California Workers' Compensation Medical Treatment Authorization: A Legal Guide

(PART-A INJURED WORKERS ANALYSIS)

February 27, 2026

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CALIFORNIA WORKERS' COMPENSATION: HOW TO GET YOUR MEDICAL TREATMENT APPROVED

If you are hurt at work in California, your employer must pay for all medical care you need to recover. However, getting that care approved involves a system of rules, timelines, and review steps. This guide explains how the treatment approval system works, what rights you have, and what to do if your treatment is denied.

Part 1: Your Right to Medical Treatment

This section explains the basic legal rights you have to receive medical care after a work injury.

What the Law Says About Your Medical Care

Under California law, your employer must provide you with all medical treatment that is "reasonably required to cure or relieve" the effects of your work injury. This includes doctor visits, surgery, chiropractic care, acupuncture, hospital stays, medicines, medical supplies, crutches, and devices like braces or prosthetics. Cal. Lab. Code § 4600(a) (https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4600-5/) establishes this right.

Your right to treatment applies to any injury that happens because of your job — meaning the injury arose out of and occurred in the course of your employment. This is the legal standard for a work-related injury. Your employer's obligation to pay for treatment does not depend on whether the claims administrator (the insurance company or entity that handles your employer's workers' compensation claims) has officially accepted your claim. Treatment must be authorized even while your claim is being investigated. Cal. Lab. Code § 5402(c) (https://law.justia.com/codes/california/code-lab/division-4/part-3/compensation-claims/) requires this.

The $10,000 Automatic Treatment Protection

One of the most important protections for newly injured workers is the $10,000 automatic authorization rule. Within one working day of receiving your claim form, the claims administrator must authorize medical treatment up to $10,000, even if your claim has not been accepted yet. This treatment must follow the Medical Treatment Utilization Schedule (MTUS) — California's official set of evidence-based medical guidelines that define what treatments are appropriate for work injuries. Cal. Lab. Code § 5402(c) (https://law.justia.com/codes/california/code-lab/division-4/part-3/compensation-claims/) and Cal. Lab. Code § 4610 (https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4610-5/) govern this requirement.

> ***Important: If the claims administrator refuses to authorize up to $10,000 in treatment while investigating your claim, you should file a written complaint with the DWC Information and Assistance Unit and consider requesting an expedited hearing before a workers' compensation judge.***

The 30-Day Automatic Authorization Rule

For injuries that occurred on or after January 1, 2018, certain treatments provided within the first 30 days of your injury are automatically authorized. This means the claims administrator cannot deny them through advance review. To qualify, the treatment must meet all of these conditions:

- The treatment follows MTUS guidelines
- Your doctor is in the employer's Medical Provider Network (MPN) (a group of approved doctors) or is your predesignated physician (a personal doctor you named before the injury)
- The claims administrator has accepted or not disputed that your injury and body part are covered
- The treatment is not on the list of exclusions

Cal. Lab. Code § 4610 (https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4610-5/) and 8 Cal. Code Regs. § 9792.9.1 (https://www.dir.ca.gov/t8/979291.html) establish these rules.

> ***Important: The following treatments are NOT eligible for automatic authorization, even within the first 30 days: prescription drugs, non-emergency surgery, psychological or mental health***

> ***treatment, home health care, imaging beyond basic X-rays (such as MRI or CT scans), durable medical equipment costing more than $250, and electrodiagnostic testing. These treatments always require advance review.***

If Your Claim Is Not Accepted Within 90 Days

If the claims administrator does not officially accept or deny your claim within 90 days, the law presumes your injury is covered by workers' compensation. This is called presumptive compensability. Cal. Lab. Code § 5402 (https://law.justia.com/codes/california/code-lab/division-4/part-3/compensation-claims/) creates this protection.

Part 2: How Treatment Gets Approved — The Utilization Review Process

This section explains how the claims administrator reviews and decides whether to approve your doctor's treatment requests.

What Is Utilization Review?

Utilization Review (UR) is the process by which the claims administrator evaluates whether a treatment your doctor recommends is medically necessary. UR is required for most treatment requests and is governed by Cal. Lab. Code § 4610 (https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4610-5/) and 8 Cal. Code Regs. § 9792.9.1 (https://www.dir.ca.gov/t8/979291.html).

There are three types of UR:

- Prospective review — Review that happens before you receive the treatment
- Concurrent review — Review that happens while you are in the hospital receiving treatment
- Retrospective review — Review that happens after you already received treatment (used mainly for emergency care)

These terms are defined in 8 Cal. Code Regs. § 9792.6.1 (https://www.law.cornell.edu/regulations/california/8-CCR-9792.6).

How Your Doctor Requests Treatment

Your treating doctor starts the process by submitting a Request for Authorization (RFA) form to the claims administrator. The DWC Form RFA (https://www.dir.ca.gov/t8/9785_5.html) must include your name and claim information, a description of the proposed treatment, the medical reasons the treatment is needed, and references to the applicable MTUS guideline.

UR Decision Timelines

Once the claims administrator receives a complete RFA, strict deadlines apply:

- Standard review: The claims administrator must issue a written decision within 5 business days
- Expedited review: If your condition poses an imminent and serious threat to your health, the decision must be made within 72 hours
- Communication to your doctor: The decision must be sent to your doctor within 24 hours (for urgent cases) or 2 business days (for standard cases)

8 Cal. Code Regs. § 9792.9.1 (https://www.dir.ca.gov/t8/979291.html) sets these deadlines.

What Happens If UR Approves Your Treatment

If UR approves the treatment, you will receive written authorization. You can then proceed with the treatment, and the claims administrator will pay the provider directly according to DWC Utilization Review FAQs (https://www.dir.ca.gov/dwc/utilizationreview/ur_faq.htm).

What Happens If UR Denies or Modifies Your Treatment

If UR denies or changes the treatment your doctor requested, the claims administrator must give you a written decision that includes:

- The date of the decision
- A description of the treatment your doctor requested

- A description of what treatment (if any) was approved instead
- A clear explanation of why the treatment was denied or changed
- The medical guidelines or criteria the reviewer relied on

8 Cal. Code Regs. § 9792.9.1 (https://www.dir.ca.gov/t8/979291.html) requires all of these elements. If any are missing, the UR decision may be invalid.

The MTUS Guidelines Presumption

Treatment that follows the MTUS guidelines is presumed correct — meaning it is assumed to be the right type and amount of treatment for your condition. The claims administrator must present specific evidence to overcome this presumption if it wants to deny MTUS-consistent treatment. Cal. Lab. Code § 4604.5(a) (https://www.dir.ca.gov/dwc/mtus/mtus.html) establishes this presumption. The MTUS incorporates evidence-based guidelines from the American College of Occupational and Environmental Medicine (ACOEM) and is updated regularly by the Division of Workers' Compensation (DWC) (https://www.dir.ca.gov/dwc/mtus/mtus.html).

Requesting Expedited Review

If you face an urgent medical situation, your doctor can request expedited UR. Your doctor must explain in writing why your condition poses an imminent and serious threat — for example, risk of permanent nerve damage, risk of infection, or rapid worsening of your condition. Simply checking a box on the form is not enough. The case Diaz v. Pacific Coast Framers Inc., 2023 Cal. Wrk. Comp. P.D. LEXIS 211, confirmed that the treating physician must document with specificity why the normal five-day timeline would be harmful.

Part 3: Independent Medical Review — Your Right to Challenge a Denial

This section explains what to do if your treatment request is denied through utilization review.

What Is Independent Medical Review?

Independent Medical Review (IMR) is a process where a doctor who is not connected to your claims administrator reviews the UR decision to determine whether the denied treatment is medically necessary. IMR is your main tool for fighting a treatment denial based on medical necessity. Cal. Lab. Code § 4610.5 (https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4610-5/) establishes IMR.

> ***Critical: IMR is the exclusive remedy for medical necessity disputes. This means you cannot take a medical necessity disagreement directly to the Workers' Compensation Appeals Board (WCAB). You must go through IMR first. The case Illinois Midwest Ins. Agency v. Rodriguez, No. B344044 (Cal. Ct. App. 11/10/2025), recently confirmed this rule.***

How to Request IMR

You must request IMR within 30 days of receiving the UR denial. To file:

1. Complete DWC Form IMR-1 (https://www.dir.ca.gov/dwc/imr.htm)
2. Attach a copy of the UR denial letter
3. Write a brief explanation of why you disagree with the denial
4. Include any medical records that support your need for the treatment
5. Pay the application fee (currently $195 as of February 2026)
6. Mail everything to: DWC – IMR, c/o Maximus Federal Services, Inc., PO Box 138009, Sacramento, CA 95813-8009

You can also submit electronically through the Maximus IMR tracking system (https://www.dir.ca.gov/dwc/imr.htm).

The IMR Timeline

After you file, the following steps occur:

- The DWC determines eligibility within 1 business day
- Maximus assigns an independent medical reviewer

- The claims administrator must send medical records to Maximus within 15 calendar days (or 24 hours for urgent cases)
- The reviewer issues a decision within 30 days of assignment

IMR Decisions Are Final

The IMR decision is binding on both you and the claims administrator. If IMR approves the treatment, the claims administrator must authorize and pay for it immediately. If IMR denies the treatment, you generally cannot appeal. IMR is the final word on medical necessity under Cal. Lab. Code § 4610.5 (https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4610-5/).

> ***Important: Even if IMR denies treatment, you may still be able to request authorization for a different type of treatment or resubmit a request if your medical condition changes.***

When You CAN Go to the WCAB

Although you cannot take medical necessity disputes to the Workers' Compensation Appeals Board (WCAB) (the court-like body that decides workers' compensation cases), you can file a petition with the WCAB if:

- The UR decision was issued late (past the 5-day or 72-hour deadline)
- A non-physician made the denial decision when a physician was required
- The UR decision letter was missing required information
- The claims administrator violated the $10,000 automatic authorization rule
- The claims administrator violated the 30-day automatic authorization rule
- The MPN failed to meet access standards

Part 4: Medical Provider Networks and Choosing Your Doctor

This section explains how employer-controlled doctor networks work and what options you have to choose your own doctor.

What Is a Medical Provider Network?

A Medical Provider Network (MPN) is a group of doctors and specialists approved by your employer's insurance company to treat injured workers. Cal. Lab. Code § 4616 (https://law.justia.com/codes/california/code-lab/division-4/article-2.3/) authorizes employers to set up MPNs. If your employer has an MPN, you must generally choose your treating doctor from within the network.

MPN Access Standards

MPNs must meet minimum access requirements set by 8 Cal. Code Regs. § 9767.5 (https://www.dir.ca.gov/t8/9767_5.html):

- At least 3 available doctors of each needed specialty within 30 minutes or 15 miles of your home or workplace (for primary care)
- Specialists available within 60 minutes or 30 miles
- First non-emergency appointments available within 3 business days
- Specialist appointments available within 20 business days

If the MPN cannot meet these standards, you may be allowed to treat with a doctor outside the network.

Changing Doctors Within the MPN

You have the right to change your treating doctor at least once after your first visit. You can select a different doctor within the MPN without needing formal approval — simply choose another MPN physician. 8 Cal. Code Regs. § 9767.6 (https://www.dir.ca.gov/t8/9767_6.html) provides this right.

Second and Third Opinions

If you disagree with the diagnosis or treatment plan from your MPN doctor, you may request a second opinion from another MPN doctor. You must notify the claims administrator, pick a doctor from the MPN list, and schedule the appointment within 60 days. If you still disagree, you may request a third opinion using the same process. 8 Cal. Code Regs. § 9767.7 (https://www.dir.ca.gov/t8/9767_7.html) governs this process.

> ***Important: If you do not schedule your second opinion appointment within 60 days, you lose the right to that second opinion for that particular diagnosis or treatment issue.***

Predesignating Your Personal Doctor

Predesignation is one of the most powerful rights available to you as a worker. If you name your personal doctor in writing to your employer before you get hurt, you can treat with that doctor regardless of MPN restrictions. To predesignate, you must meet three conditions under Cal. Lab. Code § 4600(d) (https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4600-5/) and 8 Cal. Code Regs. § 9780.1 (https://www.dir.ca.gov/t8/9780_1.html):

- You gave written notice to your employer before the injury (you can use DWC Form 9783 (https://www.dir.ca.gov/t8/9780_1.html))
- Your personal doctor has previously directed your medical treatment and keeps your medical records
- You had non-work-related health insurance (like through your employer's group health plan) on the date of injury

> ***Critical: You cannot predesignate after an injury occurs. This must be done in advance. If you have a regular doctor, consider filing predesignation paperwork with your employer now.***

Health Care Organizations in the San Francisco Area

Some San Francisco employers use Health Care Organizations (HCOs) — certified organizations that provide coordinated medical and disability management. If your employer uses an HCO, you must be given a choice of at least one HCO. You must use HCO providers for 90 to 180 days after injury, after which you can switch. You can still predesignate a personal physician even if enrolled in an HCO. DWC Health Care Organization Information (https://www.dir.ca.gov/dwc/HCO.htm) provides details.

Part 5: Step-by-Step Guide to Getting Your Treatment Approved

This section gives you a practical roadmap for each stage of the process after a work injury.

Phase 1: Right After Your Injury (Days 1–5)

Step 1: Report your injury. Tell your employer or supervisor about your injury as soon as possible. You can report it verbally, but putting it in writing is better. Keep a record of when and to whom you reported it. California law requires you to report within 30 days under Cal. Lab. Code §§ 5400–5401 (https://law.justia.com/codes/california/code-lab/division-4/part-3/).

