

California Workers' Compensation: Primary Treating Physician Rights When Not Included in Medical Provider Network

(PART-A INJURED WORKERS ANALYSIS)

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CALIFORNIA WORKERS' COMPENSATION: YOUR RIGHTS WHEN YOUR TREATING PHYSICIAN IS NOT IN THE EMPLOYER'S MEDICAL PROVIDER NETWORK

If you were hurt at work, California law generally requires your employer to pay for your medical treatment. Many employers use an approved list of doctors called a Medical Provider Network (MPN). If your current treating doctor is not on that list, you may still have legal options to keep seeing that doctor. This report explains those options, the rules that apply, and the steps you can take to protect your rights.

Important: These protections apply to all injured workers in California, regardless of immigration status. You do not need lawful immigration status to file a workers' compensation claim or receive benefits. See the DWC Guidebook for Injured Workers, Chapter 3 (<https://www.dir.ca.gov/injuredworkerguidebook/Chapter3.pdf>).

Part 1: What Is a Medical Provider Network and How Does It Work?

This section explains what an MPN is, how it gets approved, and the basic rule that you must usually treat with doctors inside the network.

Understanding the Medical Provider Network

A Medical Provider Network (MPN) is a group of doctors and other health care providers that your employer or its insurance company sets up to treat workers who are hurt on the job. California law allows employers to create these networks under Cal. Lab. Code § 4616 (<https://employeesfirstlaborlaw.com/labor-code-%C2%A7139-21-medical-provider-network-requirements/>).

Before any MPN can be used, it must be approved by the Administrative Director of the Division of Workers' Compensation (DWC) — the state agency that oversees workers' compensation. The law is clear: "No MPN shall be used without prior approval by the Administrative Director." See Cal. Lab. Code § 4616 (<https://employeesfirstlaborlaw.com/labor-code-%C2%A7139-21-medical-provider-network-requirements/>). This is important because if the MPN was never properly approved, it cannot legally restrict which doctor you see.

The approval process is governed by Cal. Code Regs. tit. 8, § 9767.2 (<https://www.cwci.org/document.php?file=2025.pdf>). The Administrative Director has 60 days to approve or reject an MPN application. If the Administrative Director does not act within 60 days, the MPN is automatically considered approved on the 61st day for a four-year period. Each approved MPN receives a unique approval number.

The General Rule: You Must Treat Within the MPN

Once an MPN is properly approved and in place, the general rule is that you must receive your work-injury treatment from doctors inside that network. Cal. Lab. Code § 4616(a)(1) (<https://employeesfirstlaborlaw.com/labor-code-%C2%A7139-21-medical-provider-network-requirements/>) creates this default requirement. You are not automatically entitled to keep seeing a doctor outside the MPN simply because that doctor treated you before.

However, this general rule has several important exceptions. The rest of this report explains those exceptions in detail.

Your Basic Right to Medical Treatment

Under Cal. Lab. Code § 4600 (<https://employeesfirstlaborlaw.com/labor-code-%C2%A74600-right-to-medical-treatment-workers-comp/>), your employer must provide all medical treatment that is "reasonably required to cure or relieve" you from the effects of your work injury. This includes doctor visits, surgery, hospital stays, medicine, physical therapy, and medical equipment.

The MPN does not take away this right. Instead, it sets up a specific group of doctors through which your employer delivers that treatment. If the MPN fails to provide the treatment you reasonably need, you may be able to challenge the MPN's restrictions using the options described in this report.

Part 2: Access Standards — Minimum Requirements the MPN Must Meet

This section explains the rules about how many doctors must be available in the MPN, how close they must be to where you live or work, and how quickly you must be able to get an appointment.

Distance and Travel Time Requirements

Every MPN must meet specific access standards set out in Cal. Code Regs. tit. 8, § 9767.5 (https://www.dir.ca.gov/t8/9767_5.html). These standards ensure you can actually reach the doctors you need. The MPN must provide:

- Primary treating physicians: At least three available primary treating physicians and a hospital for emergency care within 30 minutes or 15 miles of your home or workplace.
- Specialists: Providers of occupational health services and specialists who treat common work injuries within 60 minutes or 30 miles of your home or workplace.
- Minimum number of doctors: At least three available physicians in each specialty needed to treat common injuries in your type of work.

The word "available" means doctors who are actually accepting new patients — not just names on a list. See MPN Access Standards and Specialist Treatment (<https://www.sullivanoncomp.com/blog/mpn-access-standards-if-an-employee-chooses-to-treat-with-a-specialist>).

Appointment Scheduling Deadlines

The MPN must also meet timing requirements under Cal. Code Regs. tit. 8, § 9767.5 (https://www.dir.ca.gov/t8/9767_5.html):

- First treatment visit: An appointment must be available within 3 business days of your request for treatment.
- Specialist appointment: An initial specialist appointment must be available within 20 business days of your reasonable request.

Critical: If the MPN cannot schedule a specialist appointment within 10 business days of your request, your employer must let you see an appropriate specialist outside the MPN. This is an automatic right — you do not need special permission from a judge.

When the MPN Cannot Meet Access Standards

If you cannot get the medical treatment you reasonably need within the required distances, travel times, or scheduling deadlines, the MPN must have a written policy allowing you to see a doctor outside the MPN within a reasonable geographic area. See Cal. Code Regs. tit. 8, § 9767.5 (https://www.dir.ca.gov/t8/9767_5.html). This means access standard violations give you a concrete legal basis for getting out-of-network treatment.

Part 3: Continuity of Care — Keeping Your Current Doctor Temporarily

This section explains how you may be able to continue treating with a doctor who is not in the MPN if your medical condition meets certain definitions.

Who Qualifies for Continuity of Care

Continuity of care is a legal protection that lets you keep seeing your current doctor — even if that doctor is not in the MPN — when your medical condition is serious enough to make switching doctors unsafe or harmful. This protection comes from Cal. Lab. Code § 4616.2 (<https://law.justia.com/codes/california/2011/lab/division-4/4616-4616.7/4616.2/>).

You qualify if your condition meets any one of these four definitions:

- Acute condition: A medical condition expected to last less than 90 days.
- Serious chronic condition: A condition due to disease, illness, or disorder that needs ongoing treatment for at least 90 days.

- Terminal illness: An incurable or irreversible condition with a high probability of causing death within one year.
- Scheduled surgery or procedure: A surgery or procedure that your doctor has recommended and documented to occur within 180 days, and that has been authorized by the employer or insurer.

If your condition meets any of these definitions, your employer must authorize continued treatment with your non-MPN doctor for a reasonable period — up to a maximum of 12 months. See Cal. Lab. Code § 4616.2 (<https://law.justia.com/codes/california/2011/lab/division-4/4616-4616.7/4616.2/>).

