisions until the ATP approves.

Physicians who are willing to review comprehensive return-to-work plans for risk to their patient, and who are willing and able to talk about the merits of meaningful work, provide a valuable contribution to RTW coordinators and to the claim experience.

IV. WORK RESTRICTIONS AT MMI: THE IMPORTANCE OF FORESHADOWING AND PLANNING

Permanent work restrictions after maximum medical improvement (MMI) are another complication. Employers must determine what to do with permanent restrictions, which has different legal implications than temporary restrictions. Nearly three out of ten injured workers who conclude their claim with a settlement or compensation hearing either fail to return to work or do return to work, but at a lower wage following MMI (Tennessee Bureau of Workers' Compensation, 2024).

MMI is an important milestone in a claim. Yet many injured workers contact the Bureau's ombudsman program surprised they have suddenly reached it without any forewarning. Physicians who anticipate this transition and communicate it in advance can help injured workers emotionally and financially prepare. The timing of MMI with assigning the impairment rating also matters.

An injured worker whose employer cannot accommodate their restrictions can receive disability benefits for sixty days after MMI if their claim is not disputed and there is an impairment rating

assigned. See Tenn. Code Ann. § 50-6-234. The claim experience may be marred by a physician placing the injured worker at MMI with permanent restrictions and waiting to provide the impairment rating for sixty or ninety days.

When this happens, injured workers who are living paycheck to paycheck are adversely impacted. When the physician declares the injured worker to be at MMI, the temporary disability benefits stop, and without the rating, no permanent benefits are payable. Foreshadowing MMI, as well as changes in restrictions, gives an injured worker the ability to budget and gives her the opportunity to try to re-enter the workforce. A timely impairment rating may help mitigate the financial impact of this transition. Finally, physicians can refer patients to the Bureau's to help these workers avoid the absence of a paycheck.

V. MEDICAL RECORDS: A PILLAR OF DISPUTE PREVENTION

The failure of one party to possess medical records is a frequent driver of disputes in workers' compensation. Representatives from the Bureau's mediation and ombudsman programs are too frequently told that medical records are not in hand. Curiously, some claim adjusters who have paid months of disability benefits, and surgeries, have stated they do not have any medical records.

The release or exchange of medical records causes many people to pause and ask about the Health Insurance Portability and Accountability Act or HIPAA. Luckily, the federal government helps explain disclosures for workers' compensation purposes. (U.S. Department of Health and Human Services, 2025, May 22) Relevant to this purpose, the materials state in part:

"The Privacy Rule permits covered entities to disclose protected health information to workers' compensation insurers, State administrators, employers, and other persons or entities involved in workers' compensation systems, without the individual's authorization:

- To the extent the disclosure is required by State or other law. The disclosure must comply with and be limited to what the law requires. See 45 CFR 164.512(a).

- For purposes of obtaining payment for any health care provided to the injured or ill worker. See 45 CFR 164.502(a)(1)(ii) and the definition of "payment" at 45 CFR 164.501."

The Tennessee workers' compensation law requires the provision of records in Tenn. Code. Ann. § 50-6-204(2): "…each medical provider shall be required to release the records of any employee treated for a work-related injury to both the employer and the employee within thirty (30) days after admission or treatment. …"

Physicians who routinely and timely provide medical records directly to the claim adjuster, employer and injured worker help prevent claim disputes and improve the injured worker's and the employer's claim response. The claim experience can also be enhanced by what is in those medical records: accuracy, completeness, wording and empathy.

A quick survey amongst the mediation staff at the Bureau reveals a favorite provider for their medical records. The records are notable for the ease to discern causation, diagnosis, substantive dictation, work restrictions, and the treatment plan. In addition to dispute professionals, this clarity can help return-to-work coordinators quickly and easily understand the injured worker's progress. Clear treatment plans are key to avoiding litigation for medical authorization, a frequent driver of a negative claim experiences.

VI. TREATMENT GUIDELINES

Asking physicians to quickly appeal utilization review denials to improve the employer's response and the overall claim experience seems contradictory. Yet, we frequently see insurance companies use utilization review as a screening mechanism for adjusters who are unable, through time restraints, competency or policy, to assess whether to approve a surgery, test, therapy, or plan of treatment.

Medical records that explain the treatment guidelines and how the recommended treatment fits, or includes a justification for why it is necessary despite the guidelines, are very useful in dispute resolution and to the return-to-work coordinator.

