

The Personal Physician's Role in Helping Patients With Medical Conditions Stay at Work or Return to Work

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The personal physician has a role in assisting his or her patients minimize life and work disruption resulting from new injury or illness, changes in chronic health conditions and existing disabilities, or the advance of age. (The term physician is used throughout this document for simplicity and ease of reading, but was not intended to exclude other clinicians who often take care of injured workers. When this term is used, consider that the guidance provided also applies to nurse practitioners, physician assistants, chiropractors, psychologists, and other health care providers in a treating role.) This means helping patients maintain their daily routine as much as possible, and for working patients, helping them stay at work or return to work as soon as it is medically viable.

In order to discharge these responsibilities appropriately, it is important that physicians appreciate the importance of work to human life and well-being. In addition to providing money for necessities, work adds meaning and purpose to life and is an important source of individual identity. Studies show that worklessness (lack of work) increases morbidity and mortality and results in decreases in mental, family, social, and economic well-being.¹⁻⁶

A study found that 60% to 80% of lost workdays attributed to medical conditions in the United States involved time off from work that was not really required by the condition itself. Some work disability is necessary such as when there are unavoidable health or safety risks inherent in the

particular condition, or the patient lacks the ability to be productive in any capacity.⁷ However, most of the time, it is safe for patients to be productive—the question is how and under what circumstances. Treating physicians are usually the first to become aware of barriers to recovery and impediments to return to work. They can set the stage for teamwork with the patient, other health care providers, the employer, and the payer, thus helping to smoothly move the patient toward functional restoration.

Unnecessary work disability is caused by a wide variety of nonmedical factors. Some work disability is iatrogenic, meaning it is inadvertently caused by physicians. Medical training does not prepare physicians to address the intersection between work and health, and they often lack familiarity with workplace environments. As a result, they may be uncertain about what is appropriate to expect someone to do who is symptomatic or disabled. To decrease this iatrogenic work disability, all physicians need to be alert to the three following issues:

1. For working age adults, during recovery and despite chronic impairment or disability, the fullest possible participation in life via medically appropriate activity and work promotes positive health and overall life outcomes. Encouragement by the physician to remain active and productively engaged in life is beneficial for the patient and his or her family.
2. Patients often decide to seek care because symptoms or impairments are disrupting daily life. It is stressful for people to be in limbo. The likelihood of job loss rises rapidly with elapsed time away from work. Patients will perceive medical care focused on restoring the everyday rhythm of life as quickly as possible as both practical and helpful.
3. Appropriate physician guidance to patients, their employers, and benefits payers is a crucial and constructive part of the stay-at-work and return-to-work process. Thoughtful physician input assures that both employers and patients know how to keep safe in the workplace, and what it is medically appropriate and realistic to expect them to do. Those parties familiar with a patient's work life play an important role. Whenever feasible, all parties should work cooperatively to prevent needless work

disability by helping working patients stay employed.

GUIDANCE FOR PHYSICIANS

Physicians should encourage patients to minimize life disruption due to illness, injury, or other health conditions, and to keep as closely as possible to their usual daily routine. For the employed patient, this includes finding a way to stay at work. If work must be interrupted, then the time away from employment should be minimized, and the patient returned to transitional work or full duty as soon as it is medically reasonable and safe.

If a patient cannot safely perform his or her usual job, the physician should encourage some type of productive work activity, usually handled in the workplace through temporary restrictions on activities or functions served while at work. The exception to this general recommendation is any situation that would involve serious medical or safety hazards to the patient, his or her coworkers, and/or society, or in cases where existing laws or regulations prohibit a patient with a particular medical condition from working in certain occupations (eg, a person with a diagnosis of epilepsy may not drive a commercial motor vehicle). Patients whose care includes attention to occupational issues have faster recoveries and a more sustainable return to work. There is a relatively short window of opportunity to return patients to work in the workers' compensation arena. By the 12th week off work, there is a 50% probability that the individual will still be off at 1 year. The best "medicine" for injured workers is to return them to work as soon as safely possible.⁸

Programs to return patients to work should include

- *Medical treatment or care plans that consist of current best medical practices that are evidence-based when possible.* Treatment plans should identify the optimal sequence and timing of interventions. The physician should understand typical durations of treatment and anticipated time needed off work, and should provide rationale for any delay in return to full or light duty.
- *Prompt addressing of causality.* If the condition was caused by work, the

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evidence for this should be clearly documented. If the patient believes that the condition was caused by work, but the physician does not find it to be work-related, causation should be discussed with and explained to the patient, and then documented. Clarity around work-relatedness helps determine the appropriate payment system and reduces delays.