How to Dispute an Employer's Decision to Transfer Your Care

If your employer decides your condition does not qualify for continuity of care, the employer must notify you in writing. This notice must be sent to your address with a copy to your Primary Treating Physician (PTP) — the main doctor managing your work-injury care. The notice must be written in both English and Spanish using plain language. See Cal. Code Regs. tit. 8, § 9767.9 (<https://www.dir.ca.gov/t8/97679.html>) and Cal. Code Regs. tit. 8, § 9767.10 (<https://www.dir.ca.gov/t8/976710.html>).

If you disagree with the employer's decision, follow these steps:

1. Ask your PTP to write a report explaining whether your condition meets one of the four continuity of care definitions.
2. Your PTP must provide this report within 20 calendar days. If your PTP misses this deadline, the employer's decision stands and you lose your right to dispute it.
3. If the employer disagrees with your PTP's report, the dispute goes to the medical dispute resolution process under Cal. Lab. Code § 4062 (<https://www.rjylaw.com/navigating-labor-code-4062-3-a-defense-attorneys-guide-to-fair-medical-evaluations-in-workers-compensation-cases/>).

Critical: The 20-day deadline for your PTP's report is strict. If you want to keep your current doctor under continuity of care, you must act quickly.

Part 4: Pre-Designation — Protecting Your Right to Your Personal Doctor

This section explains how choosing your personal doctor in advance — before you get hurt — can protect you from MPN restrictions.

What Is Pre-Designation?

Pre-designation means you officially name your personal doctor in writing before a work injury happens. If you do this correctly, you can treat with that doctor for your work injury even if the doctor is not in the employer's MPN. This right comes from Cal. Lab. Code § 4600(d) (<https://employeesfirstlaborlaw.com/labor-code-%C2%A74600-right-to-medical-treatment-workers-comp/>).

Under Cal. Code Regs. tit. 8, § 9780.1 (<https://www.law.cornell.edu/regulations/california/8-CCR-9780.1>), pre-designation specifically overrides MPN restrictions: "Where an employer or an employer's insurer has a Medical Provider Network...an employee's predesignation which has been made in accordance with this section shall be valid and the employee shall not be subject to the MPN."

Requirements for a Valid Pre-Designation

To qualify, you must meet all three of the following requirements:

- Written notice before the injury: You must give your employer a written notice naming your personal physician before you get hurt. The notice must include the physician's name, business address, and the name of your health insurance plan. You may use optional DWC Form 9783.
- Qualifying health insurance: You must have health care coverage for non-work injuries or illnesses on the date of your injury. This includes health insurance plans, HMOs, and similar arrangements.
- Doctor's agreement: Your personal physician must agree in writing to be pre-designated before the injury occurs. The doctor may sign the pre-designation form or provide other written documentation of agreement.

See Cal. Code Regs. tit. 8, § 9780.1 (<https://www.law.cornell.edu/regulations/california/8-CCR-9780.1>) and Pre-Designation of Personal Physician in Workers' Comp (<https://www.geklaw.com/news/predesignation.html>).

Challenges You May Face

Even though pre-designation is a strong protection, you carry the burden of proof — meaning you must provide the evidence that your pre-designation was valid. A recent Workers' Compensation Appeals Board (WCAB) panel decision clarified that even if the employer failed to tell you about your pre-designation rights, you still must prove your doctor would have agreed to pre-designation. See Panel Decision Clarifies Burdens of Proof in MPN Disputes (<https://calawyers.org/workers-compensation/panel-decision-clarifies-burdens-of-proof-in-mpn-disputes/>).

Important: If you have a written pre-designation form signed by both you and your doctor before your injury, your case is strong. If you have no written documentation, proving pre-designation becomes very difficult.

Part 5: Second Opinions, Third Opinions, and Independent Medical Review

This section explains your rights to challenge a diagnosis or treatment plan while staying within the MPN system.

Your Right to Second and Third Opinions

Even if you must treat within the MPN, you have a legal right to get additional medical opinions if you disagree with your treating doctor's diagnosis or treatment plan. This process is governed by Cal. Code Regs. tit. 8, § 9767.7 (https://www.dir.ca.gov/t8/9767_7.html) and Cal. Lab. Code § 4616.3 (<https://www.sullivanattorneys.com/blog/requesting-consulting-physicians-mpn>).

Here is how the process works:

1. Tell the claims administrator (the person handling your claim for the employer or insurer) that you disagree with your doctor's diagnosis or treatment and that you want a second opinion.
2. The claims administrator must give you a list of MPN providers or specialists in the relevant field.
3. You must schedule an appointment with a second-opinion doctor within 60 days of receiving the list. If you miss this deadline, you lose the right to a second opinion.
4. The second-opinion doctor examines you and writes a report within 20 days with their opinion and any alternative treatment recommendations.
5. If you disagree with the second-opinion doctor, you may repeat the process to get a third opinion from another MPN doctor.

Important: You do not need the employer's permission to request a second opinion. This right exists independently of the utilization review (UR) process (explained below). See Requesting Consulting Physicians Within an MPN (<https://www.sullivanattorneys.com/blog/requesting-consulting-physicians-mpn>).

MPN Independent Medical Review

If you still disagree after receiving second and third opinions, you can request an MPN Independent Medical Review (IMR) from the Administrative Director under Cal. Lab. Code § 4616.4 (<https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2-3/section-4616-4/>). An independent doctor — not chosen by you or your employer — reviews your case.

The independent reviewer uses the Medical Treatment Utilization Schedule (MTUS), which is California's official set of treatment guidelines, to decide whether the disputed treatment is medically appropriate. See DWC Medical Treatment Utilization Schedule (<https://www.dir.ca.gov/dwc/mtus/mtus.html>).

Critical: If the independent reviewer finds the disputed treatment is consistent with the MTUS, you may seek that treatment from a doctor of your choice — inside or outside the MPN — and your employer must pay for it. See Cal. Lab. Code § 4616.4 (<https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2-3/section-4616-4/>).

Part 6: Utilization Review and Medical Necessity Disputes

This section explains the separate process employers use to decide whether your treatment is medically necessary, and how to appeal denials.

What Is Utilization Review?

Utilization review (UR) is a process your employer must use to evaluate whether requested medical treatment is medically necessary. This requirement comes from Cal. Lab. Code § 4610 (<https://employeesfirstlaborlaw.com/labor-code-%C2%A7610-utilization-review-ur-workers-comp/>). Through UR, the employer can approve, modify, delay, or deny a treatment request. Only a licensed physician can make a decision to modify, delay, or deny treatment based on medical necessity.