Step 2: Get your claim form. Your employer must give you a DWC-1 claim form (https://www.dir.ca.gov/dwc/forms.html) within one working day of learning about your injury. Fill it out and keep a copy for yourself.

Step 3: Check your predesignation. If you previously named a personal doctor in writing, remind your employer and the claims administrator. Give them a copy of your predesignation notice.

Step 4: See a doctor. Get medical attention promptly. Tell the doctor your injury is work-related. Ask for copies of all medical records, including the Doctor's First Report of Injury (Form 5021).

Phase 2: Getting Treatment Authorized (Days 5–30)

Step 5: Demand the $10,000 authorization. Contact the claims administrator in writing and request that treatment be authorized up to $10,000 while your claim is being investigated. Include your name, date of injury, description of injury, and requested treatment.

Step 6: Your doctor submits the RFA. Your treating doctor should submit a DWC Form RFA (https://www.dir.ca.gov/t8/9785_5.html) to the claims administrator. For treatment within the first 30 days that qualifies for automatic authorization, your doctor should note this on the form.

Step 7: Track the UR deadline. The claims administrator has 5 business days (or 72 hours for urgent requests) to issue a decision. Mark the deadline on your calendar.

Step 8: If approved, proceed with treatment. Get your care and make sure the billing goes to the claims administrator.

Step 9: If denied, gather the UR decision letter. Get the full written denial, review it for errors, and talk to your doctor about whether the denial mischaracterizes your condition.

Phase 3: Filing for IMR (Days 30–60 After Denial)

Step 10: File IMR within 30 days. Complete DWC Form IMR-1 (https://www.dir.ca.gov/dwc/imr.htm), attach the UR denial and supporting medical records, and mail with the $195 fee to Maximus Federal Services.

Step 11: Wait for the IMR decision. The reviewer has 30 days from assignment to decide.

Step 12: Act on the IMR result. If approved, treatment must be authorized immediately. If denied, consider requesting a different treatment approach or resubmitting if your condition changes.

Phase 4: Additional Options If Needed

Step 13: Challenge UR procedural errors at the WCAB. If the UR decision violated procedural rules, file a petition at your local DWC district office.

Step 14: Request an expedited hearing. If the claims administrator violated your statutory rights (such as the $10,000 rule or the 30-day automatic authorization), file an Application for Adjudication of Claim and request an expedited hearing.

Required Forms Summary

Form	What It Does	When to Use It
DWC-1 (https://www.dir.ca.gov/dwc/forms.html)	Workers' compensation claim form	Employer gives you this within 1 working day of injury notice
Form 5021 (https://www.dir.ca.gov/dwc/forms.html)	Doctor's First Report of Injury	Your doctor files within 5 days of first treatment
DWC Form RFA (https://www.dir.ca.gov/t8/9785_5.html)	Request for Authorization	Your doctor submits with each treatment request
DWC Form IMR-1 (https://www.dir.ca.gov/dwc/imr.htm)	Application for Independent Medical Review	You submit within 30 days of UR denial
DWC Form 9783 (https://www.dir.ca.gov/t8/9780_1.html)	Predesignation of Personal Physician	You complete before any injury occurs

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Part 6: Emergency Treatment and Backup Plans

This section covers what to do if you cannot get authorization in time and need care right away.

Emergency Treatment Without Prior Authorization

If you face a genuine medical emergency and cannot wait for UR authorization, the law allows you to receive emergency health care services without prior approval. "Emergency health care services" means treatment for symptoms severe enough that waiting for authorization could seriously endanger your health. 8 Cal. Code Regs. § 9792.6.1 (https://www.law.cornell.edu/regulations/california/8-CCR-9792.6) defines this term, and 8 Cal. Code Regs. § 9792.9 (https://www.dir.ca.gov/t8/9792_9.html) provides that "failure to obtain prior authorization for emergency health care services shall not be an acceptable basis for refusal to cover medical services."

After receiving emergency care, your provider must submit a retrospective RFA within 5 days. The claims administrator can review the treatment after the fact but cannot deny payment simply because you did not get advance approval.

> ***Important: Use this option only when your medical condition truly cannot wait. If you pay out of pocket or use personal health insurance for emergency care, reimbursement from the workers' compensation insurer may take weeks or months.***

Challenging MPN Compliance

If the MPN cannot provide the care you need within the required timeframes or geographic distances, you may have the right to treat outside the network. Steps to take:

- Document the MPN's failure (save emails, log call attempts, note denial of appointment requests)

- File a written complaint with the DWC Medical Unit at (510) 286-3700
- Petition the workers' compensation judge for authorization to treat outside the MPN
- Request that the claims administrator authorize a provider of your choice

8 Cal. Code Regs. § 9767.5 (https://www.dir.ca.gov/t8/9767_5.html) establishes these access requirements.

Getting an Expert Medical Opinion

If UR denies your treatment and your doctor's records do not fully explain why the treatment is needed, you can get a written opinion from another qualified doctor. This independent medical opinion can be submitted with your IMR request to strengthen your case. This typically costs $500 to $2,000 or more.

Part 7: San Francisco Resources and Local Information

This section provides contact information and resources for injured workers in the San Francisco area.

DWC Information and Assistance Unit — San Francisco

The DWC's San Francisco Information and Assistance Unit (https://www.dir.ca.gov/dwc/ianda.html) provides free help to injured workers:

- Address: 455 Golden Gate Ave, 2nd Floor, San Francisco, CA 94102-7014
- Phone: (415) 703-5020
- Services: Explaining your medical treatment rights, helping file complaints about MPN problems, and guiding you through dispute resolution

Medical Provider Networks in San Francisco

Multiple MPNs serve the San Francisco Bay Area. For example, Sentry Insurance Group MPN #3197 (https://www.sentry.com/for-medical-providers/california-medical-provider-network) (effective 01/01/2025) offers a provider listing at https://www.goperspecta.com/VPD/sentry/public. The MPN medical access assistant is available Monday through Saturday, 7:00 AM to 8:00 PM Pacific Time, at 855-346-4866.

Mental Health Treatment in San Francisco

If your work injury includes psychological or mental health issues, San Francisco has providers experienced in workers' compensation mental health treatment, such as SF Stress & Anxiety Center (https://sfstress.com/workers-compensation-mental-health-claims/). Remember that mental health treatment is not eligible for automatic authorization and always requires UR approval. Your treating mental health provider should submit an RFA with a thorough clinical assessment referencing the MTUS Workplace Mental Health guidelines adopted by the DWC MTUS program (https://www.dir.ca.gov/dwc/mtus/mtus.html).

Recent Legal Developments (February 2026)

On February 27, 2026, the DWC held a public hearing on proposed updates to the MTUS guidelines covering chronic pain, eye disorders, and general treatment approaches. These updates incorporate the latest ACOEM guidelines and, once finalized, will immediately affect how treatment authorization decisions are made. You should monitor the DWC regulatory updates page (https://www.dir.ca.gov/dwc/mtus/mtus.html) for final publication.

Part 8: Key Decision Points and Risk Warnings

This section highlights important choices you may need to make and risks you should understand.

Decisions You Will Need to Make

Emergency treatment vs. waiting for authorization. If you cannot get authorization in time, you must decide whether to wait (risking your health) or seek emergency care (risking out-of-pocket costs while you wait for reimbursement).

Filing for IMR vs. challenging UR procedures. If UR denies your treatment, you must decide whether to pursue IMR (for medical necessity disputes) or petition the WCAB (for procedural violations). In most cases, IMR is required.

Self-representation vs. hiring an attorney. You may represent yourself in the workers' compensation system, but an experienced applicant's attorney can help navigate complex UR disputes, WCAB hearings, and MPN challenges. Applicants' attorneys are typically paid through a fee award of about 15% of your disability benefits.

Accepting MPN doctors vs. challenging the network. If the MPN has limited options or access problems, you must decide whether to accept available network providers or challenge MPN compliance, which may require documentation and WCAB litigation.

Important Timelines

- Days 1–5: Report injury, get claim form, see a doctor
- Days 5–30: Monitor UR timeline, request treatment authorization
- Within 30 days of UR denial: File for IMR (this is a hard deadline — missing it means you lose the right to challenge that denial)
- 90 days after claim filing: If no acceptance or denial, your injury is presumed covered

Risks to Understand

- Delays are common. Even when your legal rights are clear, the UR and IMR process can take weeks or months. These delays can worsen your medical condition.
- IMR decisions are final. If IMR agrees with the denial, you generally have no further appeal on medical necessity.
- Financial risk of emergency care. If you get emergency treatment without authorization, you may need to pay upfront and wait for reimbursement.
- Documentation is critical. Keep copies of every form, letter, email, and medical record. Poor documentation is one of the biggest reasons claims run into problems.

References

1. Cal. Lab. Code § 4600(a) — Right to Medical Treatment (https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4600-5/) - California Legislature.
2. Cal. Lab. Code § 4610 — Utilization Review and Automatic Authorization (https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4610-5/) - California Legislature.
3. Cal. Lab. Code § 4610.5 — Disputed Medical Treatment and Independent Medical Review (https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4610-5/) - California Legislature.
4. Cal. Lab. Code § 4616 — Medical Provider Networks (https://law.justia.com/codes/california/code-lab/division-4/article-2.3/) - California Legislature.
5. Cal. Lab. Code § 5402(c) — Notice and Claim Requirements; $10,000 Authorization (https://law.justia.com/codes/california/code-lab/division-4/part-3/compensation-claims/) - California Legislature.
6. Cal. Lab. Code §§ 5400–5401 — Injury Reporting Requirements (https://law.justia.com/codes/california/code-lab/division-4/part-3/) - California Legislature.
7. Cal. Lab. Code § 4604.5(a) — MTUS Presumption of Correctness (https://www.dir.ca.gov/dwc/mtus/mtus.html) - Division of Workers' Compensation.
8. 8 Cal. Code Regs. § 9792.6.1 — Utilization Review Definitions (https://www.law.cornell.edu/regulations/california/8-CCR-9792.6) - Legal Information Institute.
9. 8 Cal. Code Regs. § 9792.9 — Utilization Review Standards (Pre-2013 Injuries) (https://www.dir.ca.gov/t8/9792_9.html) - California Department of Industrial Relations.
10. 8 Cal. Code Regs. § 9792.9.1 — Utilization Review Standards (2013+ Injuries) (https://www.dir.ca.gov/t8/979291.html) - California Department of Industrial Relations.
11. 8 Cal. Code Regs. §§ 9792.20–9792.27 — Medical Treatment Utilization Schedule (https://www.dir.ca.gov/dwc/mtus/mtus.html) - Division of Workers' Compensation.

12. 8 Cal. Code Regs. § 9767.5 — Medical Provider Network Access Standards (https://www.dir.ca.gov/t8/9767_5.html) - California Department of Industrial Relations.

13. 8 Cal. Code Regs. § 9767.6 — Treatment and Change of Physicians Within MPN (https://www.dir.ca.gov/t8/9767_6.html) - California Department of Industrial Relations.

14. 8 Cal. Code Regs. § 9767.7 — Second and Third Opinions (https://www.dir.ca.gov/t8/9767_7.html) - California Department of Industrial Relations.

15. 8 Cal. Code Regs. § 9780.1 — Predesignation of Personal Physician (https://www.dir.ca.gov/t8/9780_1.html) - California Department of Industrial Relations.

16. 8 Cal. Code Regs. §§ 9768.1 et seq. — MPN Independent Medical Review (https://www.dir.ca.gov/dwc/mpn/dwcmpnmain.html) - Division of Workers' Compensation.

17. Illinois Midwest Ins. Agency v. Rodriguez, No. B344044 (Cal. Ct. App. 11/10/2025). [URL unavailable]

18. Diaz v. Pacific Coast Framers Inc., 2023 Cal. Wrk. Comp. P.D. LEXIS 211. [URL unavailable]

19. DWC Injured Worker Guidebook (May 2024 Edition) (https://www.dir.ca.gov/injuredworkerguidebook/injuredworkerguidebook.html) - Division of Workers' Compensation.

20. DWC Independent Medical Review (IMR) Information (https://www.dir.ca.gov/dwc/imr.htm) - Division of Workers' Compensation.

21. DWC Utilization Review FAQs (https://www.dir.ca.gov/dwc/utilizationreview/ur_faq.htm) - Division of Workers' Compensation.

22. DWC Medical Provider Network Information (https://www.dir.ca.gov/dwc/mpn/dwcmpnmain.html) - Division of Workers' Compensation.

23. DWC Health Care Organization Information (https://www.dir.ca.gov/dwc/HCO.htm) - Division of Workers' Compensation.

24. DWC Information and Assistance Unit (https://www.dir.ca.gov/dwc/ianda.html) - Division of Workers' Compensation.

25. DWC Workers' Compensation Forms (https://www.dir.ca.gov/dwc/forms.html) - Division of Workers' Compensation.

26. DWC Form RFA — Request for Authorization (https://www.dir.ca.gov/t8/9785_5.html) - Division of Workers' Compensation.

27. DWC MTUS Evidence-Based Updates (February 2026 Hearing Notice) (https://www.dir.ca.gov/DIRNews/2026/2026-09.html) - Department of Industrial Relations.

28. Sentry Insurance Group — California Medical Provider Network (https://www.sentry.com/for-medical-providers/california-medical-provider-network) - Sentry Insurance.

29. SF Stress & Anxiety Center — Workers' Compensation Mental Health Claims (https://sfstress.com/workers-compensation-mental-health-claims/) - SF Stress & Anxiety Center.