- *Identifying and minimizing unnecessary delays in provision of health care services.* If there is a delay in approval for recommended treatment, physician involvement can expedite matters. The physician can often explain the benefits of a test or a procedure in such a way that the adjuster and/or employer more easily realize that this will move the case forward.
- Objective, accurate, and complete medical documentation to facilitate transitions in patient care, return to work, approval of medical treatment, proper setting of insurance reserves, and payment of bills. It is part of the physician's role to complete and return required forms relating to return to work in a timely fashion. Although it may seem cumbersome to provide duplicate information on additional employer, state-required, or payer-specific forms, it creates delay if not done expeditiously. (Physicians may be able to charge for the time required for documentation or case management in some workers' compensation systems).
- *Activity prescriptions for function both at home and at work are an essential part of the treatment plan.* This requires making detailed recommendations for graded or stepwise increases in activity over time. If medical and functional recovery do not proceed as expected, it is important to investigate and address the reasons for delay. There are times when the treating physician can help a patient reframe, and go from a dysfunctional way of looking at his/her situation to a more positive perspective that helps the patient resume making progress. At other times, after exploring the contribution of psychosocial issues and/or comorbid psychiatric diagnoses, it might be necessary to ask for input or assistance from other health care professionals, the employer, or others with knowledge of the situation.
- Gradual resumption of activity sometimes means that patients will return to work while they still have some symptoms and before they have reached the healing plateau. This may require careful planning and discussion with both the patient and the employer. Many patients will need education and reassurance if

they are to overcome the common misconception that rest and avoidance of activity are beneficial. Deconditioning makes return to function slower and more difficult. A classic study started in 1966 with a follow-up 30 years later showed that 3 weeks of bed rest in healthy 20-year-old men had a more profound negative impact on their physical work capacity than did three decades of aging.⁹

In complex cases, especially those with long-term implications, ongoing workplace hazards, unusual working environments, slower than expected recovery of function, or questions of potential risk to the public, the treating physician may consult appropriate specialists. Primary care physicians may benefit from the expertise of occupational medicine specialists when considering causation and complex work issues. Often, useful information and expertise is also available from employers, insurance companies, or appropriate governmental agencies.

Developing Plans for Working/Returning to Work

Physicians are in a key position to influence:

- Patient expectations;
- Communication/coordination with the employer and payer;
- Identification of impediments to staying at work;
- Helping the patient and employer find transitional opportunities for getting back to work;
- Getting assistance from the employer in return to work (job modification, ergonomic assessment).

Stay-at-work/return-to-work plans should include the following components:

- Early in the course of treatment, the physician should discuss the expected healing and recovery times with the patient, as well as the positive role in an early, graduated increase in activity has on physical and psychological healing. Early return to safe activity also prevents the negative effects of physical inactivity such as muscle weakness, joint and muscle stiffness, cardiovascular deconditioning, and depression.
- The physician should ask about the impact of the medical condition on the patient's ability to perform responsibilities at home and at work, and the availability of family and community support systems.
- The patient should be instructed that his/her behavior is, in many ways, going to

determine the extent of his or her future recovery. This can help to increase the patient's feeling of self-efficacy and allow them to bounce back more quickly from injury and illness.^{10,11}