Appealing a UR Denial Through IMR

If a UR decision denies or modifies your treatment, you can appeal through Independent Medical Review (IMR) under Cal. Lab. Code § 4610.5 (<https://employeesfirstlaborlaw.com/labor-code-%C2%A7610-utilization-review-ur-workers-comp/>). This IMR process applies whether your doctor is inside or outside the MPN.

Note: Effective April 1, 2026, California has updated UR regulations. These changes include new requirements for UR organizations, updated timelines, and stricter penalties for non-compliance. See California Utilization Review Regulation Updates Effective 2026 (<https://www.enlyte.com/insights/news-release/utilization-management/california-utilization-review-regulation-updates-effective-2026>). These updates may help reduce delays in authorizing your treatment.

Part 7: Challenging the MPN's Validity or Compliance

This section explains the legal grounds you can use to argue the MPN should not restrict your choice of doctor.

Grounds for Challenging an MPN

You may challenge the validity or compliance of an MPN if you can show it fails to meet legal requirements. Common grounds include:

- Failure to provide proper notice: The MPN must give you written notice explaining the network, how to access it, and your rights within it. If you never received this notice, the MPN may not be valid against you. See Cal. Code Regs. tit. 8, § 9767.12 (https://www.dir.ca.gov/t8/9767_12.html) and What Makes an MPN Invalid or Noncompliant (<https://employeesfirstlaborlaw.com/what-makes-a-medical-provider-network-mpn-invalid-or-noncompliant/>).
- Not enough doctors: The MPN must have at least three available physicians in each needed specialty. See Cal. Code Regs. tit. 8, § 9767.5 (https://www.dir.ca.gov/t8/9767_5.html).
- Access standard violations: The MPN must meet the distance and travel time requirements described in Part 2.
- Scheduling failures: The MPN must meet the appointment timing requirements (3 business days for first visit; 20 business days for specialists).
- Missing required policies: The MPN must maintain written policies for second and third opinions, continuity of care, dispute resolution, and out-of-network care.
- Improper approval: The MPN's approval may have been based on incomplete or false information, or the approval may have expired.

Burden of Proof at the WCAB

If you petition the Workers' Compensation Appeals Board (WCAB) — the court that decides workers' compensation disputes — to treat outside the MPN, the burden of proof depends on the specific issue. A 2023 WCAB panel decision clarified the following allocation. See Panel Decision Clarifies Burdens of Proof in MPN Disputes (<https://calawyers.org/workers-compensation/panel-decision-clarifies-burdens-of-proof-in-mpn-disputes/>):

- The employer must prove that you were properly notified of your right to pre-designate a personal physician.
- You must prove that your pre-designated physician would have accepted pre-designation.
- You must prove that the employer actually refused or neglected to provide medical care, with specific documentation such as denied authorization requests — not just your belief that treatment should have been provided.

Part 8: Filing Complaints with the Division of Workers' Compensation

This section explains how to file a formal complaint if the MPN is violating the law.

Step-by-Step Complaint Process

Under Cal. Code Regs. tit. 8, § 9767.16 (https://www.dir.ca.gov/t8/9767_16.html), you can file a complaint if you believe the MPN is not following the rules. The process has two stages:

Stage 1 — Complaint to the MPN Contact:

1. Send a written complaint to the MPN Contact (the person or office designated by the MPN to handle complaints).
2. Your complaint must include: the specific law or regulation being violated, when the violation happened, whether it is still happening, what you have already done to address it, how it has affected you, and what remedy you are seeking.
3. The MPN has 30 calendar days to respond in writing — either fixing the problem or disputing your complaint.

Stage 2 — Complaint to the DWC:

1. If the MPN does not fix the problem within 30 days or disputes your complaint, file a written complaint with the DWC using the DWC Medical Provider Network Complaint Form (https://www.dir.ca.gov/dwc/DWC_FilingAComplaint.htm).
2. Send a copy of the complaint form to the MPN Contact.
3. The Administrative Director will investigate if there is credible evidence of a violation.

Critical: If you face an immediate and serious threat to your health — including potential loss of life, limb, or major bodily function — you may file directly with the DWC without waiting 30 days for the MPN to respond.

Penalties for MPN Violations

The DWC can assess administrative penalties against non-compliant MPNs ranging from \$250 to \$5,000 or more per violation, depending on the nature and persistence of the problem. See Cal. Code Regs. tit. 8, § 9767.19 (https://www.dir.ca.gov/t8/9767_19.html). The DWC can also suspend or revoke an MPN's approval.

Part 9: Your Primary Treating Physician — Role, Rights, and Limitations

This section explains the role of the PTP and the rules about changing doctors within the MPN.

Who Is the Primary Treating Physician?

Your Primary Treating Physician (PTP) is the doctor mainly responsible for managing your work-injury care. The PTP must have examined you at least once and must monitor the effects of treatment. This role is defined in Cal. Code Regs. tit. 8, § 9785 (<https://www.dir.ca.gov/t8/9785.html>).

Key rules about your PTP:

- You may have only one PTP at a time.
- For injuries on or after January 1, 2004, a chiropractor cannot be your PTP after 24 visits unless the employer authorizes more in writing.
- The PTP makes important medical determinations about your care, including the scope of treatment, when you are released from care, and when you have reached permanent and stationary status (meaning your condition is stable and unlikely to change significantly in the next year).

Changing Doctors Within the MPN

Under Cal. Code Regs. tit. 8, § 9767.6 (https://www.dir.ca.gov/t8/9767_6.html), after your first visit with an MPN doctor, you can switch to another doctor within the MPN at any time. There is no limit on how many times you can change doctors within the MPN. You choose based on the doctor's specialty or expertise in treating your specific injury.

Important: You do not file a petition to change doctors within the MPN. You simply select a new doctor from the MPN list. The formal "Petition for Change of Treating Physician" process under Cal. Code Regs. tit. 8, § 9781 (<https://www.dir.ca.gov/t8/9781.html>) does not apply to employees already treating within an MPN.

Part 10: Your Strategic Options — Summary and Action Steps

This section summarizes your options and provides practical steps to protect your rights.

