The day a check does not arrive, the ground shifts under your feet. Rent, utilities, co-pays, groceries, and gas do not wait, and medical recovery rarely happens on a tidy schedule. When your workers' compensation wage-loss benefits stop without warning, it can feel like the system turned its back on you. I have sat with clients at kitchen tables and in clinic waiting rooms during those first anxious days. There is a path to get your benefits evaluated and, if appropriate, turned back on. It is not always quick, but it is methodical, and the details matter.

Below is how I approach these situations and what you can do now to protect your health, your case, and your household. Jurisdictions vary, but the core principles are widely applicable. Where state rules diverge, I flag the differences so you know what to ask in your area.

What likely happened when a check stops

Workers' compensation does not randomly forget to pay. Checks typically stop because the insurer believes something material changed. Sometimes they are right. Sometimes they are not, or they lack the documentation they need. Here are the most common causes I see:

- A doctor released you to some level of work, often light duty, and the insurer believes suitable work was available. Or your employer says they offered work and you did not report.
- An independent medical exam found you at maximum medical improvement, or disagreed with your doctor, and the insurer used that opinion to suspend wage-loss.
- A procedural issue, such as missing a form, late medical notes, or a change in adjuster or payment platform, caused an administrative pause.
- The insurer believes you worked or earned income, sometimes from a side job or gig work, or they logged an overpayment and applied a credit.
- A statutory time limit triggered a review, for example after 104 weeks of temporary partial disability in some states.

Each of these requires a different response. The right move depends on the paper trail and the medical record. That is why, before firing off angry emails, you want to gather facts.

What I review in the first 48 hours

When a client calls because benefits stopped, I start with the last 60 to 90 days of the claim file. That window shows us what changed and when. I request or pull:

- The most recent medical notes, including work status slips, functional capacity evaluations, and therapy records.
- Any independent medical exam reports and the cover letters that framed the questions.
- Payment ledgers and EDI filings that show the exact dates and types of benefits, and whether the system flagged an overpayment.
- All correspondence, especially suspension notices, return-to-work offers, vocational rehab reports, and any investigative memos.
- Wage records and recent earnings if there is any part-time or light-duty work.

I also confirm the bare basics. Did the check simply change to direct deposit and bounce back due to a closed account? Has the address changed? Is there a child support lien intercepting some or all of the payment? About

one out of ten stoppages turn out to be administrative snarls. You solve those with phone calls, not petitions.

Your first moves when a check goes missing

The clock starts the day the payment is late. Some states impose strict appeal windows on suspension notices, often 14 to 30 days. Even where no formal notice is required, facts go stale fast. With that in mind, take these steps as soon as you notice a missed check:

- Call the adjuster, ask why the payment stopped, and request the answer in writing. Log the date and time of the call.
- Ask for copies of all documents the insurer relied on, including IME reports, work offers, and any forms they say are missing.
- Contact your treating doctor's office to confirm your current restrictions and obtain a fresh work status note.
- Do not stop medical treatment. Keep appointments, follow recommendations, and save every receipt.
- If you received a suspension notice, calendar the appeal deadline and consult a workers compensation lawyer immediately.

Handle each item the same day if you can. Speed matters, not because the insurer deserves it, but because your leverage improves when you know exactly what is in the file and what deadlines apply.

Reading the notice like a lawyer

When an insurer suspends or terminates benefits, some states require a written notice that cites a legal basis. Others allow an adjuster to simply cut off payment and wait for you to object. If you receive a notice, read it slowly and mark four things:

- The stated reason. Look for terms like light duty available, noncooperation with medical exam, maximum medical improvement, or refusal of suitable work.
- The effective date. If the notice backdates the suspension, you may be looking at a claimed overpayment.
- The right to contest. The notice should reference a form or a process for requesting a hearing, conference, or mediation.
- Attachments. Offers of employment, IME reports, or vocational plans often ride along. These documents frequently contain factual hooks that help your case.

If there is no notice, or it is vague, that becomes part of the argument for reinstatement. Insurers must follow their own rules, and many states impose penalties for late or improper suspensions.