- When a patient is able to return safely to some form of productive work (which might well be at the initial evaluation), the physician should point this out. This presents an opportunity to offer and discuss the idea that resuming usual activities while symptoms continue to resolve is an important part of the rehabilitation process.
- The physician should look for potential obstacles to recovery of function and return to work as soon as possible. These can include predictable and understandable human worries or concerns, misunderstandings or false beliefs, other socioeconomic, legal, or workplace issues, as well as undiagnosed or under-treated physical and/or mental health conditions. When obstacles are identified, they should be appropriately documented. The care and return-to-work plans should be re-evaluated and adjusted to include these obstacles. Tissue healing is sometimes not the obstacle that presents the greatest barrier to return to work, especially in workers' compensation cases.
- Identified obstacles should be referred to parties who are appropriately involved in the patient's health-related employment situation. These other parties might be other physicians, but could also be benefits or claims payers, case managers, occupational health and safety professionals, human resources professionals, or workplace supervisors.
- The physician should encourage direct communication between patient and employer early in treatment or rehabilitation. This helps to reduce social isolation and maintain the patient's bond with the world of work. A physician's offer to participate in a three-way conversation with a patient and his or her employer (and/or others involved in the patient's health-related employment situation) can help identify and facilitate the removal of obstacles. As an objective expert, the physician has great power to influence and can help steer the case in the direction that will be best for the patient's recovery. At each visit, the physician should provide guidance to the patient and employer (with patient authorization or as permitted by law) about what job functions it is realistic to expect the patient to do. Written activity prescriptions ("work notes") will naturally change over time. Protective and preventive measures may also be prescribed as appropriate.

- If the patient is able to do something productive, but there is no work available because of statutory prohibitions or employer policies, business practices, or unwillingness or inability to make accommodations or mitigate workplace risks, the physician should offer to contact the employer on the patient's behalf. If the employer will still not accept the patient back to work with activity restrictions, the physician's report should make it clear that the patient can work but is not doing so because of the lack of suitable duties. The physician should also advise the patient to remain as active as possible, stressing that maximal functional recovery depends on this.

PRESCRIBING ACTIVITY: ESTIMATING CURRENT WORK ABILITY, MEDICAL RISK (RESTRICTION), CAPACITY (LIMITATION), AND COMFORT (TOLERANCE)

When formulating activity prescriptions, the personal physician should consider and provide guidance regarding patient function both at home and at work. Activity recommendations usually apply to both settings. Employers will rely on activity prescriptions as estimates of current work ability. The patient's medical vulnerabilities and altered functional capabilities should be considered and matched against the demands of the job and working conditions. It may be necessary for the physician to explain the activity prescription and coordinate with the employer. The physician should discuss risk and restrictions, capacity, and limitations. When patient tolerance is the limiting factor, it might be necessary to help the patient reframe how he/she is looking at the situation and negotiate returning to work.

There is little scientific literature available to serve as the basis for medical restrictions. There is some indication that the physician's personal philosophy about work and knowledge of workplaces has the largest influence.^{12,13} However, the patient or employer may well know more about the specific hazards of a particular workplace or the regulatory requirements for a specific industry than the treating physician. Thus, it may be appropriate for the personal physician to make an initial estimate and invite more detailed factual information. It should be clearly indicated that the determination is temporary, pending the additional information.

- **Capability or Capacity:** Traditionally, employers have wanted physicians to provide a work note listing "restrictions"

or "limitations," but some employers also request a description of activities the patient can do at the present time. In fact, documenting what the employee is able to do (instead of just imposing restrictions or describing limitations) encourages patients to think in terms of "ability" rather than "disability," and helps them recognize that they are actively improving. It also encourages the employer to find transitional job duties that are productive. Due to the enormous range of possibilities, it can be helpful if the employer provides a list of usual and/or proposed alternative tasks, so that the physician can check off those tasks that are currently medically appropriate. When in doubt, a referral for physical or occupational therapy assessment of ability to perform the tasks in question may provide helpful information.