Tenn. Code. Ann. § 50-6-204(a)(3)(H) provides a medical necessity presumption to the authorized treating physician's treatment plan.

Subsection (I) goes further and provides a clear and convincing standard to the medical necessity when the treatment guidelines are utilized. In court, this means the utilization review agent must show how the recommended treatment substantially deviates from the guidelines or presents an unreasonable interpretation of the treatment guidelines.

These statutory presumptions can be the difference maker for RTW coordinators and dispute professionals as they work to resolve medical necessity disputes without trial. Resolutions involving the Bureau's ombudsman program can take a few days; those in mediation can take weeks. These resolutions reduce substantial time delays that occur when cases go to court.,

VII. IMPAIRMENT RATINGS AND THE MEDICAL IMPAIRMENT RATING (MIR) REGISTRY

Records that thoroughly explain the impairment rating, such as those produced through the Medical Impairment Rating Registry, are also helpful to improve the claim experience. Ratings that don't appear to come from the A.M.A. Guides® or don't appear to make sense or are questioned may cause a party to request a compensation hearing.

When impairment ratings disputes to occur, parties who utilize the MIR Registry help reduce the amount of time needed to resolve their dispute since: "most mediations with an MIR opinion resolve with a full and final settlement without the need to go to a compensation hearing with the Court of Workers' Compensation Claims," says Martha-Lynn Lee, the Bureau's lead mediator for East Tennessee.

Not only are MIR Physicians specifically trained in the AMA Guides®, but they are required to show exactly how they obtained their impairment ratings (when giving an impairment rating under the auspices of the program). Each MIR Report is peer reviewed and enjoys a legal presumption of accuracy that can only be overcome by clear and convincing evidence to the contrary. This means that "if no evidence . . . raises a serious and substantial doubt about the evaluation's correctness, then the MIRR rating is the accurate rating" (Mansell v. Bridgestone, 2013).

CONCLUSION

Physicians play an essential role in creating a positive workers' compensation experience for injured workers in Tennessee. By engaging in early return-to-work conversations, documenting thoroughly, appealing treatment denials with supporting evidence, and collaborating with RTW coordinators, physicians support both patient recovery and system efficiency. Programs like the CPP and MIRR offer additional avenues for involvement that elevate clinical credibility and reduce litigation. When physicians participate in this integrated approach, they not only help individual patients heal—they also strengthen the integrity and sustainability of the entire compensation system.

*Jump to **references** for this article.*

Appeals Board Permits Transitional Work

Appeals Board Permits Transitional Work

By Jane Salem, staff attorney, Nashville

Jane Salem

In 2018, a split Tennessee Workers' Compensation Appeals Board rejected an employee's challenge to his employer's transitional work program. The employer wanted him to work within his restrictions at a local nonprofit, rather than his usual workplace. The injured worker declined.

The Majority opinion held that the Workers' Compensation Law's prohibition on "devices" to avoid an employer's obligations didn't apply to this program, and the worker here wasn't acting reasonably. The Dissent questioned the legal authority for these types of programs and highlighted the potential for abuse.

The opinion is important for many reasons, but mostly because it offers guidance on what makes a transitional work program "reasonable."

FACTS

Richard Lasser, a truck driver, was injured in a motor vehicle accident while working for Waste Management.

The treating physician assigned light-duty work restrictions. Lasser returned to work, picking up trash and washing trucks for a few days until he stopped, citing progressively worsening back pain. He saw another doctor, who also placed restrictions.

On that same day, Waste Management sent Lasser a letter informing him that he had been placed in "an appropriate temporary transitional duty" at the Cookeville Rescue Mission General Store. Lasser declined, and his temporary disability benefits were suspended, so he requested an expedited hearing.

At the hearing, he testified that his objection to working at the rescue mission wasn't due to safety concerns, his schedule, or the commute. Although he expressed concern that he didn't know the rules or procedures at the nonprofit, he testified he didn't accept the work because "[i]t just wasn't my job."

The trial court denied temporary disability benefits, citing case law holding that an employee acts unreasonably when he declines temporary transitional work for reasons that are merely "personal in

nature." Further, the Workers' Compensation Law doesn't prohibit an employer from offering work within his restrictions at an entity other than the employer.

Lasser appealed, and the Appeals Board split, with the Majority affirming.

THE MAJORITY

Lasser made two principal arguments.