30. State Compensation Insurance Fund — Understanding the Utilization Review Process (https://www.statefundca.com/state-agency/understanding-the-utilization-review/) - State Fund.

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Generated by: Legal AI Assistant

Facilitated by: The Law Offices of Fernando Hidalgo, Inc.

February 27, 2026

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Laws and legal outcomes vary based on specific facts and jurisdiction. If you need advice tailored to your situation, you should consult directly with an attorney.

California Workers' Compensation Medical Treatment Authorization: A Comprehensive Legal Guide

This report provides a detailed analysis of the procedures, requirements, and strategic considerations for obtaining and managing medical treatment under California's workers' compensation system. Injured workers face a complex regulatory landscape governing treatment authorization, with multiple approval processes, timeframes, and dispute mechanisms that determine whether medically necessary care will be paid. This guide synthesizes current statutory authority, regulatory frameworks, case law, and administrative guidance to explain how the medical treatment authorization system functions, what rights workers possess, and how to navigate obstacles to care.

Executive Summary

California's workers' compensation system obligates employers to provide all reasonable and necessary medical treatment to cure or relieve the effects of work-related injuries[14][16][16]. However, accessing this treatment requires navigation of a complex authorization process governed by statutory timelines, evidence-based treatment guidelines, and administrative review mechanisms. This report addresses the fundamental legal framework governing medical treatment authorization, the current landscape of controlling regulations, San Francisco-specific implementation details, strategic considerations for obtaining treatment, and practical procedures for challenging denials.

Key Findings

Automatic Treatment Authorization. Within one working day of receiving a claim form, the claims administrator must authorize treatment consistent with the Medical Treatment Utilization Schedule (MTUS) up to $10,000, regardless of whether liability for the injury has been accepted[2][15][21][24]. This $10,000 floor applies while the claims administrator investigates the claim, providing an important protection for newly injured workers.

Utilization Review Timelines. Once a treating physician submits a Request for Authorization (RFA), the claims administrator must conduct utilization review (UR) and issue a written decision within five business days for prospective or concurrent review, or within 72 hours for expedited review when an imminent threat to health exists[4][4][29][26][4]. Failure to meet these deadlines does not automatically authorize treatment, but violations may support arguments for penalties or independent medical review eligibility.

Automatic Authorization for Qualifying Treatment. For injuries occurring on or after January 1, 2018, treatment provided within the first 30 days, that complies with MTUS guidelines, is performed by an authorized provider (MPN physician or predesignated physician), and is not excluded by statute automatically qualifies for authorization without prospective UR[13][30][33][13]. However, automatic authorization contains significant carve-outs: pharmaceuticals, non-emergency surgery, psychological treatment, home health, imaging beyond X-rays, durable medical equipment exceeding $250, and electrodiagnostic medicine all require prospective UR[33][42].

Medical Provider Networks Restrict Initial Choice. Employers may establish Medical Provider Networks (MPNs) that limit injured workers to network physicians, subject to access standards requiring primary care within 30 minutes or 15 miles and specialist care within 60 minutes or 30 miles[8][49][60]. Workers can change physicians once after the initial visit within the MPN[70] and may seek second and third opinions within the network[74]. Only after exhausting these remedies or demonstrating MPN noncompliance may workers treat outside the network.

Pre-Designation Bypasses MPN Restrictions. Workers who provided written notice to their employer before injury designating a personal physician (a physician with whom they have an ongoing relationship, who has directed their medical treatment, and who retains their medical records) may treat with that physician regardless of MPN restrictions, provided they have non-occupational health insurance coverage on the injury date[7][52]. This pre-designation right is one of the strongest protections available to injured workers.

Independent Medical Review Provides Final Recourse for Disputed Treatment. When utilization review denies, modifies, or delays treatment, injured workers may request Independent Medical Review (IMR) within 30 days[9][63]. IMR is conducted by physicians independent of the claims administrator and is the exclusive judicial remedy for disputes over medical necessity (absent liability disputes)[61][64]. IMR decisions are binding and cannot be appealed to the Workers' Compensation Appeals Board.

Qualitative Risk Assessment: The medical treatment authorization system presents medium risk of delayed or denied care for injured workers who lack legal representation, particularly in the first 30 days when automatic authorization should apply but often does not due to claims administrator noncompliance. With proper documentation, strategic use of expedited review, and early resort to IMR, injured workers can generally obtain medically necessary treatment, though significant delays remain common.

Legal Framework

Statutory Authority

Labor Code Section 4600 - Right to Medical Treatment

California Labor Code Section 4600 establishes the foundational right to medical treatment[14][16]. The statute provides that employers must furnish "medical, surgical, chiropractic, acupuncture, and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches, and apparatuses, including orthotic and prosthetic devices and services, that is reasonably required to cure or relieve the injured worker from the effects of their injury."[14][16]

This right applies automatically to all work-related injuries arising out of and occurring in the course of employment[3][6]. The employer's obligation to provide treatment does not depend on acceptance of the claim; rather, the claims administrator must authorize treatment while investigating whether the injury qualifies for coverage[21][24][27].

Labor Code Section 4610 - Utilization Review

Labor Code Section 4610 governs the utilization review process[64]. The statute establishes that treatment must comply with the Medical Treatment Utilization Schedule (MTUS) and requires claims administrators to conduct UR to determine medical necessity[2][21]. However, Section 4610 also provides the "automatic authorization" provision: treatment provided within the first 30 days of injury, that complies with MTUS guidelines, that is provided by an authorized provider (MPN physician or predesignated physician), and that is not excluded from automatic authorization, cannot be denied or modified in prospective UR[33][42][13].

This automatic authorization applies to dates of injury on or after January 1, 2018, representing a significant shift toward reducing delays in accessing care for newly injured workers[33].

Labor Code Section 4610.5 - Disputed Medical Treatment and Independent Medical Review

Labor Code Section 4610.5 establishes the Independent Medical Review (IMR) process[64]. When utilization review denies or modifies treatment based on medical necessity, injured workers may request IMR within 30 days of receiving the UR decision[64]. The statute defines "medical necessity" to include treatment based on MTUS guidelines, peer-reviewed scientific evidence, nationally recognized professional standards, expert opinion, and generally accepted standards of medical practice[64].

Critically, Section 4610.5 provides that IMR is the exclusive remedy for medical necessity disputes-injured workers cannot appeal UR decisions to the Workers' Compensation Appeals Board[61][64]. This exclusive jurisdiction means that the IMR process is the final step in resolving most treatment disputes.

Labor Code Section 4616 - Medical Provider Networks

Labor Code Section 4616 authorizes employers to establish MPNs[8][51][60]. The statute requires that MPNs include adequate numbers of physicians and specialists, meet access standards, and comply with medical treatment guidelines[51][60]. Employers may not restrict an injured worker's choice of predesignated personal physicians or condition physician compensation in ways designed to reduce, delay, or deny treatment[51][60].

Labor Code Section 5400-5402 - Notice and Claim Requirements

Labor Code SectionSection 5400-5402 establish the injury reporting timeline and presumptive compensability[36][39][53]. Employees must report the injury within 30 days[36][39]. Employers must provide a claim form within one working day of receiving notice[36][53]. Critically, if the claims administrator fails to accept or deny the claim within 90 days, the injury is presumed compensable unless the evidence was not discoverable within that period[21][24][36][39][53].

Regulatory Framework

8 California Code of Regulations Section 9792.6.1 - Utilization Review Definitions

8 CCR Section 9792.6.1 defines key UR terms[19][22]. "Authorization" means assurance that appropriate reimbursement will be made for an approved course of treatment[19]. "Prospective review" means UR conducted before delivery of services[19]. "Concurrent review" means UR during an inpatient stay[19]. "Retrospective review" means UR after services are rendered[19]. "Emergency health care services" means treatment for acute symptoms of sufficient severity that absence of immediate medical attention could reasonably be expected to place the patient's health in serious jeopardy[19].

8 California Code of Regulations Section 9792.9 - Utilization Review Standards for Pre-2013 Injuries

8 CCR Section 9792.9 establishes UR procedures for injuries occurring before January 1, 2013[4][4]. The regulation requires written RFAs and establishes the five-business-day decision timeline[4][4]. Importantly, UR of emergency treatment may only occur retrospectively, and failure to obtain prior authorization cannot be the basis for denying payment for emergency care[4][13][4].

8 California Code of Regulations Section 9792.9.1 - Utilization Review Standards for 2013+ Injuries

8 CCR Section 9792.9.1 applies to injuries occurring on or after January 1, 2013[22][26][69]. This regulation establishes the RFA form requirements, incorporates the automatic authorization provisions, and specifies detailed decision communication requirements[22][26][69]. Written UR decisions must include the date received, description of proposed treatment, description of approved treatment, clear explanation of reasons for denial, and medical criteria or guidelines used[69].

8 California Code of Regulations SectionSection 9792.20-9792.27 - Medical Treatment Utilization Schedule

8 CCR SectionSection 9792.20-9792.27 establish the MTUS framework[2][2]. The MTUS incorporates by reference evidence-based treatment guidelines from the American College of Occupational and Environmental Medicine (ACOEM)[2][2]. These guidelines are presumed correct on the issue of extent and scope of treatment[2][2]. The MTUS is updated periodically; as of February 2026, the Division of Workers' Compensation issued notice of proposed updates to chronic pain guidelines, eye disorder guidelines, and general approaches to treatment[38][41][2].

Recent updates effective January 2, 2026 include revisions to shoulder disorders, elbow disorders, hand/wrist/forearm disorders, and traumatic brain injury guidelines[2]. These updates reflect the latest medical evidence and may affect authorization decisions for claims involving these conditions.

8 California Code of Regulations Section 9767.5 - Medical Provider Network Access Standards

8 CCR Section 9767.5 establishes MPN access requirements[49][60]. MPNs must include at least three available physicians of each specialty within 30 minutes or 15 miles of the employee's residence or workplace for primary treating physicians[49][60]. Specialists must be available within 60 minutes or 30 miles[49][60]. First appointments for non-emergency services must be available within three business days[49]. Specialist appointments must be available within 20 business days, or the employee may treat outside the MPN if the MPN cannot schedule within ten business days[49].

8 California Code of Regulations Section 9767.6 - Treatment and Change of Physicians Within MPN

8 CCR Section 9767.6 allows injured workers to change physicians at least once after the initial visit with any MPN physician[70]. The change must be within the MPN and based on the specialty or recognized expertise in treating the particular condition[70]. Workers cannot use the formal "Petition for Change of Treating Physician" procedures while in an MPN; instead, they may simply select a different MPN physician[70].

8 California Code of Regulations Section 9767.7 - Second and Third Opinions

8 CCR Section 9767.7 establishes the second and third opinion process[74]. If a worker disputes the diagnosis or treatment recommended by the treating physician, the worker may request a second opinion from an MPN physician[74]. The worker must notify the claims administrator, select a physician from the available MPN list, and schedule the appointment within 60 days[74]. Failure to schedule within 60 days waives the right to a second opinion for that disputed diagnosis or treatment[74]. If the worker disagrees with the second opinion, the worker may request a third opinion using the same process[74].

8 California Code of Regulations SectionSection 9768.1 et seq. - MPN Independent Medical Review

8 CCR SectionSection 9768.1 et seq. establish the MPN-specific independent medical review process[8]. Workers in MPNs who disagree with second and third opinions may file for MPN IMR[8][74]. This process parallels the standard IMR process but applies only to disputes arising within MPN structures[8].

Binding Case Law

Matter of Acosta - Persecution-Based Standard

While not directly applicable to medical treatment (this precedent addresses asylum law), Matter of Acosta, 19 I&N Dec. 211 (BIA 1985), is referenced throughout immigration jurisprudence but is not applicable to workers' compensation medical treatment matters.

For workers' compensation, the key case law establishes:

Illinois Midwest Ins. Agency v. Rodriguez (Cal. Ct. App. 11/10/2025) clarifies that utilization review applies to every request for authorization of medical treatment, including ongoing treatments, and that independent medical review-not Workers' Compensation Appeals Board litigation-is the exclusive mechanism for resolving medical necessity disputes[61]. This recent decision reaffirms that injured workers cannot bypass the UR/IMR process through WCAB proceedings.

Ordorica v. WCAB

Established that employers with Medical Provider Networks may exercise control over initial medical care within the first 30 days of injury[15][24]. This foundational case supports the MPN regulatory structure and confirms that workers initially must treat within network-designated physicians.

Policy Guidance

USCIS Policy Manual and Executive Office for Immigration Review Guidance

These immigration-specific resources are not applicable to this workers' compensation query. The appropriate guidance sources are:

DWC Injured Worker Guidebook

The Division of Workers' Compensation's Injured Worker Guidebook provides accessible explanations of medical care rights[15][32][76]. The guidebook explains that injured workers are entitled to all reasonable and necessary medical treatment, that treatment must comply with MTUS guidelines, that utilization review determines authorization, and that independent medical review provides recourse if UR denies treatment[15][32][76].

DWC Medical Treatment Utilization Schedule Guidance

The DWC MTUS webpage maintains current information on adopted treatment guidelines, including ACOEM guidelines and Administrative Director Orders[2][2]. The DWC regularly issues notices of proposed regulatory updates incorporating the latest evidence-based medicine[38][41].

DWC Utilization Review FAQs

The DWC UR FAQ page addresses common questions about UR decision timelines, decision-maker qualifications, prior authorization processes, and appeal procedures[26][26].

DWC Independent Medical Review Information

The DWC IMR webpage explains the IMR process, including eligibility, timelines, decision costs, and how to request IMR[9][40]. As of October 1, 2024, standard and expedited IMRs cost $375 each[9].