- **Restriction Based on Personal Risk:** Protective measures required to prevent recurrence, additional injury, or foster recovery are restrictions. These restrictions describe what patients should not do, even if they can (or think they can). Restrictions are the result of the physician's assessment of medical and personal safety risk and should be relevant to the job demands. Restrictions should be based on objective information such as physical examination findings, test results, incidental observations, or documented presence of recognized occupational hazards. Physicians are expected to use their best medical judgment, but no physician can guarantee safety. Restrictions must also be specific in order to make it feasible for the patient and employer to follow them. For example, an exact weight and height for lifting, a length of time per hour for a particular activity, number of times per shift that an activity can safely be performed, postures to be avoided, etc. Duration of restriction should coincide with the expected time required for wound healing and recovery of tissue integrity, for medication to take effect or side effects to abate. Return to work may be delayed when workplace modifications are being made, or hazards are being ameliorated.
- **Restriction Based on Risk to Others:** If the patient is in a safety-sensitive position, and working with his/her current medical condition could significantly endanger the safety of others, public interest must come before that of the patient. The physician must specifically consider local, state, and federal regulatory requirements regarding fitness for duty of patients who are exposed to hazardous working environments, or

whose duties affect public safety, such as pilots, commercial drivers, police officers, firefighters, and nuclear power plant workers. Physicians need to understand that their choice of medications may affect safe return to work.

- **Limitation (Inability):** Limitation describes what the patient is simply unable to do. These are existing constraints to his or her physical or mental capability in performing the required job tasks. The physician is advised to rely on objective findings to the maximum extent possible. Some losses are obvious and permanent. For example, a fused joint makes full flexion impossible or the loss of an eye eliminates binocular vision. If a patient can only exert to 4 METs during treadmill testing after a heart attack, then he or she cannot do a job that requires an average energy expenditure of 5.5 METs. (It should be noted that if cardiac recovery/improvement is anticipated, some limitations may be temporary.)

Limitations due to pain-related involuntary guarding and weakness can often be elicited during the physical examination or through incidental observations. Patient self-reporting is not a reliable method of making this determination. It is more common for patients to underestimate than overestimate their capabilities, although both occur. Some patients overlimit themselves based on excessive caution, clinically insignificant symptoms, inaccurate beliefs, or a desire for secondary gain. Thus, limitations should not necessarily reflect what patients are actually doing, but should guide them and their employers toward what they can safely be doing, given the nature of the injury/illness in combination with age, body habitus, and current state of conditioning. Limitations secondary to deconditioning are transient and may be rapidly reduced, as strength, endurance, and flexibility return with the increased activity of a graduated return to work.

- **Comfort (Tolerance):** Although temporary restrictions for new symptoms such as pain, numbness, and fatigue may be appropriate for a few days or weeks after the onset of an injury or illness, they are often not medically appropriate or necessary for chronic symptoms of this type. After an adequate work-up, and particularly in the setting of degenerative or soft tissue conditions, or familiar symptoms of pain and fatigue unsupported by corresponding objective findings, complaints need not be interpreted as ongoing warning signs of medical risk. It can be helpful to educate patients about the distinction between hurt and

harm. Hurt implies pain, while harm implies reinjury or further tissue damage. It is important to reassure patients that while activity may hurt, ongoing pain does not necessarily mean there is any ongoing risk of tissue injury. From a biological perspective, most tissues have healed within 6 to 8 weeks. With ongoing subjective complaints that exceed objective findings, given that a major purpose of care is to restore the rhythm of everyday life, physicians should become rehabilitators, and focus questions to patients on how they are functioning rather than how much pain they are feeling.

In stable conditions, with the absence of demonstrable risk of further physiological derangement or tissue damage due to activity, pain that increases with activity is quite often an issue of tolerance. Defined as the ability to carry out and endure sustained work at a given level, tolerance is often less than capacity or current ability, making it the limiting factor in return to work in many situations. However, tolerance is not scientifically verifiable or measurable. The physician needs to distinguish between the typical aches and pains of daily life and aging bodies, and pain that signals tissue damage. Tolerance sits at the intersection of the biological/physical and psychosocial.

Reassurance, education, resolving non-medical issues, and mental and/or physical reconditioning may be helpful. Millions of Americans work with some degree of discomfort, as it is part of everyday life, especially aging. People who know how to use effective nonpharmacological techniques to manage their own symptoms tend to cope with pain better than those who depend entirely on medical treatments. People who must live with chronic pain often report that exercise, distraction, and staying busy improve their quality of life.