First, he contended that the transitional work program violated section 50-6-114(a), which states that "[n]o contract or agreement, written or implied, or rule, regulation or other device, shall in any manner operate to relieve any employer, in whole or in part, of any obligation created by this chapter[.]" Lasser argued the transitional work program here was a "device" designed to relieve Waste Management of its workers' compensation obligations. He likened forcing him to work at the rescue mission to a retaliatory discharge.

Judge David Hensley, writing for the majority, disagreed:

"Here, the temporary transitional work program is not intended, nor does it allow, Employer to avoid any obligation to provide workers' compensation benefits. Rather, taking into account Employee's work restrictions, Employer has arranged for a modified duty placement, consistent with his work restrictions, which would result in Employer's paying Employee's full wages, rather than the lesser amount that temporary partial disability benefits would represent. Accordingly, we hold that Employer's temporary transitional work program does not violate section 50-6-114(a)."

The Majority similarly rejected Lasser's argument that "public policy" weighs against transitional work programs. Lasser asserted that "unscrupulous" employers would take advantage of unsophisticated workers and place them in jobs where they might be subject to harassment or bullying.

But Lasser hadn't alleged any actual intimidation by Waste Management, the Majority reminded. "He has not asserted the proposed transitional assignment was unreasonable for any reason

other than the work was to be performed for a different employer," Judge Hensley wrote.

Second, Lasser also argued the proposed placement wasn't reasonable under the circumstances. Case law directs:

"If an injured worker is unable to continue working because of the injury, there generally will not have been a meaningful return to work. However, if the employee returns to work and sometime thereafter stops working due to personal reasons or other reasons not related to the work injury, then such circumstances are considered as making a meaningful return to work. Ultimately, the resolution of what is reasonable must rest upon the facts of each case[.]"

The Majority concluded that Lasser's refusal was unreasonable. It wasn't based on his physical inability to perform the work; the location of the work offered being inconvenient or dangerous; or the number of hours. In fact, his pay was roughly equivalent to his preinjury wages. Further, working at the rescue mission wouldn't have "severed or altered the terms of the employer/employee relationship." Therefore, Lasser's reasons were "purely personal," they held.

Moreover, the statutory provision on temporary partial disability is silent on whether the work offered must be limited to the employer's worksite and could not be elsewhere. "It is not our role to add a limitation to the statutory provision that is not present. Any such decision is for the legislature," The Majority wrote.

THE DISSENT

Presiding Judge Marshall Davidson's dissent focused largely on the lack of law governing transitional work. "There is no statute, no regulation, and no case that addresses, much less sanctions, this practice," he wrote.

The Dissent found it "troublesome" that an employer could "compel[] injured workers to choose between working for an organization having no connection with either the employer or the employee against the employee's will and receiving workers' compensation benefits to which they are entitled."

The employer contracted with an unrelated, out-of-state third-party to arrange the transitional placement. Judge Davidson wrote, "The employee contends the practice of mandating that injured employees work for whatever entity the employer and the third party placement company choose amounts to a tool by which employers can skirt their obligations under the workers' compensation laws. I agree that such a practice is ripe for abuse and may, depending on the circumstances, amount to a 'device' used to avoid an employer's obligations[.]"

The Dissent echoed the employer's position that transitional work "is good for injured workers and good for the community given the free labor enjoyed by the nonprofit entities for which the injured employees must work." But that overlooks the fundamental question of whether employers should be free to force injured employees to work for a completely unrelated entity performing completely unrelated work under completely different circumstances than the employee contemplated, much less agreed to, when he was hired – all under the threat that the injured worker will forfeit his workers' compensation benefits for refusing.

In this case, Lasser was hired to work as a truck driver. Now, however, to avoid forfeiting his benefits, he had to work as a janitor at a rescue mission, a business in an entirely different industry, performing entirely different work.

Nowhere in Tennessee's workers' compensation statutes is an employer authorized to require an injured employee to work for whatever entity the employer decides the employee should work, the Dissent continued. Some states had legislatively sanctioned transitional work programs, but Tennessee hasn't.

The Dissent concluded, "The potential for abuse is real, as are the tangible and lasting effects on injured workers who unexpectedly find themselves having to choose between performing work for a new and distinct entity with its own rules, requirements, and expectations (and having to perform an entirely different type of work at that) and receiving their disability benefits. Injured workers should not have to make that choice."

THE BIG PICTURE

Because the order was interlocutory, by statute, Lasser could not seek further review, and no appellate courts have considered transitional work programs since. Also, lawmakers have not felt it necessary to codify the legality of transitional work programs.