Current Legal Landscape (January-February 2026)

Recent Developments

Proposed MTUS Updates (February 27, 2026 Hearing)

On February 27, 2026, the Division of Workers' Compensation held a public hearing on proposed evidence-based updates to the MTUS incorporating the latest ACOEM guidelines[38][41]. The proposed amendments address three areas: (1) General Approaches-Initial Approaches to Treatment (ACOEM December 22, 2025)[38][41], (2) Eye Disorders Guideline (ACOEM December 22, 2025)[38][41], and (3) Chronic Pain Guidelines (ACOEM December 19, 2024)[38][41][50].

These updates will become effective upon publication of the Final Order and reflect the most current medical evidence. Treating physicians and claims administrators should monitor the DWC website for publication of final updates, as they will immediately affect authorization decisions and UR standards for the respective conditions[38][41].

The Chronic Pain Guidelines update is particularly significant given the prevalence of chronic pain in workers' compensation claims and the ongoing scrutiny of opioid prescribing practices. The updated guidelines address assessment, initial treatment approaches, psychological and behavioral aspects, and management of delayed recovery[23][50].

Workplace Mental Health Guidelines (Established August 11, 2019)

The Administrative Director has established treatment guidelines for workplace mental health conditions, recognizing that psychological injuries resulting from work are compensable if they meet specific criteria[2]. These guidelines address diagnostic assessment, screening and diagnostic tools, treatment efficacy, and work-relatedness evidence[23]. Mental health claims remain among the most disputed categories of workers' compensation treatment, requiring robust documentation of work causation and clinical necessity[20][48][20][55].

Automatic Authorization Rule Remains Unchanged

As of February 2026, Labor Code Section 4610's automatic authorization provision remains in effect for qualifying treatment within the first 30 days of injury[33][42][13]. However, the statute's carve-outs for pharmaceuticals, surgery, psychological treatment, home health services, and advanced imaging continue to generate disputes, particularly where claims administrators misapply the exclusions or refuse to authorize treatment pending liability determination[30][33][42].

Ninth Circuit Controlling Authority

The Ninth Circuit Court of Appeals, whose decisions control in California, has not issued significant recent decisions specifically addressing workers' compensation medical treatment authorization procedures. However, the circuit's administrative law jurisprudence applies to challenges to DWC administrative determinations. Hernandez-Montiel v. INS, 225 F.3d 1084 (9th Cir. 2000), while an immigration case, is cited here only to illustrate that the Ninth Circuit applies substantial evidence review to administrative agency decisions, a principle applicable to challenges to DWC administrative determinations under applicable state administrative procedure law.

California Supreme Court Precedent

The California Supreme Court has not issued recent decisions addressing medical treatment authorization in workers' compensation. However, the Court's decisions on statutory interpretation, particularly its emphasis on plain language and legislative intent, apply when interpreting Labor Code provisions governing medical treatment[36].

Circuit Splits and Strategic Considerations

Because workers' compensation is governed by state law, circuit splits are not directly applicable. However, practitioners should note that other states' workers' compensation systems operate under fundamentally different frameworks. For example, Florida requires "major contributing cause" causation for occupational disease claims, a higher burden than California's "arising out of and occurring in the course of employment" standard[72][75]. This distinction affects how practitioners structure medical evidence for conditions with multiple causative factors.

Pending Regulatory Developments

The DWC has indicated that proposed MTUS updates will follow the February 27, 2026 public hearing and comment period[38][41]. Additionally, the Department of Industrial Relations has noted plans to require electronic filing of Doctor's First Report of Injury (Form 5021) in the future, currently operating as a voluntary pilot program[66].

San Francisco-Specific Context

San Francisco Immigration Court Procedures (Note on Scope Limitation)

The San Francisco Immigration Court is located at 100 Montgomery Street, Suite 800; 630 Sansome Street, 4th Floor, Room 475; and has a satellite location at 1855 Gateway Boulevard, Suite 850, Concord[35]. However, immigration courts have no jurisdiction over workers' compensation medical treatment matters. This research brief addresses workers' compensation, not immigration law. References to immigration courts are inapplicable.

San Francisco Workers' Compensation Context

San Francisco injured workers access workers' compensation medical treatment through multiple mechanisms:

San Francisco-Based Claims Administration. Major workers' compensation insurers maintain regional offices in San Francisco, including State Fund and numerous private carriers. These administrators are subject to the same DWC regulations as carriers statewide[12].

Medical Provider Networks in San Francisco Area. Multiple MPNs operate in the San Francisco Bay Area. Sentry Insurance Group MPN #3197 (effective 01/01/2025) provides an example of current MPN operations[11]. Injured workers can access the provider listing at https://www.goperspecta.com/VPD/sentry/public[11]. MPN medical access assistants are available Monday through Saturday, 7:00 am through 8:00 pm Pacific Time, at 855-346-4866[11].

DWC Information and Assistance Unit-San Francisco Office. The DWC's San Francisco Information and Assistance Unit, located at 455 Golden Gate Ave, 2nd Floor, San Francisco, CA 94102-7014, phone (415) 703-5020, provides free assistance to injured workers[35]. This office can help injured workers understand medical treatment rights, file complaints about MPN noncompliance, and access dispute resolution procedures[35].

San Francisco Health Care Organizations (HCOs). San Francisco employers and insurers may utilize certified HCOs to provide integrated medical and disability management[58]. Employees must be offered a choice of at least one HCO and have the right to predesignate a personal physician regardless of HCO enrollment[58]. Once enrolled, employees must use HCO providers for 90-180 days after injury, after which they may switch providers or exit the HCO[58].

Access to Mental Health and Behavioral Treatment. San Francisco has multiple providers experienced in workers' compensation mental health treatment, including SF Stress & Anxiety Center, which specializes in providing clinically sound mental health treatment within the workers' compensation framework[55]. Mental health treatment requires authorization through UR and must comply with MTUS Workplace Mental Health guidelines[23][55].

California State Law Interactions

Proposition 47 and Immigration Consequences (Inapplicable Note)

References in the personalization instructions to PC Section 1203.43 (post-conviction relief for immigration consequences) are not applicable to workers' compensation medical treatment. These provisions address criminal law consequences of convictions and have no bearing on medical treatment authorization.

SB 54 (California Values Act) and Immigration Enforcement Cooperation (Inapplicable Note)

References to SB 54 limiting immigration enforcement cooperation are not applicable to workers' compensation matters. SB 54 governs law enforcement immigration enforcement cooperation, not workers' compensation medical treatment.

Strategic Analysis Framework for Obtaining Medical Treatment

Arguments Favoring Injured Worker Position for Treatment Authorization

Argument 1: Statutory Right to All Reasonable and Necessary Care

Controlling Authority: Labor Code Section 4600(a) provides that employers must furnish all medical treatment "reasonably required to cure or relieve the injured worker from the effects of their injury."[14][16] This statutory right is not conditioned on the claims administrator's decision to accept liability or the MPN's availability of preferred providers[14][16].

Strength: STRONG. This is the foundational statute and has been consistently interpreted to provide broad coverage for medically necessary care.

How to Deploy: When facing denial of treatment, emphasize that the statutory right exists independently of any claims administrator determination. Medical necessity-not administrative convenience-is the test. If the treating physician has recommended treatment based on the injured worker's clinical condition, the burden shifts to the claims administrator to prove the treatment is not medically necessary through formal UR.

Argument 2: $10,000 Automatic Authorization Pending Liability Determination

Controlling Authority: Labor Code Section 5402(c) and Section 4610 require the claims administrator to authorize and pay for treatment up to $10,000 within one working day of receiving the claim form, even while the claims administrator investigates whether the injury is covered[15][21][24][27].

Strength: STRONG. This protection applies automatically and does not require any action by the injured worker beyond filing the claim form.

How to Deploy: Immediately after filing the claim form and informing the claims administrator of the need for treatment, make a written demand that treatment be authorized under the $10,000 floor. Document all communications. If the claims administrator refuses to authorize the $10,000 in automatic treatment pending liability determination, file a written complaint with the DWC Information and Assistance Unit, which may pressure the claims administrator to comply. If treatment is still refused, seek an expedited hearing before the workers' compensation administrative law judge arguing violation of Section 5402(c).

Key Caveat: The $10,000 automatic authorization applies only to treatment that "is consistent with the Medical Treatment Utilization Schedule."[24][33] Claims administrators may argue that requested treatment is not MTUS-consistent. To overcome this argument, obtain documentation from the treating physician explaining why the treatment aligns with applicable MTUS guidelines.

Argument 3: Automatic Authorization for First-30-Day Treatment (Effective January 1, 2018+)

Controlling Authority: Revised Labor Code Section 4610 (effective January 1, 2018) provides that treatment provided within the first 30 days of injury, that complies with MTUS guidelines, that is provided by an authorized provider (MPN physician or predesignated physician), and that is not excluded by statute, automatically qualifies for authorization and cannot be denied through prospective UR[13][30][33][42][13].

Strength: STRONG for qualifying treatment. The statute provides no discretion to deny or modify automatically authorized treatment.

How to Deploy: Before seeking any authorization from the claims administrator during the first 30 days, verify that the proposed treatment meets all conditions: (1) injury date January 1, 2018 or later; (2) treatment date within 30 days of injury; (3) treating physician is in the MPN or was predesignated; (4) body part/condition liability is accepted or undisputed; and (5) treatment is not excluded (surgery, inpatient care, psychological treatment, advanced imaging, durable medical equipment >$250, electrodiagnostic testing, or other Administrative Director-designated exclusions)[33][42].

If all conditions are met, the provider should submit the RFA and Doctor's First Report within 5 days of treatment[33]. The claims administrator may conduct only retrospective UR to ensure MTUS compliance; it cannot deny the treatment prospectively[33].

Key Caveat: The "automatic authorization" provision contains so many carve-outs that it is often useless for complex cases[30][33][42]. Additionally, the condition requiring that "liability for body part and condition is accepted" means that treatment is not automatically authorized if the claims administrator disputes whether

the condition is compensable-rendering the auto-auth provision "a farcical non-solution" for many newly injured workers[30]. A claim that the condition is not compensable will bar automatic authorization.

Argument 4: Expedited Utilization Review for Imminent Health Threats

Controlling Authority: 8 CCR Section 9792.9.1(c)(4) requires that when "the injured worker's condition is such that the injured worker faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function," the UR decision must be made within 72 hours of receipt of the request[4][4][29][69]. Prospective communication of the decision must occur within 24 hours[29][69].

Strength: STRONG when the medical facts support an imminent threat. The regulation does not require that the threat be immediate or exist right now; it only requires that the normal five-business-day UR timeline would be detrimental to the worker's condition[29].

How to Deploy: In the RFA, have the treating physician explicitly certify in writing that expedited review is necessary because the worker faces an imminent and serious threat to health[29][69]. Provide supporting medical documentation explaining why delayed treatment would harm the worker[29]. Examples: imminent risk of permanent nerve damage without immediate surgery; risk of infection without timely treatment; progression of condition causing functional deterioration[29].

Strategic Consideration: Diaz v. Pacific Coast Framers Inc. (2023) clarifies that the WCAB will scrutinize whether expedited review is genuinely justified[29]. Simply checking a box on the RFA or making conclusory statements will not suffice. The treating physician must explain with specificity why the normal timeframe would be detrimental.

Argument 5: MTUS Guidelines Presumption in Favor of Treatment

Controlling Authority: Labor Code Section 4604.5(a) provides that MTUS guidelines are "presumed correct" on the issue of "extent and scope of medical treatment."[2][2] Treatment that complies with MTUS guidelines must be authorized unless the claims administrator can rebut the presumption with contrary evidence[2][2].

Strength: STRONG. The presumption shifts the burden to the claims administrator to justify denial.

How to Deploy: Obtain the specific MTUS guideline for the injured worker's condition[2][2]. Confirm that the treating physician's recommendation falls within the scope and extent recommended in the guideline. If it does, cite the guideline in any UR dispute and argue that the claims administrator cannot rebut the statutory presumption without presenting specific evidence contrary to the guideline.

Example: For low back pain, the MTUS Low Back Disorders guideline (effective November 23, 2021) specifies evidence-based initial assessment, conservative treatment, imaging protocols, and criteria for referral to specialists. If the treating physician's recommendation aligns with this guideline, a UR denial must be supported by evidence demonstrating that the guideline does not apply to this worker's specific clinical situation.

Argument 6: Predesignation Right Overrides MPN Restrictions

Controlling Authority: Labor Code Section 4600(d) and 8 CCR Section 9780.1 allow injured workers to predesignate a personal physician before the injury and treat with that physician regardless of MPN restrictions[7][14]. Three conditions must be met: (1) notice given to employer in writing before injury; (2) personal physician has previously directed the worker's medical treatment and retains medical records; and (3) worker had non-occupational health insurance coverage on the injury date[7][52].

Strength: STRONG if the three conditions are met. Predesignation is perhaps the most powerful medical treatment right available to injured workers.

How to Deploy: If a worker predesignated a physician before injury, provide documentation (written notice or email to HR, acknowledgment from physician) to the claims administrator immediately upon injury[7]. Demand that the claims administrator authorize all treatment with the predesignated physician without MPN restrictions[7].

Key Caveat: Timing is critical. The predesignation must be made before the injury occurs[7]. Workers cannot predesignate after injury.

Argument 7: MPN Noncompliance Allows Treatment Outside Network

Controlling Authority: 8 CCR Section 9767.5(c), (d), (g) provide that if the MPN fails to meet access standards (e.g., cannot schedule a specialist appointment within 20 business days, or cannot provide necessary care within reasonable geographic area), the injured worker may obtain treatment outside the MPN[49]. Failure to meet access standards is grounds for filing a complaint with the DWC and requesting authorization to treat outside the MPN[49].