Physicians who take a biopsychosocial approach (and treat the whole patient in the context of his/her environment) know that distress does not always stem from disease or injury severity. It is important to direct attention not only to the structural, biologic diagnosis, but also to recognize and manage psychosocial issues. If the patient's current medical condition stems from a mild initial injury or illness that has had time to heal, consider reasons other than the purely biomedical for medically unexplained physical or mental symptoms and/or unwillingness to return to work that should be within the patient's capability. Psychosocial or economic barriers might well be at play. Gather enough

information to recognize specific fears or other problems that might be troubling the patient and giving rise to perceptions of pain. Physicians are qualified to discern medical from nonmedical issues. If the physician explicitly names various factors influencing a situation, it can help clarify things for the patient as well as other parties.

Social or Workplace Environment Limitations or Restrictions: Some patients will demonstrate difficulty working under specific social conditions. For example, a brain injury, mental illness, or personality disorder may temporarily or permanently reduce a patient's ability to cope with social or workplace conditions perceived as stressful, threatening, or overstimulating. The patient may be able to cope if modifications are provided such as working alone, doing self-paced tasks, or working in a quiet place. Stepwise reintegration back into the usual working environment may need to be part of the treatment plan to reduce anxiety or fear. Patients with these limitations or restrictions may benefit from the involvement of others who have more specialized training to assist in the return to work process.

Environmental Limitations or Restrictions: Some patients will be at medical risk under certain environmental circumstances. For example, allergic symptoms usually require complete avoidance of exposure, but irritant symptoms may abate with reduced exposure to specific chemicals. Some medical conditions require avoidance of cold, heat, or constant vibration.

Schedule Modifications: Temporary provision for shorter work weeks, or periods of rest alternating with exertion, may allow a patient with overuse symptoms or reduced stamina due to illness or surgery to work during recovery. On rare occasions, long-term shift changes have a legitimate medical basis, such as documented physical or mental health sequelae of chronic sleep disturbance, or demonstrated worsening of blood sugar control due to circadian rhythm disruptions in a diabetic.

Workplace Accommodations (Medical Aids, Adaptive Equipment, Personal Protective Equipment, etc.): In addition to providing medical restrictions and activity limitations, the physician should inform the employer when assistive and protective devices are available to help the patient augment or restore his or her ability to conduct particular tasks or perform key functions despite temporary or permanent impairment. When appropriate, the physician can give specific examples of such devices and leave it up to the employer to determine which accommodations to provide.

- Under the Americans with Disabilities Act (ADA), it is the responsibility of the

employer to decide how to accommodate an employee's medical needs and functional limitations. Employer policies, union collective bargaining agreements, and other constraints may preclude certain types of accommodations and permit others.

- The physician should be wary of signing a medical note for specific things like an assignment to a particular work station, shift, work schedule, a particular brand of chair, or some other kind of adaptive equipment. If the patient walks into the workplace with a physician's prescription and demands that the device be obtained, it can precipitate some conflict. This can usually be avoided if the physician consults the employer's safety or human resources department to discuss the patient's situation before prescribing these items.
- Some workers try to manipulate their employer by "medicalizing" a nonmedical issue such as underlying workplace conflict, job dissatisfaction, or family disruption. Examples might be requests for physician notes that specific coworkers or supervisors should be avoided for medical reasons. Physicians should help patients address the underlying issues more appropriately. For example, the employer's employee assistance program (EAP) or community faith or other support systems might be options.

Duration of Work Disability

Each activity prescription should specify whether restrictions and limitations are expected to be temporary or indefinite (permanent), estimate their future duration, and set the date for the next reassessment. Disability duration guidelines are available that display typical lengths of impairment/work disability for specific conditions and surgical procedures based on data from large numbers of actual episodes. These guides can help the physician set realistic expectations, although normed population data are less useful in psychiatric conditions.