Summary of Options

Option	Strength	Risk Level
Pre-designation (if done before injury)	Very strong if documented	Low if evidence exists; high if not
Continuity of care (for qualifying conditions)	Strong if condition qualifies	Medium — strict 20-day deadline
Challenge MPN access standards	Moderate	High — heavy burden of proof
File DWC complaint	Low risk, may pressure MPN	Moderate — slow process
Second/third opinions and MPN IMR	Moderate	Medium — depends on MPN doctors
Petition WCAB for out-of-network treatment	Direct remedy	High — requires strong evidence

Practical Steps to Take Now

1. Check for pre-designation. Look for any written documents naming your personal doctor that you gave to your employer before your injury. This is your strongest protection.
2. Assess your medical condition. Determine whether your condition qualifies as acute, serious chronic, terminal, or involves scheduled surgery. If yes, immediately request a written report from your PTP confirming this within the 20-day deadline.
3. Document MPN access problems. Record every failed attempt to get an appointment, the distance to available doctors, and any delays in scheduling. Keep written records with dates and names.
4. File a complaint if the MPN is violating the rules. Send a written complaint to the MPN Contact first, then to the DWC after 30 days if the problem is not fixed.
5. Use the second and third opinion process. Request additional opinions from MPN specialists. If they support your treatment needs, pursue MPN IMR for potential authorization to treat outside the network.
6. File with the WCAB if necessary. If other steps fail, file an Application for Adjudication of Claim with the WCAB seeking the right to treat outside the MPN. Include all evidence gathered in earlier steps.

Protection Against Retaliation

Your employer cannot fire, threaten, or punish you for filing a workers' compensation claim or asserting your rights under workers' compensation law. This protection comes from Cal. Lab. Code § 132a (<https://www.nourmandlawfirm.com/practice-areas/class-action-lawsuits/california-labor-code-section-132a/>). See also *Laws That Prohibit Retaliation and Discrimination* (<https://www.dir.ca.gov/dlse/howtofilelinkcodesections.htm>).

Legal Help and Attorney Fees

Workers' compensation attorneys in California typically work on a contingency fee basis — meaning you pay nothing upfront and the attorney receives a percentage (usually 10–15%) of benefits recovered, subject to approval by the workers' compensation judge. See *Workers' Comp Attorney Fees Explained* (<https://visionarylawgroup.com/how-much-does-a-workers-comp-attorney-charge/>) and *How Much Do Workers Comp Lawyers Charge in California* (<https://scherandbassett.com/how-much-do-workers-comp-lawyers-charge-in-california/>).

Free legal resources include:

- Legal Aid At Work (<https://legallaidatwork.org>) — Free legal services for low-income workers.
- Free Legal Help — State Bar of California (<https://www.calbar.ca.gov/public/legal-resources/free-legal-help>) — Directory of free and low-cost legal services.
- DWC Information and Assistance Unit (<https://www.dir.ca.gov/dwc/contactdwc.htm>) — Free guidance from the state agency (not attorney representation).

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36. Free Legal Help — State Bar of California (<https://www.calbar.ca.gov/public/legal-resources/free-legal-help>)
37. DWC Information and Assistance Unit / Contact DWC (<https://www.dir.ca.gov/dwc/contactdwc.htm>)
38. Navigating Labor Code 4062.3 for Medical Evaluators — RJY Law (<https://www.rjylaw.com/navigating-labor-code-4062-3-a-defense-attorneys-guide-to-fair-medical-evaluations-in-workers-compensation-cases/>)
39. Reasonable Geographic Area in Work Comp — Judge O'Brien (https://judgeobrien.com/index.php?option=com_content&view=article&id=1184&Itemid=573)
40. Navigating California's Workers' Compensation Exclusivity Rule — WSHB Law (<https://www.wshblaw.com/publication-navigating-californias-workers-compensation-exclusivity-rule-in-civil-litigation-and-settlement-strategy>)

California Workers' Compensation: Primary Treating Physician Rights When Not Included in Medical Provider Network

(PART-B LEGAL ANALYSIS)

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California Workers' Compensation: Primary Treating Physician Rights When Not Included in Medical Provider Network

Executive Summary

When an injured worker's Primary Treating Physician (PTP) is not included in an employer's Medical Provider Network (MPN), the legal situation depends on timing, circumstances, and compliance with California statutory requirements. In most cases, once an MPN is properly approved and implemented, injured workers are restricted to receiving treatment within that network for the duration of their claim[2]. However, several statutory exceptions and regulatory pathways allow injured workers to continue treatment with non-MPN providers under specific circumstances. This report analyzes the controlling legal framework, procedural requirements for challenging MPN restrictions, the conditions under which out-of-network treatment may be authorized, and the strategic options available to workers whose treating physicians fall outside approved network boundaries. The analysis encompasses California Labor Code sections governing MPNs, applicable regulatory standards, recent WCAB precedent clarifying access requirements, and practical remedies including complaints to the Division of Workers' Compensation and petitions to challenge MPN validity.

Key Findings: Injured workers are not automatically entitled to continue with a non-MPN physician simply because that physician was their treating provider before an MPN took effect. However, California law provides multiple protective mechanisms: continuity of care provisions allowing temporary extensions for certain medical conditions, pre-designation protections for physicians designated before injury, transfer-of-care procedures with medical dispute resolution, and grounds for challenging the MPN itself if it fails to meet access standards or was improperly noticed. The burden of proving MPN noncompliance rests with the injured worker, but the DWC has administrative authority to suspend or revoke MPNs that violate statutory requirements.

Client Risk Assessment: Medium to High, depending on whether the injured worker (a) has a valid pre-designation, (b) meets continuity-of-care exceptions, (c) can demonstrate MPN access violations, or (d) must rely on challenging the MPN's validity or adequacy. The strongest position exists when the injured worker can show the MPN was not properly noticed or fails to provide adequate access to appropriate specialists.

Primary Strategic Options: (1) Assert continuity-of-care protections if the injury is acute or the worker has a serious chronic condition or terminal illness; (2) establish a valid pre-designation if done before the MPN became effective; (3) challenge the MPN's compliance with access standards under California Code of Regulations Section 9767.5; (4) file a complaint with the DWC alleging MPN violations; (5) request a second or third opinion within the MPN and follow the Independent Medical Review (IMR) process if disputes exist; (6) petition the Workers' Compensation Appeals Board if the claims administrator improperly denies out-of-network care or the MPN is found invalid.

Qualitative Assessment of Likelihood of Success: Low to Medium overall, but varies significantly by circumstance. Success depends heavily on whether the worker meets specific statutory exceptions (continuity of care, pre-designation, access standards violations) or can demonstrate procedural defects in MPN approval or notice.

Timeline Considerations: Critical deadlines include the 20-day window for the PTP to respond to continuity-of-care dispute notices, the 30-day period for filing an MPN complaint with the MPN Contact before escalating to the DWC, and the statute of limitations for workers' compensation claims generally. If the MPN was recently implemented, workers should act promptly to challenge its validity before the claim progresses further.

California Labor Code Framework Governing Medical Provider Networks and Physician Selection

Statutory Foundation for Medical Provider Networks

California Labor Code Section 4616 establishes the foundational authority for employers and insurers to establish and operate Medical Provider Networks[3]. Under this statute, every employer or insurer that uses an MPN must file a complete MPN plan with the Administrative Director of the Division of Workers' Compensation for approval[3]. The statute is categorical: "No MPN shall be used without prior approval by the Administrative Director"[3]. This requirement creates the first critical checkpoint for injured workers

seeking to challenge an MPN-if the MPN was never properly approved, it cannot legally restrict the worker's choice of physician.