Strength: MODERATE to STRONG, depending on whether actual access failures can be documented.

How to Deploy: If the MPN cannot provide required care within the regulatory timeframes, document this failure (written requests for appointments, denials of appointments, lack of available specialists)[49]. File a written complaint with the DWC Information and Assistance Unit documenting the access failure[49]. Request authorization to treat with a provider of choice outside the MPN based on the MPN's failure to meet regulatory standards[49].

Example: If a worker needs orthopedic specialist care but the MPN has no orthopedists available within 60 minutes or 30 miles of the worker's residence, the worker may treat outside the MPN.

Arguments Opposing Worker Position (Claims Administrator's Strongest Responses)

Counter-Argument 1: Not Medically Necessary / Exceeds MTUS Guidelines

The claims administrator will argue that the requested treatment falls outside the MTUS guidelines or exceeds the extent or duration recommended in the guideline[2][2][4]. To succeed with this argument, the claims administrator must present evidence (typically through a utilization review physician) explaining why the guideline does not support the treatment[2][2][4].

Worker's Response: Challenge the claims administrator's interpretation of the guideline and cite medical literature supporting the physician's recommendation[2][2]. If the UR physician misread the guideline or applied it incorrectly, file for Independent Medical Review arguing that the UR decision was based on a misinterpretation of the medical evidence[9][64].

Counter-Argument 2: Liability Not Determined / Treatment Not Covered by $10,000 Floor

The claims administrator may argue that because liability for the specific body part or condition has not been accepted, the treatment does not qualify for the $10,000 automatic authorization[15][21][24][33][13].

Worker's Response: Labor Code Section 5402(c) requires authorization of treatment "consistent with guidelines" up to $10,000 while the claims administrator investigates the claim, regardless of whether the specific condition has been accepted[21][24][27]. The claims administrator cannot condition authorization on a preliminary liability finding. However, if the claims administrator has definitively denied liability for the injury (not just the specific body part), the $10,000 floor may not apply. Document whether the claims administrator has issued a final liability denial or is merely investigating.

Counter-Argument 3: Emergency Treatment Can Be Obtained Without Prior Authorization

The claims administrator may argue that if urgent care is needed, the worker can proceed with treatment and seek reimbursement through a retrospective RFA and potential bill review processes[13][13].

Worker's Response: While Section 5402(e) and 8 CCR Section 9792.9(e) permit emergency treatment without prior authorization, this should be a last resort[4][13][4][13]. The law requires that the claims administrator authorize treatment proactively, not force injured workers to pay out of pocket and seek reimbursement later[21][24][27]. Additionally, if the worker uses personal funds or group health insurance, coverage may be limited, and the worker may face significant out-of-pocket costs. Demand prospective authorization before treatment.

Counter-Argument 4: Utilization Review Decision Was Timely; No IMR Grounds

If UR denied treatment, the claims administrator will argue that the UR decision was issued within the five-business-day timeframe (or 72 hours for expedited review) and was supported by competent evidence[4][26][4][69]. The claims administrator will further argue that the injured worker must pursue IMR rather than seek WCAB relief[61][64].

Worker's Response: If the UR decision violated regulatory procedures (late decision, improper notice, decision by non-physician), file a petition with the WCAB arguing the UR decision is invalid[61]. Additionally, file for IMR within 30 days of the UR decision[9][64]. IMR is the exclusive remedy for medical necessity disputes and will provide a binding decision[9][64].

Counter-Argument 5: Treatment Excluded from Automatic Authorization

For injuries within the first 30 days, the claims administrator may argue that the requested treatment falls into one of the statutory exclusions and therefore does not qualify for automatic authorization[33][42].

Worker's Response: If the claims administrator claims the treatment is excluded (e.g., "this is psychological treatment"), obtain the MTUS guideline for the condition and consult with the treating physician to rebut the categorization. For example, some claims administrators incorrectly categorize pain management consultations as "psychological treatment" when they are actually medical management. Additionally, even if the treatment is excluded from automatic authorization, the treatment may still be authorized through standard prospective UR if it complies with applicable MTUS guidelines[33][42].

Risk Assessment Summary

Likelihood of Obtaining Treatment Authorization (Qualitative Assessment):

HIGH likelihood if treatment complies with MTUS guidelines, is performed by an authorized provider, and is within the first 30 days (automatic authorization applies)[33][42][13].

MEDIUM-HIGH likelihood if treatment is MTUS-consistent, is performed by a provider in the MPN or is the predesignated physician, but is beyond 30 days (standard UR will apply, but MTUS presumption favors treatment)[2][2].

MEDIUM likelihood if treatment involves a complex or novel diagnosis, requires extension of MTUS-recommended duration, or involves alternative modalities (acupuncture, etc.). These cases often require IMR[9][64].

MEDIUM-LOW likelihood if treatment is explicitly excluded from automatic authorization (surgery, inpatient care, psychological treatment, advanced imaging) and the claims administrator challenges medical necessity. UR and IMR will be required[33][42][64].

HIGH likelihood of eventual authorization even if initial UR denial occurs, because IMR provides an objective review by a physician independent of the claims administrator[9][64].

Best-Case Scenario: Treatment qualifies for automatic authorization, is provided within 30 days, and the provider submits compliant RFA and Doctor's First Report within 5 days. No denial occurs; treatment is provided and paid. Likelihood: Medium-High (assumes provider compliance and claims administrator does not impose unnecessary delays).

Worst-Case Scenario: Highly complex case involving novel diagnosis; UR denies based on medical necessity; worker pursues IMR but IMR reviewer agrees with claims administrator's interpretation; worker must pursue WCAB litigation if grounds exist (usually none, as IMR is exclusive remedy). Likelihood: Low (most medical evidence issues ultimately result in treatment authorization at IMR level).

Practical Implementation: Securing Medical Treatment Authorization

Step-by-Step Procedural Roadmap

Phase 1: Immediate Post-Injury Actions (Days 1-5)

Step 1: Report Injury to Employer

As soon as practical, inform your employer or supervisor of the work-related injury. Provide as much detail as possible about when, where, and how the injury occurred. California law does not require a specific form for this initial report; oral notification is acceptable, though written notification is preferable[36][53].

Documentation: Keep a record of when and to whom you reported the injury.

Step 2: Obtain DWC-1 Claim Form

By law, your employer must provide you with a DWC-1 (Notice of Potential Eligibility) claim form within one working day of receiving notice of your injury[21][24][36][53]. The form should include information about your rights and the claims administrator contact information.

Documentation: Keep the completed DWC-1 and any confirmations of receipt.

Step 3: Predesignation Documentation

If you have a personal physician who has directed your medical treatment and maintains your medical records, provide written notice to your employer (or send directly via email/certified mail to the company HR department) designating that physician[7][52]. Use DWC Form 9783 if available, or provide written notice including the physician's name, address, specialty, and confirmation that you have health insurance coverage for non-occupational injuries[7][52].

Timing Critical: This notice must be before the injury. If you have previously designated a physician, reference that prior notice.

Documentation: Keep copies of any written predesignation notice and confirmation that it was received by the employer.

Step 4: Seek Medical Treatment

Obtain prompt medical attention for your injury. This serves two purposes: (1) documents the injury contemporaneously, and (2) ensures your health is protected. Inform the treating physician that the injury is work-related[15][32].

Documentation: Request copies of all medical records, including the Doctor's First Report of Injury (Form 5021), examination notes, and imaging results.

Phase 2: Treatment Authorization (Days 5-30)

Step 5: Request Immediate Treatment Authorization

Within one working day of receiving the claim form, contact the claims administrator and request that treatment be authorized consistent with the MTUS, up to the $10,000 floor, pending determination of liability[21][24][27]. Provide the claims administrator with:

Your name, date of birth, and claim number (if assigned)

Date of injury

Description of injury and affected body parts

Requested treatment (physician, specialist, procedures)

Estimated cost

Justification that treatment is reasonably necessary based on the injury

Send this request in writing (email, fax, or certified mail) and keep a copy[21][24].

Step 6: Treating Physician Submits Request for Authorization (RFA)

Your treating physician should submit a completed DWC Form RFA to the claims administrator within 5 days of your initial examination[4][4][19][22]. The RFA should include:

Injured worker identification

Specific course of proposed treatment

Medical justification for the treatment based on clinical findings

Estimated duration and cost

Reference to applicable MTUS guidelines if the treatment is MTUS-consistent

For First-30-Day Treatment (2018+ injury dates): If the treatment meets all conditions for automatic authorization (30-day window, MTUS-consistent, authorized provider, liability accepted or undisputed), the provider should note on the RFA that the treatment qualifies for automatic authorization and therefore should not be subject to prospective UR[33][42].

Step 7: Monitor UR Timeline

Once the RFA is submitted, the claims administrator has five business days to issue a UR decision for standard prospective review, or 72 hours for expedited review[4][4][29][69]. Track the deadline.

Normal UR decision deadline: 5 business days from receipt of completed RFA

Expedited UR decision deadline: 72 hours from receipt of completed RFA

Communication requirement: Decision must be communicated to physician within 24 hours (concurrent/expedited) or 2 business days (prospective) of the decision[29][26][69]

Step 8: Respond to UR Approval

If UR approves the treatment, the claims administrator will provide written authorization[4][4][26]. Proceed with treatment and ensure the billing is submitted properly to the claims administrator[12][44].

Step 9: Respond to UR Denial or Modification

If UR denies or modifies the treatment, the claims administrator must provide a written UR determination that includes:

Date of decision

Description of proposed treatment requested

Specific description of treatment approved (if any)

Clear explanation of reasons for denial or modification

Description of medical criteria or guidelines used[4][4][4][69]

Immediate Actions upon Denial:

Obtain a copy of the full UR determination and supporting documentation

Review the UR determination for procedural defects (late decision, non-physician reviewer making modification/denial, insufficient explanation)

Request the UR file from the claims administrator (all materials reviewed in making the decision)

Consult with your treating physician about whether the UR decision mischaracterizes your clinical situation

Phase 3: Independent Medical Review (Days 30-60 after UR Denial)

Step 10: Prepare IMR Application

If you disagree with the UR denial, you have 30 days to request Independent Medical Review[9][64]. Complete DWC Form IMR-1 and include:

Your name and identifying information

Date of injury and claim number

Copy of the UR determination being challenged

Brief explanation of why you disagree with the UR decision

Medical information supporting your position that the treatment is medically necessary

As of February 2026, the IMR application fee is $195[9][40].

Step 11: Submit IMR Application

Mail the completed IMR-1 form, copy of the UR determination, and $195 fee to:

DWC - IMR c/o Maximus Federal Services, Inc. PO Box 138009 Sacramento, CA 95813-8009

Alternatively, submit electronically through the Maximus IMR tracking system if you register[9].

Step 12: Follow IMR Process

Once the DWC determines that your case is eligible for IMR (within 1 business day), Maximus will issue a Notice of Assignment[9]. Maximus will assign an Independent Medical Reviewer who is not employed by or affiliated with the claims administrator[9].

Standard IMR timeline: The reviewer has 30 days from assignment to issue a decision[9]

Information submission: The claims administrator must provide required medical records to Maximus within 15 calendar days (standard) or 24 hours (expedited)[9]

Step 13: IMR Decision

Maximus will issue a written IMR decision determining whether the disputed treatment is medically necessary based on MTUS guidelines and evidence-based medicine[9][64]. The decision is binding on both the injured worker and the claims administrator[9][64]. The claims administrator cannot appeal the IMR decision to the WCAB; IMR decisions are final[9][64].

If IMR Approves Treatment: The claims administrator must authorize and pay for the treatment immediately[9].

If IMR Denies Treatment: Unfortunately, you cannot appeal the IMR decision to the WCAB. IMR is the exclusive remedy for medical necessity disputes[61][64]. However, you may be able to pursue a different course of treatment, or if circumstances change (new medical evidence, changed clinical condition), you may request treatment authorization again.

Phase 4: Alternative Dispute Resolution (If Necessary)

Step 14: Challenge UR Procedural Defects (WCAB)

If the UR decision violated procedural requirements (e.g., was issued late, was made by a non-physician reviewer when a physician decision was required, or lacked required explanation), you may file a Petition with the Workers' Compensation Appeals Board arguing the UR decision is invalid and should be overturned[61].

Where to file: Your local DWC district office

Form: Petition for Reconsideration or other appropriate pleading

Timeline: File within the time limits specified by WCAB rules of procedure

Relief: If the UR decision is found invalid, the claims administrator must re-conduct UR or authorize treatment[61]

Step 15: Seek Expedited Hearing (WCAB)

If you face denial of treatment and believe the denial violates your statutory rights (e.g., denies the $10,000 automatic authorization pending liability determination), you may request an expedited hearing before the workers' compensation administrative law judge[21][24].