The employment provisions of the ADA as amended are intended to help workers who acquire disabilities keep their jobs. Most physicians and many workers are unaware of the very real risk of job loss when the physician's restrictions preclude the workers from performing the essential functions of their jobs for a significant period. Job loss means unemployment—with its negative economic, social, and mental health repercussions.

Out of desire to protect patients and keep them safe, physicians are sometimes paternalistic and overly protective. With regard to risk of harm to self or others, the ADA defines "direct threat" as "a significant risk of substantial harm to self

or others.” Physician estimates of capability or tolerance vary and do not accurately predict success at work.¹⁴ It is important to avoid making a disabled patient lose his or her job because your medical opinion and advice was based on an inaccurate guess about the possibility of future harm.

It is wise to assume that patients may be or may become protected under the ADA whenever

- Their medical condition is affecting their ability to work;
- Their recovery period is measured in weeks instead of days;
- The condition is or has the potential to become chronic.

When any of these circumstances arise, both the patient and employer should be alerted to this fact. Interactive discussion as to whether a reasonable accommodation is possible may be crucial for avoiding unnecessary life and income disruption, job loss, or for allowing the best possible transition.

Understanding the Roles and Responsibilities of Others

The optimal resolution of health-related employment situations will often require the exchange of information, and a problem-solving collaboration with other legitimate stakeholders. These stakeholders include occupational health specialists, medical and rehabilitation professionals, case managers, family members, benefits payers and insurance adjusters, and employer-based resource personnel such as workplace supervisors, return-to-work coordinators, human resources managers, and union representatives.

The role and responsibilities of the employer include the following:

- *Make employment decisions.* The employer determines whether, when, and how an employee is put to work within the medical restrictions and functional limitations prescribed by the physician. The employer decides when to provide:
 - On a voluntary basis, a temporary reduction of work demands and/or productivity expectations via time-limited adjustments to assigned tasks or the work environment;
 - As required by ADA, an interactive process to determine the feasibility of reasonable accommodation that permits the worker to fulfill all essential job functions and meet usual performance standards.

The employer is also responsible for ensuring that the workplace culture

supports a timely return to meaningful and productive work. The employer has a responsibility to provide the physician with the employment-related information necessary to enable appropriate medical advice and support. As some patients have difficulty describing their jobs accurately and are unaware of their employers' ability to make temporary adjustments or accommodate special needs, the physician should request that the employer provides a written or video job description that identifies the job risks, essential functions, and available work modifications. Direct communication between an employee and his or her employer after an illness or injury is beneficial, and often improves the employee's perception of his or her ability to work. If a job description is not available, biomechanical restrictions specific to the injury should be imposed for use both at home and at work.

Examples of a supportive workplace culture include ensuring that any restrictions and limitations prescribed by the treating physician are respected, that any necessary temporary or permanent worksite adjustments are promptly made, that advice from appropriately qualified experts is obtained before deviating from treating the physician's recommendations, and that the patient feels appropriately safe in the workplace.

Provide a Safe Workplace

The Occupational Safety and Health Administration (OSHA) General Duty Clause holds employers responsible for maintaining a safe workplace. When a patient reports that he or she is concerned about the safety of the workplace, it may be appropriate to refer the patient to a safety manager, human resources manager, or a union representative. Another alternative is to refer the patient to an occupational medicine physician or other local professional resource who is prepared to handle situations of this type. Some university medical centers have occupational medicine consultation services. Formal referral to an occupational medicine specialist ordinarily must be authorized by a payer.

Protect Workers With Disabilities (Including New or Temporary Disabilities)

Enacted in 1990, the ADA changed the decision-making process related to employment. It made it the employer's responsibility to determine whether or not a person with a disability is able to perform the essential functions of a job. Employers may (and often do) rely on health care professionals to provide the information essential to making that determination. However, diagnosis does not equal

disability. An individual may be identified as having a disability if there is record of an impairment that has substantially limited one or more major life activities, or if the individual is regarded as having a disability.