The Majority suggests what a transitional work program should be:

- within the worker's physical abilities;
- at a location that isn't inconvenient or dangerous;
- reasonable in the number of hours; and
- doesn't "sever or alter" the terms of the employer/employee relationship.

Plus, it helps if the pay is the same as what the employee earned preinjury.

> But remember, it's a fact-intensive inquiry. One size doesn't fit all.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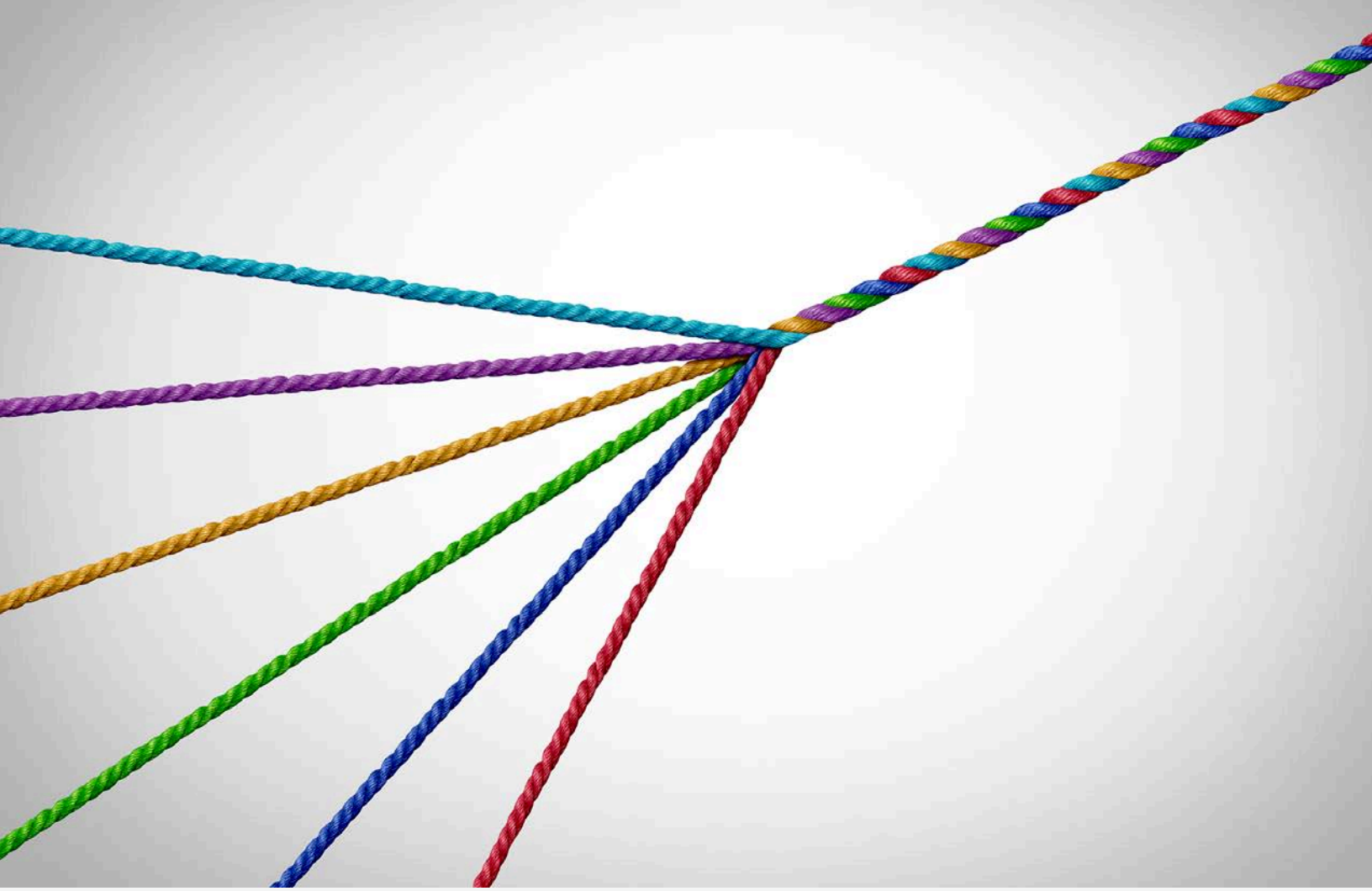

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