Grounds for expedited hearing include:

Denial of medical treatment required under Labor Code Section 4600[14][16]

Violation of the $10,000 automatic authorization requirement[21][24]

Violation of first-30-day automatic authorization (for 2018+ injuries)[33][42]

MPN noncompliance (access standards violations, improper restrictions)[49][70]

Process:

File an Application for Adjudication of Claim with your local DWC office

Request a mandatory settlement conference (MSC) with an expedited hearing

Present evidence of your medical need and the claims administrator's violations

Seek an order requiring the claims administrator to authorize treatment

Required Forms and Documentation

DWC Forms

| Form | Purpose | Timing |

|---|---|---|

| DWC-1 | Notice of Potential Eligibility / Claim Form | Employer provides within 1 working day of injury notice |

| Form 5020 | Employer's Report of Occupational Injury or Illness | Employer files with insurer within 5 days of injury |

| Form 5021 | Doctor's First Report of Occupational Injury or Illness | Physician files within 5 days of initial treatment[68] |

| DWC Form RFA | Request for Authorization (UR submission form) | Physician submits with each treatment request |

| DWC Form IMR-1 | Application for Independent Medical Review | Injured worker submits within 30 days of UR denial[9] |

| DWC Form 9783 | Predesignation of Personal Physician (optional) | Injured worker completes before injury to predesignate physician[7] |

Supporting Documentation to Obtain and Maintain

Medical Records:

Doctor's First Report of Occupational Injury (Form 5021)

Progress notes from treating physician

Imaging results (X-rays, MRI, CT)

Lab results and diagnostic testing

Treatment plans and progress summaries

Specialist consultation reports

Proof of all UR requests submitted

Administrative Documents:

Completed claim form (DWC-1)

Written confirmation from claims administrator acknowledging receipt of claim

UR determination letter (if UR denial occurs)

IMR application and confirmation of submission

All written communications with claims administrator (emails, letters, fax confirmations)

Evidence of Medical Necessity:

Treating physician's clinical assessment of why treatment is necessary

References to applicable MTUS guidelines

Peer-reviewed medical literature supporting the treatment

Affidavit or declaration from treating physician explaining necessity

Timeline of clinical deterioration if treatment is delayed

San Francisco-Specific Medical Treatment Details

San Francisco Asylum Office Procedures (Inapplicable Clarification)

The San Francisco Asylum Office is not involved in workers' compensation medical treatment matters. References in the research instructions to asylum office procedures are inapplicable to this workers' compensation brief.

San Francisco Medical Treatment Implementation

San Francisco Medical Provider Networks and HCOs

Injured workers in San Francisco access treatment through:

Medical Provider Networks (MPNs): Multiple MPNs operate in the San Francisco Bay Area, providing networks of occupational and non-occupational physicians. Workers initially receive treatment from MPN physicians assigned or selected from the available list, but may change to another MPN physician after the first visit[8][70].

Health Care Organizations (HCOs): San Francisco employers may establish certified HCOs providing integrated medical and disability management[58]. Employees must be offered choice of HCOs and may predesignate personal physicians who fall outside the HCO[58].

Predesignated Physicians: San Francisco injured workers who predesignated personal physicians before injury may treat with those physicians regardless of MPN or HCO restrictions[7][52].

San Francisco Mental Health Treatment

San Francisco has robust mental health treatment resources, including SF Stress & Anxiety Center, which specializes in workers' compensation-eligible psychological injury treatment[55]. However, mental health treatment is categorized as "psychological treatment" and is not eligible for automatic authorization[33][42]. Mental health treatment requires prospective UR authorization[33][42].

To obtain mental health treatment authorization in San Francisco:

Ensure treating physician is in the MPN or is the predesignated physician

Have the treating psychologist/psychiatrist submit an RFA with comprehensive clinical assessment explaining why the mental health treatment is necessary based on MTUS Workplace Mental Health guidelines[23][55]

Expect UR to apply; expedited UR may be available if worker faces imminent deterioration[29][69]

If UR denies, file IMR arguing the guideline supports the treatment[9][64]

DWC Information & Assistance Unit-San Francisco Contact

The DWC's San Francisco Information & Assistance Unit provides free assistance to injured workers:

Address: 455 Golden Gate Ave, 2nd Floor, San Francisco, CA 94102-7014

Phone: (415) 703-5020

Hours: Weekday business hours

Services: Information about medical treatment rights, assistance with filing complaints, guidance on dispute resolution[35]

Workers experiencing difficulty obtaining medical treatment authorization should contact this unit for assistance and potential intervention.

Country Conditions & Persecution Evidence (Inapplicable Section)

This section is not applicable to California workers' compensation medical treatment. References in the research instructions to country conditions documentation for asylum claims are inapplicable to workers' compensation. This section is intentionally omitted as it addresses international human rights documentation, not domestic workers' compensation law.

Preservation and Appeal Strategy for Medical Treatment Disputes

Immigration Court Level (Inapplicable)

References to immigration court procedures are not applicable to workers' compensation medical treatment matters. Workers' compensation disputes are resolved through the Division of Workers' Compensation, not immigration courts.

Workers' Compensation Appeals Board Level

When to Appeal UR Decisions to WCAB

Do not appeal a UR decision denying medical necessity to the WCAB. Instead, pursue Independent Medical Review[9][61][64]. The WCAB lacks jurisdiction over medical necessity disputes; those disputes are exclusively resolved through IMR[61][64].

However, appeal to the WCAB is appropriate when:

UR Decision Violated Procedure: The UR decision was issued late, was made by a non-physician reviewer when a physician decision was required, or lacks required explanation[61][4][69]

Violation of Statutory Medical Treatment Rights: The claims administrator denied the $10,000 automatic authorization pending liability determination, denied first-30-day automatic authorization, or violated MPN access standards[61]

Threshold Dispute: The claims administrator disputed liability for the injury or body part, making IMR unavailable pending resolution of the liability dispute[61][63]

Arguments Suitable for Winning at WCAB Level:

Procedural Violation of UR Rules: Cite specific regulatory violations (8 CCR Section 9792.9.1) showing the UR decision failed to comply with required procedures[61][4][69]. If a non-physician made a modification or denial decision, the UR decision is invalid[26][4].

Statutory Right to Automatic Treatment Pending Liability: Argue that Labor Code Section 5402(c) requires treatment authorization up to $10,000 while the claims administrator investigates, and the claims administrator violated this requirement[21][24][61].

MPN Access Standard Violation: Document that the MPN failed to meet access standards (cannot schedule appointments within required timeframes, has no available specialists in required specialty, etc.) and therefore the worker is entitled to treat outside the MPN[49][61].

Arguments to Preserve for Appeal Even if Unlikely to Win at WCAB:

Statutory Interpretation of "Medically Necessary": If WCAB is somehow reviewing a medical necessity issue (unusual, as IMR is exclusive remedy), preserve arguments about statutory construction of "medically necessary" under Labor Code Section 4610.5[64].

MTUS Guideline Interpretation: If the specific application of a MTUS guideline to this worker's circumstances is disputed, preserve arguments about correct interpretation of the guideline[2][2].

Record-Building for Appeal:

Even if you expect WCAB jurisdiction to be limited, build a complete record:

Ensure all medical records are included in the hearing exhibit list

Preserve the RFA submissions and supporting medical documentation

Preserve UR determination with all supporting materials

Document procedural violations (dates, deadlines, decision-maker identifications)

Obtain declarations from treating physician explaining medical necessity

If applicable, obtain MTUS guidelines and expert analysis of how the guideline applies

BIA Appeal Level (Inapplicable)

The Board of Immigration Appeals has no jurisdiction over workers' compensation matters. This section does not apply.

Federal Court Challenges to DWC Determinations

When Habeas Corpus or Administrative Procedure Act Challenges Are Appropriate

In rare circumstances, a workers' compensation party may challenge a DWC administrative determination in federal court. However, such challenges require exhaustion of state administrative remedies (UR, IMR, WCAB) and present significant barriers.

Potential Federal Court Claims:

Violation of Due Process: If the DWC denies injured worker an opportunity to be heard or present evidence, a due process challenge may be pursued

Administrative Procedure Act Challenge: If DWC adopts regulations that are arbitrary and capricious, an APA challenge under the federal Administrative Procedure Act may be available

Injunction Against Enforcement: If state law is being applied in an unconstitutional manner, seeking an injunction in federal court may be appropriate

However, these are rare and complex remedies. Before considering federal court, ensure all state remedies are exhausted (UR, IMR, WCAB proceeding).

Pending Litigation Affecting Medical Treatment Authorization

As of February 2026, no major pending litigation affects the medical treatment authorization framework. However:

Proposed MTUS Updates: The February 27, 2026 public hearing on evidence-based updates to MTUS guidelines may result in final regulatory amendments that will affect treatment authorization decisions[38][41].

Monitoring Electronic Filing Requirements: The DWC plans to require electronic filing of Doctor's First Report of Injury in the future, currently operating as a voluntary pilot[66]. Practitioners should monitor for final rulemaking requiring electronic filing, which will affect provider compliance procedures.

Alternative Strategies and Contingencies

Plan B: Emergency Treatment and Retrospective Authorization

If prospective authorization cannot be obtained within the required timeframe and the worker faces a genuine emergency, the law permits emergency treatment without prior authorization[13][13]. Key points:

No Prior Authorization Required for Emergency Care: 8 CCR Section 9792.9(e) provides that "failure to obtain prior authorization for emergency health care services shall not be an acceptable basis for refusal to cover medical services."[4][13][4]

Emergency Health Care Services Defined: "Emergency health care services" are services for "a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to place the patient's health in serious jeopardy."[13][19][13]

Retrospective Review: Emergency treatment may be subjected to retrospective UR[4][13][4]. However, if the treatment was genuinely emergency care, the claims administrator cannot deny payment based on lack of prior authorization[4][13][4].

Procedure: After receiving emergency care, the provider must submit an RFA retrospectively, typically within 5 days[33][13]. The claims administrator then conducts retrospective UR.

Risks of Plan B:

If the worker pays out of pocket or uses personal health insurance for emergency care, reimbursement may take weeks or months

Retrospective UR may deny the emergency treatment as not medically necessary, requiring IMR appeal

Worker bears the financial burden initially

Use Plan B Only When:

Prospective authorization cannot be obtained in time

Medical condition poses genuine risk to health if treatment is delayed

All reasonable efforts to obtain prospective authorization have been exhausted

Plan C: Challenging MPN Validity or Compliance

If the MPN violates regulatory requirements or fails to meet access standards, the injured worker may challenge the MPN's validity and seek authorization to treat outside the network.

Grounds to Challenge MPN:

Access Standard Violations: MPN cannot schedule appointments within required timeframes (3 business days for initial appointment, 20 business days for specialist)[49]

Inadequate Physician Network: MPN lacks minimum number of physicians in required specialties[49]

Continuity of Care Failure: MPN fails to provide continuity of care if a treating physician leaves the network[49]

Improper Physician Compensation Structure: MPN compensates physicians in a way designed to reduce, delay, or deny treatment[51][60]

MPN Plan Violations: MPN operates outside the scope of its approved plan[8]

Procedure to Challenge MPN:

Document the specific MPN violation (written denials of appointment requests, absence of specialists, lack of timely availability)

File a written complaint with DWC Medical Unit at (510) 286-3700

Petition the workers' compensation administrative law judge for authorization to treat outside the MPN based on MPN noncompliance

Obtain authorization from the claims administrator to treat with physician of choice outside the MPN

Strength of Plan C: MEDIUM to HIGH if genuine MPN violations can be documented. If successful, injured worker may access any qualified physician outside the network.

Plan D: Obtaining Qualified Medical Evaluator (QME) or Agreed Medical Evaluator (AME) Opinion

If the injured worker disputes the treating physician's opinion on causation, disability level, or permanent impairment, a Qualified Medical Evaluator (QME) or Agreed Medical Evaluator (AME) may be selected to resolve the dispute.

Note: QME evaluations address causation and disability issues, not medical necessity of treatment. However, a QME opinion confirming that the injury is work-related and the worker requires ongoing treatment strengthens subsequent UR disputes.

Procedure:

If claims administrator disputes causation or permanent disability, either party may request a QME panel[21]

QME examination is mandatory and binding on medical necessity issues within the QME's assigned scope[21]

The QME opinion becomes evidence in any subsequent UR dispute or WCAB hearing[21]

Use Plan D When: The treating physician's credibility is questioned, or when claims administrator argues the injury is not causally related to work.

Plan E: Coordination with Criminal Defense Counsel (Inapplicable)

References in the research instructions to criminal conviction modification (PC Section 1473.7) are not applicable to workers' compensation medical treatment. Workers' compensation and criminal law are separate systems. However, if a worker has criminal convictions that might affect employment status or credibility, consult with criminal defense counsel about potential post-conviction relief to strengthen workers' compensation claim.

Plan F: Obtaining Expert Medical Affidavit or Opinion

If UR denies treatment and the treating physician's documentation is insufficient to overcome the denial, obtain an affidavit or written opinion from another qualified physician supporting medical necessity.

Procedure:

Retain an independent physician (not the treating physician) who specializes in the relevant body part/condition

Provide the physician with the medical records and UR determination

Request a written affidavit or opinion stating that the disputed treatment is medically necessary based on the worker's clinical presentation and applicable MTUS guidelines

Submit the affidavit as part of the IMR request[9][64]

Cost: Typically $500-$2,000+ for an expert opinion, depending on the complexity and physician's fee.

Ethical & Professional Conduct Considerations

California Rules of Professional Conduct (If Represented by Attorney)

If an injured worker is represented by an attorney, the attorney must comply with California Rules of Professional Conduct, including:

Competence (Rule 1.1): Attorney must have legal knowledge and skill to represent the injured worker in workers' compensation medical treatment disputes

Candor to Tribunal (Rule 3.3): Attorney must disclose factual information to the workers' compensation administrative law judge and must not mislead the tribunal

Client Communication (Rule 1.4): Attorney must communicate with the client about the status of the claim and the risks/benefits of available strategies

Conflicts of Interest (Rule 1.7): Attorney must avoid conflicts of interest; typically, an applicant's attorney may not simultaneously represent the employer or claims administrator

Competence Requirements for Non-Attorney Representatives

If the injured worker represents themselves or is assisted by a non-attorney representative:

Candor: Provide truthful information to the claims administrator and any DWC proceedings

Documentation: Maintain organized files with copies of all communications, UR determinations, and medical records

Timeliness: Meet all filing deadlines (30 days for IMR, etc.)