The statutory structure of Labor Code Section 4616 requires that the MPN plan include adequate numbers and types of physicians based on the occupational injuries expected in the industry and the geographic areas where employees are located[2]. The statute mandates compliance with specific access standards, continuity of care policies, notice requirements to employees, and dispute resolution procedures[2]. When an MPN meets all statutory requirements and receives proper approval from the Administrative Director, it becomes the controlling framework for medical treatment for all injured employees of that employer, with limited exceptions[2].

The scope of the MPN's control is substantial. California Labor Code Section 4616(a)(1) provides that the injured worker must be treated within the MPN unless the worker properly objects or an exception applies[2]. This language creates a default rule requiring in-network treatment unless the worker affirmatively demonstrates that an exception exists. The burden to prove an exception-whether based on access standards, pre-designation, or other grounds-typically rests with the injured worker or their attorney[43].

Right to Medical Treatment Under Labor Code Section 4600

California Labor Code Section 4600 establishes the foundational right to medical treatment for work injuries[44]. The statute requires that "medical, surgical, chiropractic, acupuncture, and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches, and apparatuses" that is "reasonably required to cure or relieve the injured worker from the effects of their injury shall be provided by the employer"[44]. This broad language appears to guarantee access to necessary treatment without geographic or network restrictions. However, when read in conjunction with Section 4616, the courts have interpreted this right as subject to MPN restrictions once an approved MPN is implemented[2].

The interaction between Sections 4600 and 4616 creates a hierarchy: Section 4600 establishes the entitlement to treatment, while Section 4616 defines the mechanism through which employers may structure that treatment via approved networks[2]. When properly implemented, an MPN does not violate Section 4600; rather, it provides a structured method of delivering the required treatment through approved providers[2].

However, Section 4600 retains importance as a baseline requirement. If an MPN fails to provide treatment that meets the "reasonably required" standard, the MPN's restrictions may be challenged as failing to satisfy the worker's underlying right to adequate treatment. This is particularly relevant when the injured worker's condition requires specialist care that the MPN cannot provide locally within the mandated access standards.

Medical Provider Network Approval and Implementation Process

The administrative process for MPN approval is governed by California Code of Regulations Title 8, Section 9767.2[69]. The Administrative Director has 60 days from receipt of a complete application to approve or disapprove the MPN[69]. Critically, if the Administrative Director does not act within this 60-day period, the MPN is deemed approved on the 61st day for a four-year period[69]. This "deemed approval" mechanism is important because it means an MPN can become binding even without explicit written approval if the Administrative Director fails to act timely.

Once approved, the MPN applicant must assign a unique approval number, and this number must be included in all correspondence with the DWC regarding the MPN[69]. For injured workers challenging the validity of an MPN, verifying that the MPN has a valid approval number and checking the DWC's publicly maintained list of approved MPNs is an essential first step.

Access Standards and Geographic Requirements for Medical Provider Networks

Mandatory Access Standards Under Regulation 9767.5

The access standards for medical provider networks are specified in California Code of Regulations Title 8, Section 9767.5[2][2]. These standards establish minimum requirements that every MPN must satisfy. The regulation requires that an MPN have "at least three available physicians of each specialty to treat common injuries experienced by injured employees based on the type of occupation or industry in which the employee is engaged and within the access standards set forth"[2][2].

The access standards themselves are tiered by provider type. For primary treating physicians, the MPN must provide "at least three available primary treating physicians and a hospital for emergency health care services, or if separate from such hospital, a provider of all emergency health care services, within 30 minutes or 15 miles of each covered employee's residence or workplace"[2][2]. This is the most stringent standard, requiring geographic proximity that can be measured either by travel time (30 minutes) or distance (15 miles).

For specialists and occupational health service providers, the standard is more lenient: "providers of occupational health services and specialists who can treat common injuries experienced by the covered injured employees within 60 minutes or 30 miles of a covered employee's residence or workplace"[2][2]. This distinction means an injured worker seeking specialist care is not required to prove the existence of three specialists within 15 miles, but only within 30 miles or 60 minutes travel time.

Importantly, if an injured worker cannot obtain "reasonable and necessary medical treatment within the applicable access standards" and within the required timeframes, "the MPN shall have a written policy permitting the covered employee to obtain necessary treatment for that injury from an appropriate specialist outside the MPN within a reasonable geographic area"[2]. This statutory safeguard means that access standard violations are not theoretical—they provide a concrete basis for permitting out-of-network treatment when the MPN cannot deliver.

Timing Requirements for Medical Appointments

The regulation specifies that for non-emergency services, the MPN applicant must ensure that an appointment for the first treatment visit is available within 3 business days of a covered employee's notice to an MPN medical access assistant that treatment is needed[2]. For specialist services, the standard is more generous: the MPN must ensure that an initial appointment with a specialist in an appropriate referred specialty is available within 20 business days of the covered employee's reasonable request[2].

However, there is a critical fail-safe: "If an MPN medical access assistant is unable to schedule a timely medical appointment with an appropriate specialist within ten business days of an employee's request, the employer shall permit the employee to obtain necessary treatment with an appropriate specialist outside of the MPN"[2]. This provision means that delays in scheduling specialist appointments can, by themselves, entitle a worker to seek out-of-network care.

Continuity of Care: Treatment for Workers Previously Receiving Non-MPN Care

Statutory Framework for Continuity of Care

California Labor Code Section 4616.2 establishes continuity of care protections that allow injured workers in certain circumstances to continue treatment with a provider who is not part of the MPN[12][12]. This statute applies when an MPN is newly implemented or when a provider's contract with the MPN is terminated. The key provision states that completion of treatment shall be provided by a non-MPN provider (or a terminated provider) if the injured worker meets one of four specified conditions[12][12].

The four conditions allowing continuity of care are: (1) an acute condition, defined as having a duration of less than 90 days; (2) a serious chronic condition, defined as a medical condition due to disease, illness, or medical problem or medical disorder that is expected to require ongoing treatment for at least 90 days; (3) a terminal illness, defined as an incurable or irreversible condition that has a high probability of causing death within one year or less; or (4) performance of a surgery or other procedure that is authorized by the insurer or employer as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days[12][12].

Importantly, if the injured worker's condition meets one of these four categories, the employer must authorize continuation of treatment with the non-MPN provider[12][12]. The period of continuation is defined as "a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the employer or its claims administrator in consultation with the injured employee and the terminated provider and consistent with good professional practice," but this period does not exceed 12 months from the date of notification[12][12].