In passing the ADA Amendments Act of 2008, Congress made it easier for an individual seeking protection under the ADA to establish that he or she has a disability within the meaning of the statute. Congress overturned several Supreme Court decisions that Congress believed had interpreted the definition of “disability” too narrowly, resulting in a denial of protection for many individuals with impairments such as cancer, diabetes, and epilepsy. ADA states that the definition of disability should be interpreted in favor of broad coverage of individuals.

ADA prohibits discrimination on the basis of disability against a qualified individual with a disability, and an employer cannot deny employment to an otherwise qualified individual with a disability unless that individual would pose a direct threat in the position. Medical professionals should give the employer enough objective medical information to be able to make that decision. However, it is the employer who is legally accountable for making decisions about employment and reasonable accommodation. Congress has sent a clear message that it expects all but the smallest employers to help individuals with medical problems and related functional impairment (disabilities) to get and keep their jobs by passing ADA and the Family Medical Leave Act (FMLA).

The Equal Employment Opportunities Commission (EEOC), which enforces the ADA, has said that an employer who receives a physician's note with restrictions and limitations for an employee with a nontrivial condition is on notice that this employee may be a qualified person with a disability.

When impairment or work disability is anything other than transitory, EEOC states that employers are under legal obligation to make reasonable accommodations for otherwise qualified employees with covered disabilities under the ADA, and to hold the jobs of ill or injured employees for up to 12 weeks under FMLA. Some state laws are even more expansive in protecting workers. For example, EEOC says that ADA does not apply to workers with “transient” or “temporary” disabilities, but California's Fair Employment and Housing Act (FEHA) is silent on the issue of duration. That means FEHA protections apply starting from the first day of disability onset or work disruption. Moreover, FEHA applies in workplaces with five or more workers; ADA coverage requires at least 15 workers.

Provide Workers' Compensation Benefits

Most employers are required by law to provide workers' compensation insurance that covers all costs for medical care and provides partial wage replacement during a patient's time away from work. The 50 states each have their own workers' compensation statutes, and there is considerable variation. In addition, there are federal programs that cover work-related injuries in particular industries (railroads, maritime, port workers, and federal employees). In many states, some workers are excluded, for example, agricultural workers or sole employers. Even though employers are required to have programs, they may or may not have an insurer to handle their claims.

A patient who says his or her injury or illness is work-related is entitled to file a claim for workers' compensation benefits, whether or not the employer agrees, although the claim may later be denied. Who actually submits the claim varies by system. Most often it is the employer, but can be the physician or the employees themselves. Most workers' compensation claims are not accepted unless the patient asserts a claim and an attending physician corroborates that the injury or illness is caused by work. This statement must be medically reasonable and supported by a mechanism of injury accompanied by opinion-appropriate objective and subjective factors.

In some states, the physician is obligated to report work-related conditions. Thus, the physician should be familiar with the basic facts of workers' compensation in his or her jurisdiction, and refer patients to the state or federal agency responsible for workers' compensation for information.

Benefits claim administrators and insurance adjusters often act as communication intermediaries on behalf of employers. Nurse case managers are often engaged to expedite the process of care and facilitate communication among all parties. In disputed cases, lawyers may assume the role of a communication conduit. Physical or occupational therapists, ergonomists, and employer-based health and safety professionals may be able to assist when functional demands of jobs need to be specified, options for work accommodations need to be developed, or hazardous conditions need to be rectified.

Although rare, there are times a patient does not fully recover and the employer concludes that there is no reasonable accommodation to allow that individual to return to performing the essential functions of his or her job safely or transfer to another open position for which he or she

is qualified. In those situations, the patient will need to find a different job. In these situations, suggesting the support of vocational rehabilitation services can be helpful.