Medical status drives entitlement

Temporary total and temporary partial disability benefits rise and fall with your work capacity, not with pain alone. Three medical milestones make or break wage-loss:

- Current restrictions. Most states require ongoing proof of disability. That proof takes the form of a work status note or treatment record stating you cannot work, or you can only work with limits. If your last note is older than 30 to 60 days, some adjusters will pause benefits until they see an updated note. Fixing this can be as simple as a same-day appointment or a telehealth visit to document current restrictions.
- Suitable work. If your employer offers a job within your restrictions, you must evaluate it carefully. You do not have to accept a sham job. But if the job is real, within your limits, and reasonably close to your prior pay,

turning it down can legally suspend wage-loss. I look at the actual duties, shift, commute, and production expectations. I have seen offers that say sit-down duty but place the worker at a gatehouse with no shade in August. That is not suitable for someone with heat-exacerbated conditions.

- Maximum medical improvement, or MMI. When an IME or treating doctor declares MMI, some states allow wage-loss benefits to end unless and until permanent disability is established. Others continue temporary benefits until a hearing. I compare the IME's reasoning to the treating physician's notes, imaging, and the response to therapy. Many IME opinions soften on cross examination when the doctor confronts gaps in the record they never received from the insurer.

Your job, and mine if we are working together, is to keep the medical evidence current and aligned with real function. Never guess at your restrictions. If you cannot safely lift more than 10 pounds, you need a note that says so.

Light duty and the trap of the phantom job

A common flashpoint is the light-duty offer. Employers sometimes move fast to bring you back, particularly where a supervisor dislikes seeing overtime stack up in your absence. Other times they paper the file with an offer but never plan to schedule you. I have seen offers handed to an injured custodian that require frequent ladder climbing. I have also seen genuine attempts to accommodate, like reassigning a warehouse picker to inventory control with a rolling stool.

Ask for specificity: a written description, the shift, the building, the supervisor, and the expected start date. Visit the worksite if the rules allow. If the offer is miles from your home or on a night shift you never worked before, that matters in some jurisdictions. If the job exceeds your restrictions, you are allowed to say so, ideally after a quick call to your doctor to clarify what those restrictions actually mean. Then, document your response. Silence looks like refusal. A clear letter looks like good *Georgia workers' comp process* faith.

Overpayments, offsets, and why a "credit" can freeze you

Adjusters track payments against entitlement. If they pay at an incorrect rate, or if they later argue you were not entitled for a period, the ledger may show an overpayment. Many states let insurers take a credit against future checks. I have seen credits swallow entire months. Before you agree that an overpayment exists, check the math:

- Average weekly wage. Overtime, second jobs, and bonuses may belong in the calculation. The difference between 66 and two-thirds percent of $850 per week and of $950 per week is $66.67 weekly. Over 30 weeks, that is $2,000, which can wipe out a supposed overpayment entirely.
- Taxes and offsets. Some programs reduce comp payments by unemployment or short-term disability benefits. Others do not. Insurers sometimes apply offsets that the statute does not allow.
- Timing. An overpayment caused by the insurer's own delay processing wage information is handled differently in some states than an overpayment caused by your failure to disclose earnings.

A workers compensation lawyer spends a surprising amount of time with spreadsheets. Correcting the wage base or offset math often restores eligibility and shrinks or eliminates claimed credits.

Work you can do, work you did, and the line you should not cross

Side income during a comp claim can turn a late check into a stopped check. Even small gigs count. Most states require you to report earnings, and many carriers monitor public social media, business licenses, and marketplace

accounts. If you worked, say it. Honesty gives us room to argue that the work is sheltered, sporadic, or consistent with partial disability. Concealing income can tank a legitimate claim.

There is nuance here. In one case, a landscaper with a shoulder tear sold secondhand tools on weekends to make ends meet. The insurer screamed work. The sales were sporadic, done with his non-dominant hand, and happened from a folding table his spouse set up. We documented the receipts, medical limits, and the tax return. The judge agreed that the activity showed partial capacity, not fraud, and ordered partial benefits.

If you truly can return to some work, consult your doctor first to update restrictions, then coordinate with the insurer on partial disability benefits. A short gap in payments while the insurer recalculates is different from an indefinite cutoff.

When to push, when to petition

There are times to solve a stoppage with a phone call. Missing a work note or misrouting a direct deposit falls in that category. There are other times to request a conference or file a petition immediately:

- An IME says you are at MMI despite ongoing recommended treatment, and the insurer will not reconsider.
- The employer's job offer is outside your restrictions or does not actually exist as described.
- The insurer suspended benefits without notice even though your state requires a specific form and reason.
- The adjuster insists on a credit for an overpayment that rests on bad wage calculations.
- You face an impending hard deadline, like a 14-day window to contest a suspension.