Procedural Requirements for Continuity of Care Disputes

When an employer or insurer determines that an injured worker's condition does not meet the continuity of care criteria, it must follow a specific procedure. The employer must notify the covered employee of the determination regarding completion of treatment and whether the employee will be required to select a new provider from within the MPN[8]. The notification must be sent to the covered employee's address with a copy to the covered employee's primary treating physician, and the notification must be written in both English and Spanish and use layperson's terms to the maximum extent possible[8].

If the terminated provider agrees to continue treating the injured covered employee and the employee disputes the medical determination, the employee may request a report from the covered employee's primary treating physician addressing whether the covered employee falls within the continuity of care conditions[8]. Critically, the treating physician must provide this report within 20 calendar days of the request[8]. If the treating physician fails to issue the report within this 20-day period, the employer's determination applies-the worker loses the ability to dispute the transfer and must select a new in-MPN provider[8].

If the employer or insurer objects to the medical determination by the treating physician, the dispute is resolved pursuant to Labor Code Section 4062[8]. This means either party can pursue the established procedures for resolving medical disputes, including obtaining a Qualified Medical Evaluator (QME) determination if the injured worker is represented or has not yet had a QME evaluation[8].

Pre-Designation: Protection for Workers with Prior Personal Physicians

Requirements for Valid Pre-Designation

Under California Labor Code Section 4600(d), an injured employee who properly pre-designates a personal physician prior to an industrial injury can treat with that physician despite an employer's otherwise properly established MPN[9]. To qualify for pre-designation, specific requirements must be met[22]:

First, the notice of pre-designation must be in writing and must be provided to the employer prior to the industrial injury[22]. The notice must include the personal physician's name and business address and the name of the plan, policy, or fund providing the employee with health care coverage for non-occupational injuries or illnesses[22]. California Code of Regulations Section 9780.1(a) and the optional DWC Form 9783 (pre-designation form) can facilitate compliance with this requirement.

Second, the employee must have health care coverage for non-occupational injuries or illnesses on the date of injury in a plan, policy, or fund as described in Labor Code Section 4616.7[22]. The statute specifically includes plans, policies, or funds providing coverage to employees or their dependents for medical treatment of non-occupational injuries or illnesses, including health insurance plans, health maintenance organization plans, and other similar arrangements[22].

Third, the employee's personal physician must agree to be pre-designated prior to the injury[22]. The personal physician may sign the optional pre-designation form or provide other documentation that the physician agrees to be pre-designated[22]. If the personal physician does not sign the pre-designation form, there must be other documentation that the physician agrees to be pre-designated[22].

Significantly, the employee's pre-designation remains valid even when the employer implements an MPN[22]. The regulation explicitly states: "Where an employer or an employer's insurer has a Medical Provider Network pursuant to section 4616 of the Labor Code, an employee's predesignation which has been made in accordance with this section shall be valid and the employee shall not be subject to the MPN"[22]. This means pre-designation is one of the few absolute protections against MPN restrictions.

Practical Limitations and Evidentiary Requirements

While pre-designation provides strong protection, injured workers seeking to rely on pre-designation face evidentiary challenges. In the workers' compensation appeals process, the worker typically bears the burden of proving that the pre-designation meets all statutory requirements[43]. This means the worker must provide evidence showing: (1) written notice was given to the employer before the injury, (2) the employee had qualifying health insurance at the time of injury, and (3) the designated physician agreed in writing to treat the worker for industrial injuries.

In a recent WCAB decision addressing pre-designation, the court held that even if the employer failed to provide required pre-designation notices to employees, the worker still bore the burden of proving that the

designated physicians would have accepted pre-designation[43]. This places the evidentiary load on the worker despite the employer's potential failure to comply with notice requirements.

Challenging Medical Provider Network Validity and Compliance

Grounds for Challenging MPN Validity

An injured worker may challenge the validity of an MPN by demonstrating that the MPN fails to meet statutory or regulatory requirements. The grounds for such challenges include but are not limited to:

Failure to Provide Proper Notice: The MPN must provide written notice to every affected injured covered employee explaining the MPN, how to access it, rights within it, and the availability of second and third opinions[40]. If this notice was not provided before or immediately after the injury, the MPN's validity may be compromised[18].

Inadequate Number of Physicians: The MPN must maintain at least three available physicians of each specialty necessary to treat common injuries in the employee's industry[2][2]. If the injured worker can document that the MPN does not have three available physicians (not just listed physicians, but those actually willing to accept new patients) in the relevant specialty, the MPN may fail this requirement[6][6].

Access Standard Violations: If the MPN cannot provide access to primary treating physicians within 30 minutes or 15 miles of the employee's residence or workplace, or specialists within 60 minutes or 30 miles, the access standards are violated[2][2]. This requires specific factual evidence about travel times and distances[42].

Failure to Meet Appointment Scheduling Requirements: If the MPN cannot schedule a first appointment within 3 business days (or specialist appointments within 20 business days, with an automatic exception at 10 business days), these timing violations may support a challenge[2].

Absence of Required Policies: The MPN must maintain written policies for second and third opinions, continuity of care, dispute resolution, and out-of-network care when access standards are not met[2]. If these policies are absent or inadequate, the MPN fails to comply[2].

Improper Approval Process: If the Administrative Director's approval was obtained through misrepresentation, the application was incomplete, or the approval exceeded its four-year term, the MPN's authority may be revoked[69].

Procedure for Challenging MPN Validity Before the WCAB

If an injured worker believes the MPN is invalid or non-compliant, the worker may petition the Workers' Compensation Appeals Board for a determination that the worker is entitled to treat outside the MPN[43]. The burden of proof on this issue depends on the specific challenge. Generally, if the worker claims the employer refused or neglected to provide necessary care, the worker bears the burden of proving the refusal or neglect[43].

A 2023 WCAB decision addressed the allocation of burdens in MPN disputes[43]. The court held that: (1) the employer bears the burden of proving that the worker was properly notified of the right to pre-designate; (2) the worker bears the burden of proving that pre-designated physicians would have accepted pre-designation; and (3) the worker bears the burden of proving that the employer unlawfully refused or neglected to provide medical care[43]. Importantly, the court found that "failure to provide care" requires specific evidence-not merely the worker's belief that the treatment should be provided, but documentation of actual denials or neglect (such as failed authorization requests)[43].

Second and Third Opinions Within the Medical Provider Network

Statutory Right to Second and Third Opinions

Even within an MPN, if an injured worker disputes either the diagnosis or the treatment prescribed by the treating physician, the worker has a statutory right to obtain second and third opinions from other MPN physicians[21][23]. This process is governed by Labor Code Section 4616.3 and California Code of Regulations Section 9767.7.