Ethical Conduct: Do not misrepresent facts or medical conditions to obtain authorization

California Applicants' Attorneys Fees

Applicants' attorneys in workers' compensation are paid through a fee award issued by the workers' compensation administrative law judge. Attorney fees typically are 15% of the permanent disability award or 15% of the increase obtained by the attorney's efforts. For medical treatment authorization disputes, if litigation is required, the attorney may seek a reasonable fee based on the work performed.

Risk Warnings & Disclaimers

Inherent Risks in Medical Treatment Disputes

Delays in Care: Even when legal rights are clear, delays often occur due to UR processing timeframes, IMR delays, or administrative backlogs. These delays may harm the injured worker's medical condition.

Irreversible Treatment Consequences: Delays in authorization for time-sensitive conditions (e.g., surgery for spinal cord compression) may result in permanent neurological damage that cannot be reversed.

Incomplete IMR Relief: If IMR denies treatment, the injured worker's only recourse is to pursue alternative treatments or seek WCAB intervention for procedural violations. IMR decisions are final on medical necessity.

Financial Risk: If emergency treatment is obtained without authorization, the injured worker may initially bear the financial burden pending authorization/reimbursement.

MPN Restrictions: Even with valid legal claims to treatment outside the MPN, the claims administrator may refuse authorization, requiring litigation to enforce the right.

Information Requiring Expert Consultation

Medical Expertise Required:

Assessment of whether proposed treatment complies with applicable MTUS guidelines

Interpretation of medical evidence for UR disputes

Evaluation of IMR reviewer's reasoning

Determination of appropriate specialist referrals

Consult with the treating physician or an independent medical expert on these issues.

Legal Expertise Recommended:

UR procedural defects

Calculation of IMR filing deadlines and procedural requirements

WCAB pleadings for procedural disputes

MPN compliance violations

Federal court APA challenges (if applicable)

Consult with an applicant's attorney on legal strategy.

Tax and Financial Planning:

Medical expense deductions

Coordination of workers' compensation benefits with tax implications

Settlement structured to minimize tax burden

Consult with a tax professional if large settlements are anticipated.

Client Decision Points Requiring Informed Consent

Decision Point 1: Emergency Treatment vs. Prospective Authorization

If prospective authorization cannot be obtained in time, the worker must decide whether to:

Wait for authorization (risking medical deterioration)

Proceed with emergency treatment and seek retrospective authorization (risking out-of-pocket costs)

Decision Point 2: IMR vs. Escalation to WCAB

If UR denies treatment, the worker must decide whether to:

Pursue IMR (exclusive remedy, binding decision, 30-day deadline)

Challenge UR procedurally to WCAB (only if procedural defect exists)

Decision Point 3: Retaining Attorney vs. Self-Representation

The worker must decide whether to:

Represent themselves (potentially cost-saving but risk of procedural errors)

Retain an applicants' attorney (fee arrangement, but professional representation)

Decision Point 4: MPN Challenge vs. Accept Network Provider

If the MPN has access problems or limited options, the worker must decide whether to:

Challenge MPN validity (requires documentation, potentially requires WCAB litigation)

Accept available MPN provider and seek treatment authorization within network

Use predesignation or other legal right to opt out of MPN

Timeline for Client Decision-Making

Days 1-5: Decide on predesignation, report injury, request claim form

Days 5-30: Engage treating physician, monitor UR timeline, prepare for UR denial if anticipated

Days 30-60: File IMR if UR denial occurs (30-day deadline is hard deadline)

Days 60+: Pursue WCAB or alternative remedies if IMR denies

Appendices

Appendix A: Relevant Statutes (Full Text Citations)

Labor Code Section 4600 - Right to Medical Treatment California Labor Code Section 4600: "Medical, surgical, chiropractic, acupuncture, and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches, and apparatuses, including orthotic and prosthetic devices and services, that is reasonably

required to cure or relieve the injured worker from the effects of their injury shall be provided by the employer."

Labor Code Section 4600(d) - Predesignation of Personal Physician California Labor Code Section 4600(d): Allows employees who have notified their employer in writing prior to injury of a personal physician to be treated by that physician if the employee has non-occupational group health coverage.

Labor Code Section 4610 - Utilization Review and Automatic Authorization California Labor Code Section 4610: Establishes UR procedures, MTUS compliance requirements, and automatic authorization for qualifying treatment within first 30 days of injury (effective January 1, 2018+).

Labor Code Section 4610.5 - Disputed Medical Treatment and Independent Medical Review California Labor Code Section 4610.5: Establishes IMR as exclusive remedy for medical necessity disputes, defines "medically necessary," and establishes 30-day deadline for requesting IMR.

Labor Code Section 4616 - Medical Provider Networks California Labor Code Section 4616: Authorizes establishment of MPNs, requires access standards, prohibits denial or delay of treatment based on physician compensation structure.

Labor Code SectionSection 5400-5402 - Injury Reporting and Presumptive Compensability California Labor Code Section 5402: Establishes 90-day deadline for claim acceptance/denial and requires treatment authorization up to $10,000 pending liability determination.

Appendix B: Relevant Regulations (Full Text Citations)

8 CCR Section 9792.6.1 - Utilization Review Definitions 8 California Code of Regulations Section 9792.6.1: Defines authorization, prospective/concurrent/retrospective review, emergency health care services.

8 CCR Section 9792.9 - Utilization Review Standards (Pre-2013 Injuries) 8 California Code of Regulations Section 9792.9: Establishes 5-business-day UR decision timeline, RFA procedures, emergency treatment procedures.

8 CCR Section 9792.9.1 - Utilization Review Standards (2013+ Injuries) 8 California Code of Regulations Section 9792.9.1: Establishes RFA form requirements, automatic authorization, expedited UR (72-hour) timeline, decision communication requirements.

8 CCR SectionSection 9792.20-9792.27 - Medical Treatment Utilization Schedule 8 California Code of Regulations SectionSection 9792.20-9792.27: MTUS framework incorporating ACOEM guidelines, establishing presumption of correctness, updating procedures.

8 CCR Section 9767.5 - Medical Provider Network Access Standards 8 California Code of Regulations Section 9767.5: Access standards (30 minutes/15 miles primary, 60 minutes/30 miles specialist), appointment availability requirements.

8 CCR Section 9767.6 - Treatment and Change of Physicians Within MPN 8 California Code of Regulations Section 9767.6: Right to change physicians after first visit, prohibition on using formal change-of-physician petition while in MPN.

8 CCR Section 9767.7 - Second and Third Opinions 8 California Code of Regulations Section 9767.7: Procedures for requesting second and third MPN opinions, 60-day appointment deadline, consequences of missed deadlines.

8 CCR SectionSection 9768.1 et seq. - MPN Independent Medical Review 8 California Code of Regulations SectionSection 9768.1 et seq.: MPN-specific IMR process for disputes after second and third opinions.

8 CCR SectionSection 9792.27.18-9792.27.23 - MTUS Drug Formulary 8 California Code of Regulations SectionSection 9792.27.18-9792.27.23: Evidence-based drug formulary requirements, P&T committee procedures.

8 CCR Section 9780.1 - Predesignation of Personal Physician 8 California Code of Regulations Section 9780.1: Procedures for predesignating personal physician prior to injury, conditions for valid predesignation.

Appendix C: Key Case Holdings

Illinois Midwest Ins. Agency v. Rodriguez, No. B344044 (Cal. Ct. App. 11/10/2025)

Holding: Utilization review applies to every request for authorization of medical treatment, including ongoing treatments. Injured workers cannot bypass UR/IMR through WCAB proceedings. Independent medical review is the exclusive mechanism for resolving medical necessity disputes. When UR denies ongoing home health care based on medical necessity, the proper recourse is IMR, not WCAB litigation.

Application to Medical Treatment: This recent decision reaffirms that medical necessity disputes must follow the UR->IMR sequence and cannot be litigated before the WCAB.

Diaz v. Pacific Coast Framers Inc., 2023 Cal. Wrk. Comp. P.D. LEXIS 211

Holding: The WCAB will scrutinize whether expedited review is genuinely justified based on evidence presented. Simply checking a box or making conclusory statements that expedited review is necessary will not suffice. The treating physician must document with specificity why the normal five-business-day UR timeline would be detrimental.

Application to Medical Treatment: When requesting expedited UR, provide detailed medical documentation explaining the imminent threat to health.

Appendix D: Forms Currently in Use (February 2026)

All forms are available at https://www.dir.ca.gov/dwc/forms.html

DWC-1: Notice of Potential Eligibility (Claim Form)

Form 5020: Employer's Report of Occupational Injury or Illness

Form 5021: Doctor's First Report of Occupational Injury or Illness (Physician to complete within 5 days)

DWC Form RFA: Request for Authorization (for UR submissions by treating physicians)

DWC Form IMR-1: Application for Independent Medical Review

DWC Form 9783: Predesignation of Personal Physician (optional form for predesignation)

DWC Form 9784: Predesignation of Personal Chiropractor or Acupuncturist

Appendix E: Current Policy Memos and DWC Guidance (February 2026)

DWC Injured Worker Guidebook (May 2024 Edition): Comprehensive guide to workers' compensation rights and procedures

DWC Medical Treatment Utilization Schedule: Current MTUS guidelines with regular updates

DWC Independent Medical Review Information: IMR procedures, costs, deadlines, and how to request

DWC Utilization Review FAQs: Answers to common UR questions

DWC Medical Provider Network Information: MPN approval, modification, and requirements

DWC Health Care Organization Information: HCO certification and procedures

Notice of Proposed MTUS Updates (February 27, 2026): Proposed updates to chronic pain, eye disorders, and general treatment approach guidelines

Appendix F: Medical Evidence and Country Conditions (Inapplicable)

This section is omitted as it is not applicable to workers' compensation medical treatment. Country conditions documentation is relevant to asylum and international protection claims, not domestic workers' compensation.

Appendix G: San Francisco Immigration Court Local Rules and Procedures (Inapplicable)

This section is omitted as immigration courts have no jurisdiction over workers' compensation matters. Workers' compensation disputes are resolved through the Division of Workers' Compensation, not immigration courts.

Appendix H: California Criminal Law Statutes (Inapplicable)

References to PC Section 1203.43 (post-conviction relief for immigration consequences) and PC Section 1473.7 (vacatur of convictions with immigration consequences) are not applicable to workers' compensation medical treatment and are omitted.

Complete References and Sources

A. Statutes and Legislation

California Labor Code Division 4 - Workers' Compensation and Insurance

California Labor Code Section 4600 - Right to Medical Treatment

California Labor Code Section 4600.5 - Requirements for Health Care Organizations

California Labor Code Section 4610 - Utilization Review

California Labor Code Section 4610.5 - Disputed Medical Treatment and Independent Medical Review

California Labor Code Section 4616 - Medical Provider Networks

California Labor Code SectionSection 5400-5402 - Notice and Claim Requirements

B. California Administrative Code Regulations (Title 8)

8 CCR Section 9767.5 - Access Standards for Medical Provider Networks

8 CCR Section 9767.6 - Treatment and Change of Physicians Within MPN

8 CCR Section 9767.7 - Second and Third Opinions

8 CCR Section 9780.1 - Employee's Predesignation of Personal Physician

8 CCR Section 9792.6 - Utilization Review Standards (General)

8 CCR Section 9792.6.1 - Utilization Review Definitions

8 CCR Section 9792.9 - Utilization Review Standards (Pre-2013 Injuries)

8 CCR Section 9792.9.1 - Utilization Review Standards (2013+ Injuries)

8 CCR Section 9792.10.1 - Utilization Review Dispute Resolution

8 CCR SectionSection 9792.20-9792.27 - Medical Treatment Utilization Schedule

8 CCR Section 9792.24.2 - Chronic Pain Guidelines

8 CCR SectionSection 9792.27.18-9792.27.23 - MTUS Drug Formulary

C. Case Law

Illinois Midwest Ins. Agency v. Rodriguez, No. B344044 (Cal. Ct. App. 11/10/2025)

Diaz v. Pacific Coast Framers Inc., 2023 Cal. Wrk. Comp. P.D. LEXIS 211

D. Division of Workers' Compensation Guidance and Resources

DWC Medical Treatment Utilization Schedule (MTUS)

DWC Independent Medical Review (IMR)

DWC Utilization Review FAQs

DWC Medical Provider Networks

DWC Health Care Organizations

DWC Information and Assistance Unit

DWC Injured Worker Guidebook (May 2024)

DWC Medical Care - Injured Worker Resources

DWC FAQs for Employees

DWC Independent Bill Review (IBR)

DWC MTUS Evidence-Based Updates (February 2026 Hearing Notice)

E. Secondary Legal Resources and Practice Guidance

Goldschmid, Silver & Spindel - Getting Medical Treatment Authorized

daisyBill - Automatic Authorization Guide for California Workers' Comp

daisyBill - RFA for Emergency Treatment in California Workers' Comp

daisyBill - Treatments That Do Not Qualify for Automatic Authorization

daisyBill - Automatic Authorization Fails CA Injured Workers

Torrez Legal - Appeals Process for Denied Workers' Compensation Claims

Employees First Labor Law - Labor Code Section 4600 - Right to Medical Treatment

Employees First Labor Law - Labor Code Section 5814 - Penalties for Unreasonable Delay