In contested matters, I gather the latest medical notes, secure a short statement from the treating doctor about ongoing disability, and prepare a focused filing that targets the legal reason cited for suspension. I avoid kitchen-sink petitions. Judges and hearing officers have limited time. A clear narrative with two or three exhibits often beats a binder of everything.

What hearings look like and how fast you can get one

Speed varies. In some states you can get an emergency conference within one to three weeks. In others, even expedited motions take a month or more. Many jurisdictions allow temporary orders or interim relief when the record shows clear ongoing disability and a defective suspension. If you work with counsel, ask about:

- The standard of proof for interim benefits. Some places require only a showing of likelihood of success, others require stronger evidence.
- Whether penalties accrue for late payment. Daily penalties add leverage in negotiation and, in some cases, can cover a month of rent on their own.
- Whether attorney fees shift to the insurer if you win a reinstatement. Fee-shifting statutes affect strategy, especially for smaller arrears.

I prepare clients for short, focused testimony. Judges want to know what changed, whether you can work, what your doctor says, and whether you received and understood any job offer. Bring your calendar, pay stubs if you earned any interim wages, and mileage logs. Small details make you credible.

Keeping your treatment uninterrupted

Nothing unravels a claim faster than missed medical visits with no explanation. Insurers read gaps in treatment as recovery. If a bus fare or co-pay is the problem, tell your lawyer or the adjuster in writing. Many states reimburse

mileage and sometimes transportation. Ask your doctor's office to schedule follow-ups before you leave the building. If coverage is in dispute at the pharmacy, request a short supply while the adjuster fixes the authorization. Then email the adjuster a photo of the denial screen. Documentation is your friend.

I also pay attention to provider type. An orthopedic surgeon's note carries more weight on a knee injury than a walk-in clinic's form letter. If you started with urgent care, move to a specialist as soon as your plan allows, and make sure every note clearly lists work restrictions in functional terms, not just diagnoses.

Budget triage without pausing your case

While we litigate, the bills do not stop. I tell clients to prioritize rent or mortgage, utilities, food, and insured medical care. Talk to your landlord early. Many will accept a partial payment with a date certain for the balance if you show a pending hearing notice. Postpone non-urgent expenses and avoid high-interest loans that become traps. If short-term disability or FMLA are options through your employer, weigh them carefully. In some states, accepting unemployment conflicts with your workers' compensation testimony that you are unable to work, but in others it may be compatible with partial disability. Get advice tailored to your jurisdiction before you apply.

The insurer's toolbox, and how to answer it

Knowing what may be coming reduces fear. When checks stop, insurers sometimes:

- Set an independent medical exam to bolster their position. Consider bringing a concise timeline and a list of current medications. Be courteous and brief. Do not minimize your symptoms, but do not exaggerate.
- Conduct surveillance. Assume you are visible in public spaces. Living your life is not evidence of fraud. Lifting a 20-pound bag of dog food when your restriction is 10 pounds, on the other hand, will appear on video in the worst possible light.
- Request recorded statements. If you already gave one, you can usually decline another without a subpoena. If you give one, keep it factual and short, and confirm the topic in advance.
- Offer a small lump sum or backpay to close out the dispute. Sometimes this is wise, especially if returning to work is within reach. Sometimes it is an attempt to cheap out on a larger arrearage. Evaluate any offer against the expected value of reinstatement.

A measured response keeps the focus on the strongest issue: your capacity to work and the evidence that supports it.

Examples from the trenches

Maria, a hotel housekeeper, had her temporary total checks stop after an IME placed her at MMI for a lumbar strain. Her treating doctor had just ordered an MRI that later showed a disc protrusion. The insurer never received that order because the clinic faxed it to a closed number after the adjuster changed. We obtained the MRI, a fresh restriction note, and a short letter from the doctor explaining why MMI was premature. At an expedited conference three weeks later, the judge reinstated benefits and imposed a penalty for late payment due to the defective notice. The case settled months later for a fair permanent partial rating after therapy and injections.

DeShawn, a delivery driver, accepted a light-duty offer in the warehouse at the same pay. On day two, the supervisor told him to jump on a truck to help with a route. He refused because the job exceeded his 20-pound limit and required prolonged sitting he could not tolerate. The employer wrote him up for insubordination, then reported a refusal of suitable work. We collected time cards, the written job description, and a witness statement

from a co-worker. The insurer reversed course before the hearing and paid back benefits, plus an attorney fee under the state's fee-shifting rule.