The process requires that the employee inform the claims administrator (or the person designated by the employer or insurer) of the dispute and request a second opinion[21]. The employee may notify verbally or in writing[21]. The employer or insurer must then provide at least a "regional area listing" of MPN providers or specialists to the employee for selection based on the specialty or recognized expertise in treating the particular injury or condition[21].

Once the employee selects a second opinion physician, the employee must make an appointment within 60 days[21]. If the appointment is not made within 60 days of receiving the provider list, the employee is deemed to have waived the second opinion process[21]. The employer or insurer must then notify the second opinion physician in writing that he or she has been selected to provide a second opinion and must provide the nature of the dispute[21].

The second opinion physician must render an opinion in writing and may offer alternative diagnosis or treatment recommendations[21]. The second opinion physician may order diagnostic testing if medically necessary[21]. A copy of the written report must be served on the employee, the person designated by the employer or insurer, and the treating physician within 20 days of the appointment or receipt of test results, whichever is later[21].

If the injured covered employee disagrees with the diagnosis or treatment of the second opinion physician, the employee may seek the opinion of a third physician within the MPN using the identical process[21]. If the employee disagrees with the diagnosis or treatment of the third opinion physician, the employee may file with the Administrative Director a request for an MPN independent medical review[21].

Strategic Use of Second and Third Opinions

The second and third opinion process can be strategically valuable even when the underlying treating physician is not technically "in" the MPN. If a worker's pre-injury physician is in the MPN (or if the worker has otherwise been allowed to continue with a non-MPN provider), the worker can use the second and third opinion process to obtain additional MPN physician opinions, and if those physicians agree with the treating provider's recommendations, the employer becomes obligated to fund the agreed-upon treatment[23].

Recent WCAB precedent has confirmed that the second opinion process under Labor Code Section 4616.3 is distinct from the utilization review (UR) process and does not require that UR first deny the treatment[23]. An injured worker can invoke the second opinion right directly, without needing the employer's approval first[23]. This is important because it means a worker can obtain a second MPN physician's evaluation even if the initial employer decision is to restrict care to the MPN.

Independent Medical Review for Disputed Treatment

MPN Independent Medical Review Process

After obtaining second and third opinions within the MPN, if the treatment or diagnostic service remains disputed, the injured employee may request an MPN independent medical review regarding the disputed treatment[7]. This process is governed by Labor Code Section 4616.4 and California Code of Regulations Section 9767.8 and related sections.

The Administrative Director contracts with individual physicians or independent medical review organizations to perform MPN IMRs[7]. The physicians selected must be licensed in California and meet specific qualifications, including appropriate credentialing, current specialty board certification, and a history free of disciplinary action[7].

An application for MPN IMR must be submitted to the Administrative Director on the prescribed form and must include a signed release from the injured employee authorizing the release of medical and treatment information[7]. Following receipt of the application, the employer or insurer must provide the MPN independent medical reviewer with all information that was considered in relation to the disputed treatment[7]. This includes copies of all correspondence from and received by treating physicians[7].

The MPN independent medical reviewer may conduct a physical examination of the injured employee at the employee's discretion and may order diagnostic tests if necessary[7]. The reviewer must utilize the Medical Treatment Utilization Schedule established pursuant to Labor Code Section 5307.27 and determine whether

the disputed health care service is consistent with the MTUS based on the specific medical needs of the injured employee[7].

Critically, if the MPN IMR determination finds that the disputed treatment is consistent with the MTUS, the injured employee may seek the disputed treatment from a physician of his or her choice from within or outside the medical provider network[7]. Treatment outside the MPN is then provided consistent with the MTUS, and the employer becomes liable for the cost[7].

Utilization Review and Independent Medical Review for Non-MPN Treatment Denials

Parallel UR and IMR Processes

Separate from the MPN-specific IMR process, California Labor Code Section 4610 requires all employers to establish a utilization review process for evaluating whether medical treatment is medically necessary[11]. UR decisions can modify, delay, or deny treatment requests based on medical necessity[11]. Only licensed physicians can make decisions to modify, delay, or deny treatment requests for medical necessity[11].

If a UR decision denies or modifies medical treatment, an injured worker can appeal through independent medical review under Labor Code Section 4610.5[11]. This IMR process applies to any UR decision denying or modifying treatment, regardless of whether the treatment involves an MPN or non-MPN provider[11]. Recent 2026 regulatory changes have updated the UR standards and timelines, including new deadlines for IMR requests and requirements for URAC accreditation of UR organizations[37].

Complaints to the Division of Workers' Compensation

Filing MPN Complaints

If an injured worker believes the MPN is not complying with statutory requirements, the worker can file a complaint with the DWC against the MPN[15][27]. The complaint process is governed by California Code of Regulations Section 9767.16 and related sections.

A worker contending that an MPN is in violation of statutory or regulatory requirements can submit a written complaint directly to the MPN Contact[15]. The written complaint must provide an explanation with sufficient detail of the MPN's alleged violation, including: (1) citation of the specific statutory or regulatory provision violated; (2) when the alleged violation occurred; (3) whether the alleged violation is still occurring; (4) what attempts the complainant has made with the MPN to address the violation; (5) what impact the violation has had on an injured worker; and (6) what remedy is sought[15].

The MPN applicant has 30 calendar days from receipt of the complaint to respond in writing to the complainant[15]. The response must either take reasonable actions to remedy the violation (and state any additional actions if more than 30 days are needed) or verify in writing that the MPN is disputing the complaint and denying there is a violation[15].

If the MPN applicant has not remedied the violation or taken reasonable action within 30 calendar days, or if the MPN confirms it is disputing the complaint, the complainant may file a written complaint with the Division of Workers' Compensation against the MPN[15]. If the complainant can show imminent and serious threat to the health of an injured worker, including potential loss of life, limb, or other major bodily function, the complainant may file with the DWC even before the initial 30-day period expires[15].

The written complaint filed with the DWC must be made on the DWC Medical Provider Network Complaint Form and must provide written details of the MPN's violation along with documentary evidence that the MPN has been notified according to the procedure[15]. A copy of the complaint form must be served on the MPN Contact[15].

Administrative Investigation and Penalties

The Administrative Director has discretion to limit investigations to complaints that provide credible evidence that a violation exists[15]. If the investigation confirms a violation, the Administrative Director notifies the MPN's authorized individual and MPN Contact in writing of the specific violation found[15]. The Administrative Director then follows procedures set forth in related regulations regarding remediation, penalties, and potential suspension or revocation[15].

The DWC has authority to assess administrative penalties against MPNs that violate statutory or regulatory requirements[66]. These penalties range from \$250 to \$2,500 per violation or type of violation, with potential escalation to \$5,000 or higher depending on the nature and persistence of the violation[66]. Importantly, MPNs are not exempted from penalties even when they make good-faith efforts to comply-strict compliance is the standard.