Employees First Labor Law - Workers' Compensation for Mental Health Claims

Employees First Labor Law - How to Change Your Workers' Comp Doctor in the MPN

Employees First Labor Law - Labor Code Section 139.21 - Medical Provider Network Requirements

Roy Yang Law - Workers' Compensation for Mental Health Claims

SF Stress & Anxiety Center - Workers' Comp & Mental Health Claims

Friedman Law Offices - The 24-Visit Cap in Workers' Comp

Sullivan & Associates - Expedited Review of Requests for Treatment

Sullivan & Associates - Workers' Compensation Time Limits Guide

CWCI - Employers - California Workers' Compensation Institute

Pacific Workers - Workers' Comp Second Opinions in California

State Fund - Understanding the Utilization Review & IMR Process

Sentry Insurance - California Medical Provider Network

SF Physician Predesignation

Vasquez Law - California Workers' Compensation: A 2026 Complete Guide

Judge O'Brien - Reasonable Geographic Area in Workers' Comp

California Workers' Compensation Institute - SB 863 Amendments

California Department of Human Resources - Workers' Compensation Preview

DWC FAQs on Utilization Review for Claims Administrators

DWC FAQs on RBRVS Physician Fee Schedule

Boxer & Gerson - The Penalty Box - Labor Code Section 5814 Penalties

DWC Medical Provider Network Definitions

Electronic Doctor's First Report Filing

DWC - If My Claim Was Denied

F. Federal and Interstate Comparative Resources

Hernandez-Montiel v. INS, 225 F.3d 1084 (9th Cir. 2000) - (Note: Immigration law case; cited only for administrative law principles regarding substantial evidence review)

Illinois Workers' Compensation - Doctor Selection

Florida Workers' Compensation - Occupational Diseases

Florida Statutes Section 440.151 - Occupational Diseases

Report Generated: February 27, 2026

Disclaimer: This report provides general legal information about California workers' compensation medical treatment authorization procedures. It is not legal advice and does not constitute an attorney-client relationship. Individuals facing specific medical treatment authorization issues should consult with a licensed California attorney. Information in this report is accurate as of February 27, 2026, but workers' compensation law and regulations are subject to change. Practitioners should regularly consult the DWC website for current guidance.

References

California Labor Code Section 4600 (https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4600-5/)

Labor Code Section 4610 (https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4610-5/)

Labor Code Section 4616 (https://law.justia.com/codes/california/code-lab/division-4/article-2.3/)

Labor Code SectionSection 5400-5402 (https://law.justia.com/codes/california/code-lab/division-4/part-3/)

8 CCR Section 9792.6.1 (https://www.law.cornell.edu/regulations/california/8-CCR-9792.6)

8 CCR Section 9792.9 (https://www.dir.ca.gov/t8/9792_9.html)

8 CCR Section 9792.9.1 (https://www.dir.ca.gov/t8/9792_9_1.html)

8 CCR SectionSection 9792.20-9792.27 (https://www.dir.ca.gov/dwc/mtus/mtus.html)

8 CCR Section 9767.5 (https://www.dir.ca.gov/t8/9767_5.html)

8 CCR Section 9767.6 (https://www.dir.ca.gov/t8/9767_6.html)

8 CCR Section 9767.7 (https://www.dir.ca.gov/t8/9767_7.html)

8 CCR SectionSection 9768.1 et seq. (https://www.dir.ca.gov/dwc/mpn/dwc_mpn_main.html)

Matter of Acosta, 19 I&N Dec. 211 (BIA 1985) (https://www.justice.gov/eoir/virtual-law-library)

The Division of Workers' Compensation's Injured Worker Guidebook (https://www.dir.ca.gov/injuredworkerguidebook/injuredworkerguidebook.html)

The DWC UR FAQ page (https://www.dir.ca.gov/dwc/utilizationreview/ur_faq.htm)

The DWC IMR webpage (https://www.dir.ca.gov/dwc/imr.htm)

Hernandez-Montiel v. INS, 225 F.3d 1084 (9th Cir. 2000) (https://scholar.google.com/scholar_case?case=hernandez_montiel)

State Fund (https://www.statefundca.com/state-agency/understanding-the-utilization-review/)

Sentry Insurance Group MPN #3197 (effective 01/01/2025) (https://www.sentry.com/for-medical-providers/california-medical-provider-network)

SF Stress & Anxiety Center (https://sfstress.com/workers-compensation-mental-health-claims/)

Labor Code Section 5402(c) (https://law.justia.com/codes/california/code-lab/division-4/part-3/compensation-claims/)

Diaz v. Pacific Coast Framers Inc. (2023) (https://www.sullivanattorneys.com/blog/expedited-review-requests-treatment/)

8 CCR Section 9780.1 (https://www.dir.ca.gov/t8/9780_1.html)

DWC-1 (Notice of Potential Eligibility) (https://www.dir.ca.gov/dwc/forms.html)

DWC Form RFA (https://www.dir.ca.gov/t8/9785_5.html)

8 California Code of Regulations SectionSection 9792.27.18-9792.27.23 (https://www.dir.ca.gov/dwc/mtus/MTUS-Formulary.html)

DWC Health Care Organization Information (https://www.dir.ca.gov/dwc/HCO.htm)

Notice of Proposed MTUS Updates (February 27, 2026) (https://www.dir.ca.gov/dwc/DWCPropRegs/2025/MTUS-Evidence-Based-Update-November/Workplace-Mental-Health-Introduction.pdf)

PC Section 1203.43 (https://law.justia.com/codes/california/penal-code/part-1/title-3/chapter-8/section-1203.43/)

PC Section 1473.7 (https://law.justia.com/codes/california/penal-code/part-3/title-14/chapter-1/section-1473.7/)

California Labor Code Division 4 - Workers' Compensation and Insurance (https://law.justia.com/codes/california/code-lab/division-4/)

8 CCR Section 9792.10.1 - Utilization Review Dispute Resolution (https://www.dir.ca.gov/t8/9792_10_1.html)

8 CCR Section 9792.24.2 - Chronic Pain Guidelines (https://www.dir.ca.gov/t8/9792_24_2.html)

Illinois Midwest Ins. Agency v. Rodriguez, No. B344044 (Cal. Ct. App. 11/10/2025) (https://www.workerscompensation.com/daily-headlines/calif-court-clarifies-steps-for-disputing-utilization-review-decisions/)

Diaz v. Pacific Coast Framers Inc., 2023 Cal. Wrk. Comp. P.D. LEXIS 211 (https://www.sullivanattorneys.com/blog/expedited-review-requests-treatment)

DWC Information and Assistance Unit (https://www.dir.ca.gov/dwc/ianda.html)

DWC Medical Care - Injured Worker Resources (https://www.dir.ca.gov/dwc/medicalcare.htm)

DWC FAQs for Employees (https://www.dir.ca.gov/dwc/wcfaqiw.html)

DWC Independent Bill Review (IBR) (https://www.dir.ca.gov/dwc/ibr.htm)

DWC MTUS Evidence-Based Updates (February 2026 Hearing Notice) (https://www.dir.ca.gov/DIRNews/2026/2026-09.html)

Goldschmid, Silver & Spindel - Getting Medical Treatment Authorized (https://www.gsscomplaw.com/your-rights/getting-medical-treatment-authorized/)

daisyBill - Automatic Authorization Guide for California Workers' Comp (https://blog.daisybill.com/complete-2018-automatic-authorization-guide-for-california-workers-comp)

daisyBill - RFA for Emergency Treatment in California Workers' Comp (https://kb.daisybill.com/topics/authorization-treatment)

daisyBill - Treatments That Do Not Qualify for Automatic Authorization (https://blog.daisybill.com/treatments-that-do-not-qualify-for-automatic-authorization-workers-comp)

daisyBill - Automatic Authorization Fails CA Injured Workers (https://blog.daisybill.com/automatic-authorization-fails-ca-injured-workers)

Torrez Legal - Appeals Process for Denied Workers' Compensation Claims (https://torrezlegal.com/blog/the-appeals-process-for-denied-workers-compensation-claims/)

Employees First Labor Law - Labor Code Section 4600 - Right to Medical Treatment (https://employeesfirstlaborlaw.com/labor-code-%C2%A74600-right-to-medical-treatment-workers-comp/)

Employees First Labor Law - Labor Code Section 5814 - Penalties for Unreasonable Delay (https://employeesfirstlaborlaw.com/labor-code-%C2%A75814-penalties-for-unreasonable-delay-or-denial/)

Employees First Labor Law - Workers' Compensation for Mental Health Claims (https://employeesfirstlaborlaw.com/workers-comp-for-psychological-injuries-in-california-your-rights-explained/)

Employees First Labor Law - How to Change Your Workers' Comp Doctor in the MPN (https://employeesfirstlaborlaw.com/how-to-change-your-workers-comp-doctor-in-the-mpn-california-guide/)

Employees First Labor Law - Labor Code Section 139.21 - Medical Provider Network Requirements (https://employeesfirstlaborlaw.com/labor-code-%C2%A7139-21-medical-provider-network-requirements/)

Roy Yang Law - Workers' Compensation for Mental Health Claims (https://royyanglaw.com/workers-comp/mental-health-claims/)

Friedman Law Offices - The 24-Visit Cap in Workers' Comp (https://www.friedmanlawoffices.com/2023/01/the-24-visit-cap-a-sixty-second-seminar-in-workers-compensation-claims-handling/)

Sullivan & Associates - Workers' Compensation Time Limits Guide (https://www.sullivanattorneys.com/hubfs/website/resources-page-docs/MS&A%20Work%20Comp%20Time%20Limits.pdf)

CWCI - Employers - California Workers' Compensation Institute (https://www.cwci.org/Employers_.html)

Pacific Workers - Workers' Comp Second Opinions in California (https://www.pacificworkers.com/blog/2025/october/second-opinions-in-california-workers-comp-when-/)

SF Physician Predesignation (https://sfdhr.org/physician-pre-designation)

Vasquez Law - California Workers' Compensation: A 2026 Complete Guide (https://www.vasquezlawnc.com/blog/california-workers-compensation-guide)

Judge O'Brien - Reasonable Geographic Area in Workers' Comp (https://judgeobrien.com/index.php?option=com_content&view=article&id=1184&Itemid=573)

California Workers' Compensation Institute - SB 863 Amendments (https://www.cwci.org/document.php?file=2038.doc)

California Department of Human Resources - Workers' Compensation Preview (https://www.calhr.ca.gov/workers-compensation-preview)

DWC FAQs on RBRVS Physician Fee Schedule (https://www.dir.ca.gov/dwc/FAQ/RBRVS_Faqs.html)

Boxer & Gerson - The Penalty Box - Labor Code Section 5814 Penalties (https://www.boxerlaw.com/workerscompzone/the-penalty-box-part-one/)

DWC Medical Provider Network Definitions (https://www.dir.ca.gov/t8/9767_1.html)

Electronic Doctor's First Report Filing (https://www.dir.ca.gov/dwc/Electronic-Reporting-System-for-DFR/Index.htm)

DWC - If My Claim Was Denied (https://www.dir.ca.gov/dwc/myclaimwasdenied.htm)

Illinois Workers' Compensation - Doctor Selection (https://www.connollyinjurylaw.com/blog/does-illinois-workers-compensation-choose-my-medical-provider/)

Florida Workers' Compensation - Occupational Diseases (https://www.brandonjbroderick.com/florida/understanding-florida-workers-compensation-benefits-occupational-diseases)

Florida Statutes Section 440.151 - Occupational Diseases (https://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&URL=0400-0499%2F0440%2FSections%2F0440.151.html)

goperspecta.com (https://www.goperspecta.com/VPD/sentry/public[11)

chcf.org (https://www.chcf.org/wp-content/uploads/2017/12/PDF-WorkersCompOverview06.pdf)

dir.ca.gov (https://www.dir.ca.gov/dwc/mtus/MTUS_DisclosureOfConflicOfInsterest.html)

dir.ca.gov (https://www.dir.ca.gov/injuredworkerguidebook/Chapter3.pdf)

law.justia.com (https://law.justia.com/codes/california/2007/lab/4600-4614.1.html)

dir.ca.gov (https://www.dir.ca.gov/t8/9792_6_1.html)

qpwblaw.com (https://qpwblaw.com/wp-content/uploads/2024/08/CA-WC-Placard-General.pdf)

covid19.sullivanattorneys.com (https://covid19.sullivanattorneys.com/ebook/When_Must_a_Claim_Form_Be_Provided%3F)

bpkfirm.com (https://bpkfirm.com/labor-code-5500-5-date-of-injury/)

dir.ca.gov (https://www.dir.ca.gov/dwc/IBR/IBR_FAQs.htm)

dir.ca.gov (http://www.dir.ca.gov/dwc/DWCPropRegs/2026/MTUS/Index.htm)

dir.ca.gov (https://www.dir.ca.gov/t8/9788_1.html)

law.justia.com (https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4603-2/)

kb.daisybill.com (https://kb.daisybill.com/articles/do-the-new-mandatory-billing-guidelines-in-sb-1175-apply-to-dates-of-service-prior-to-january-1-2017)

law.justia.com (https://law.justia.com/codes/california/2007/lab/4616-4616.7.html)

law.justia.com (https://law.justia.com/codes/california/2011/lab/division-4/4616-4616.7/4616)

galantipatti.com (https://www.galantipatti.com/can-you-switch-doctors-during-a-workers-comp-claim-in-illinois/)

dir.ca.gov (https://www.dir.ca.gov/dwc/forms/5021.pdf)