Linh, a machinist working two jobs, saw her checks stop due to an alleged overpayment after the insurer recalculated her average weekly wage without her part-time weekend work. We pulled tax records and pay stubs that clearly showed 15 to 20 hours per weekend for the six months before injury. The recalculation raised her wage base by $140 per week. The supposed overpayment evaporated, and the insurer cut a catch-up check. Without clean documentation, she would have carried a zero balance for months.

How a workers compensation lawyer structures the case

Behind the scenes, the work is part detective, part bookkeeper, part litigator. Here is how I build the file for a reinstatement:

- Triage the factual trigger for suspension and line it up against the statute and rules. If a defect appears, such as lack of notice, lead with it.
- Stabilize medical proof by securing current restrictions and clarifying ambiguity. If the doctor's note says light duty with no details, ask for specific lifting, standing, and sitting limits.
- Fix math errors in the wage base and check for offsets, liens, and credits that explain the stoppage. Support with documents, not argument.
- Choose the right forum, whether an expedited conference, a motion for interim benefits, or a full petition. File tightly written papers with concise exhibits.
- Keep the client functioning. Encourage continued treatment, supervised return-to-work if appropriate, and budgeting that avoids catastrophe.

This mix of strategy and care management is where an experienced workers compensation lawyer adds value beyond phone calls to an adjuster.

Geographic quirks that change the playbook

Every state claims to be unique, and many are in practice. A few examples:

- Some states require an insurer to file a specific form to suspend benefits. If they do not, you may be entitled to penalties and interest. In others, the adjuster can suspend informally but must justify it after the fact at a conference.
- The length of temporary benefits varies. Several jurisdictions cap temporary partial at 260 to 364 weeks. Others have no hard cap but use MMI as a practical endpoint.
- Fee shifting is different everywhere. In some places, if you win reinstatement, the insurer must pay your lawyer a statutory fee that does not reduce your check. In others, the fee comes from your arrears or weekly benefit up to a cap.
- Some states require a showing of job search for partial disability if you are not working, even when the employer never offered light duty. Documenting a good faith search can keep partial benefits alive.
- Vocational rehabilitation is robust in a handful of jurisdictions and thin in others. Where it is meaningful, participation strengthens your case for ongoing benefits.

Knowing these nuances helps set realistic timelines and expectations.

What to bring to your first meeting with counsel

If you decide to consult counsel, you will save time and money by arriving prepared. Gather, if possible, your most recent benefit check stub or deposit record, any notices or letters from the insurer, the latest clinic note with work restrictions, and a short timeline of recent events. If your phone is full of texts with HR about a return-to-work assignment, screenshot them and email them to yourself. They are evidence.

Most initial consultations are free, and many firms work on contingency with court-approved fee caps. Ask how fees are calculated and whether they come from your check or from the insurer under your state's law. A clear fee agreement reduces stress later.

Staying realistic without surrendering your rights

Not every stoppage is wrongful. If you truly can work within safe limits and your employer has a good job available, returning may be the shortest path to normal life. Protect your body and your credibility. Do not rush back into a role that will hurt you, but do not lock yourself into an all-or-nothing stance if partial capacity is real. Judges respect honesty about what you can and cannot do.

On the other hand, do not accept the insurer's position just because a letter looks official. When you confront the facts with current medical proof, many stoppages unravel. The days after a missed check are hard. There is a plan, and you do not have to walk it alone. A seasoned workers compensation lawyer has been through this drill many times and knows where small moves, like a same-day work status note or a precise challenge to a defective notice, can make a big difference.

A closing thought from practice

I remember a client named Sal who kept a yellow legal pad on his coffee table. Every call, date, appointment, and receipt landed on that pad. When his checks stopped after an IME, that humble record carried the day. We matched the entry where he requested an MRI to the delay in the insurer's file, paired it with a fresh restriction note, and walked into an expedited hearing with a clean, human timeline. The judge reinstated his benefits on the spot. Systems like order. When your life feels disordered, small acts of organization can reclaim control and, paired with solid advocacy, get the checks and the treatment back on track.

If your check stopped this week, breathe. Call the adjuster, get the reason in writing, secure a current work note, and ask about deadlines. Then, if the explanation does not add up or your state's rules were not followed, talk to someone who does this work every day. The path is not always straight, but it is there, and you can walk it.