Respecting Patient Confidentiality in Managing Medical Information:

- In general, the physician should not give information to anyone concerning the condition of a patient or any service rendered to a patient without the patient's consent. However, there are exceptions to this rule. For example, laws in most jurisdictions provide for at least a partial waiver of the right to medical confidentiality for workers' compensation claimants, usually limited to information specific to a particular workers' compensation claim. Some states specifically prohibit direct communication between the physician and employer or other parties about a benefits claim or the medical record unless the claimant consents or is present.
- The physician should be aware of the legal requirements in his or her jurisdiction, and compliance with national laws such as the US Health Insurance Portability and Accountability Act (HIPAA), the ADA, the FMLA, and medical codes of ethics for other areas that are not covered by the workers' compensation waiver.
- HIPAA does not apply when patients provide their own information to the employer, for example, if a patient is given a note, letter, or formal activity restriction statement by the physician, and the patient then provides this to the employer, the information is no longer protected by HIPAA.
- Regarding workers' compensation, HIPAA states that physicians may disclose protected health information to workers' compensation insurers, State administrators, employers, and others involved in state workers' compensation systems without the patient's consent as necessary to comply with state or federal laws that provide benefits for work-related injuries or illness without regard to fault, or otherwise required by law. The disclosure must be limited to the minimum necessary information to accomplish the workers' compensation purposes and subject to the limitations and scope of the authorized disclosures under state law, if disclosing without an authorization. Therefore, in workers' compensation, protected health information should be shared on a need-to-know basis based on the recipient's role in the system.
- A physician may always choose to request a HIPAA and state law compliant

authorization from the patient authorizing the disclosure of information. Physicians should understand what information can be released under the applicable workers' compensation system, and what information requires specific authorization from the employee for release. However, an employee's unwillingness to authorize release of information to the insurer may result in loss of benefits.

- The physician should make an effort to support the reasonable business processes of the employer and insurers by obtaining authorizations from the patient to release pertinent information on a need-to-know basis. The information provided in the resulting medical reports and forms should be tailored to the intended audience and purpose. For example, a report directed to a patient's work supervisor should only contain what that supervisor needs to know in order to manage attendance, schedule work shifts, provide medically appropriate work and accommodations, and manage a workplace safety program. Most often, an estimate of work capacity, medical restrictions, and functional limitations will suffice. In contrast, assuming that appropriate authorization has been obtained from the patient, reports directed to benefits or claims administrators should also contain all diagnostic and treatment information reasonably necessary to evaluate and adjudicate claims. The physician can also play a critical role in communicating with the designated company representative. A transactional discussion after the initial injury visit can be particularly valuable. The physician can start building a relationship with the employer as well as the patient, as outcomes are best in workers' compensation cases when all of the stakeholders are on the same page and there is mutual trust (or at least a modicum of understanding of each other's perspectives). The physician can clarify the treatment plan and ascertain that the employer understands what the appropriate activity parameters are for the patient. The physician also has the opportunity to better understand workplace factors (those psychosocial aspects) that might become a barrier return to work, and can thus deal with them more effectively.
- The patient usually has the right to examine and obtain copies of his or her medical records, as set forth under HIPAA and applicable state laws. The treating physician should routinely provide the patient with a copy of all activity prescriptions and employment-related forms prepared for the employer or benefits/claims administrator.

Billing for Care Coordination and Communication Services:

- It is appropriate for the medical office to charge separate fees (unless prohibited by law or contract) for communication, care coordination, and completion of reports designed to facilitate stay-at-work and return-to-work for the patient. These services take time as well as professional knowledge and judgment by the physician and support staff. These activities provide value to the patient, other members of the health care team, the employer, and insurers.
- Larger fees are justified in situations that require the physician to go beyond the provision of routine medical care to review materials and formulate answers to questions posed by an employer, a workers' compensation payer, or a disability benefits claims payer.
- Billing policies should be explained in advance of providing service and all activities performed should be documented.

CONCLUSION

ACOEM believes that by following the principles outlined in this document, physicians can help their patients continue enjoying the salutary effects of being productive members of society, mitigate the impact of health conditions on the quality of everyday life, and avoid the manifold adverse consequences of prolonged worklessness. While paying attention to occupational issues may require extra time and effort on the physician's part, it is vital to the patient's wellbeing. The physician who does this

will enhance patients' medical and functional outcomes, prevent medically needless work disability, and help patients stay employed. Keeping a patient employed not only benefits that individual but also has a positive impact on the patient's family, community, employer, and society in general.

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