Transfer of Ongoing Care from Non-MPN to MPN Providers

Statutory Framework for Transfer of Care

When an MPN is newly implemented and an injured worker has been receiving treatment from a non-MPN provider, the worker may be transferred into the MPN for ongoing care under Labor Code Section 4616.2(d) and California Code of Regulations Section 9767.9[51]. However, the transfer is not automatic; it requires compliance with specific procedures and may not occur if the worker's condition meets continuity of care criteria.

The employer or insurer may transfer the covered employee's medical care to the MPN only if the employee's condition does not meet one of four specified criteria[51]. These are identical to the continuity of care criteria: (1) an acute condition with duration less than 90 days; (2) a serious chronic condition requiring ongoing treatment for at least 90 days; (3) a terminal illness with high probability of death within one year or less; or (4) performance of a surgery or procedure authorized as part of a documented course of treatment and recommended to occur within 180 days[51].

Procedural Requirements for Transfer of Care Disputes

Before transferring an injured covered employee's care into the MPN, the employer or insurer must notify the covered employee of the determination regarding completion of treatment and the decision to transfer care[51]. The notification must be sent to the covered employee's address with a copy to the primary treating physician, and must be written in English and Spanish in layperson's terms[51].

If the injured worker disputes the medical determination that the worker's condition does not meet continuity of care criteria, the worker may request a report from the covered employee's primary treating physician addressing whether the worker falls within any of the four conditions[51]. The treating physician has 20 calendar days to provide this report[51]. If the treating physician fails to issue the report, the employer's determination applies and the transfer goes forward[51].

If the employer or insurer objects to the medical determination by the treating physician, the dispute is resolved pursuant to Labor Code Section 4062[51]. If the treating physician does not agree with the employer's determination that the condition does not meet continuity of care criteria, the transfer shall not go forward until the dispute is resolved[51].

Primary Treating Physician Selection and Change Procedures Within MPN

Initial Selection and Right to Change

Once an MPN is in place, the employer or insurer must authorize treatment within the MPN for alleged injuries and must continue providing treatment until the claim is rejected[17]. The employer or insurer must notify the employee of the right to be treated by a physician of his or her choice within the MPN after the first visit with the MPN physician[17]. The employer must provide the method by which the list of participating providers may be accessed[17].

At any point after the initial medical evaluation with an MPN physician, the covered employee may select a physician of his or her choice from within the MPN[17]. Selection must be based on the physician's specialty or recognized expertise in treating the particular injury or condition[17]. There are no restrictions on how many times an injured worker may change physicians within the MPN; each change is a new exercise of the statutory right[17].

If a chiropractor is selected as a treating physician, the chiropractor may act as treating physician only until the 24-visit cap is met (for injuries on or after January 1, 2004) unless the employer or insurer authorizes additional visits in writing[17]. If the employee fails to select another non-chiropractic treating physician after the 24-visit cap, the insurer or employer may assign another treating physician[17].

Importantly, the Petition for Change of Treating Physician procedure outlined in Labor Code Section 4603 and California Code of Regulations Section 9786 cannot be used to seek a change of physician for a covered employee who is already treating with a physician within the MPN[17]. This means the only mechanism for an MPN employee to change physicians is the self-help right to select another MPN provider directly-no petition to the Administrative Director is required.

Reporting Duties and Medical Determinations by Primary Treating Physician

Statutory Definition and Scope of Primary Treating Physician

The Primary Treating Physician is defined as the physician who is primarily responsible for managing the care of an employee and who has examined the employee at least once for the purpose of rendering or prescribing treatment and has monitored the effect of treatment thereafter[5][5]. The PTP is the physician selected by the employer, the employee, or under the MPN procedures[5][5].

For injuries on or after January 1, 2004, a chiropractor cannot be a PTP after the employee has received 24 chiropractic visits unless the employer authorizes additional visits in writing[5][5]. This prohibition does not apply to postsurgical physical medicine prescribed by the employee's surgeon or physician designated by the surgeon[5][5].

An employee may have no more than one PTP at any given time[5][5]. However, the employee may designate a new PTP of his or her choice if the current PTP has determined that there is a need for continuing medical treatment or future medical treatment[5][5]. The employee may designate a new PTP to render future medical treatment either before treatment becomes necessary or at the time such treatment becomes necessary[5][5].

Medical Determinations and Dispute Resolution

The "Primary Treating Physician" makes "medical determinations"-decisions regarding any and all medical issues necessary to determine the employee's eligibility for compensation[5][5]. Medical determinations include the scope and extent of continuing medical treatment, whether to release the employee from care, when the employee has reached permanent and stationary status, and the necessity for future medical treatment[5][5].

If the employee disputes a medical determination made by the PTP, including a determination that the employee should be released from care, the dispute is resolved under applicable procedures set forth in Labor Code sections 4060, 4061, 4062, 4600.5, 4616.3, or 4616.4[5][5]. If the employee objects to a decision made to modify, delay, or deny a treatment recommendation, the dispute is resolved by independent medical review under Labor Code Section 4610.5, or otherwise pursuant to Labor Code Section 4062[5][5].

Permanency and Stationary Status

When the PTP determines that the employee's condition is permanent and stationary-meaning the employee has reached maximal medical improvement and the condition is well stabilized and unlikely to change substantially in the next year with or without medical treatment-the PTP has special reporting obligations[5][5]. The PTP must report to the claims administrator within 20 days of the determination concerning the existence and extent of permanent impairment[5].

Significantly, if the PTP releases the employee from care (making a determination that the employee's condition has reached permanent and stationary status with no need for continuing or future medical treatment), the employee generally cannot designate a new PTP merely because future medical care might be warranted[48]. Instead, the employee must dispute the release from care through the QME or AME process under Labor Code Sections 4061 and 4062[48].

Northern California-Specific Procedural Considerations

San Francisco Immigration Court and EOIR Context Note

The user's system prompt references Northern California immigration law practice, but this research brief addresses workers' compensation law, which is distinct. However, to the extent immigrant workers in Northern California are injured at work, the workers' compensation protections detailed herein apply equally regardless of immigration status. An injured worker need not have lawful immigration status to pursue workers' compensation benefits in California[49].

Division of Workers' Compensation Regional Offices

The Division of Workers' Compensation operates multiple regional offices throughout Northern California where injured workers can file complaints, seek information and assistance, and obtain administrative review of MPN-related disputes[61][64]. The DWC Information and Assistance Unit provides free guidance on workers' compensation rights, including MPN issues[61].

For Northern California workers, the relevant administrative bodies include the Workers' Compensation Appeals Board (WCAB), which has multiple judges and panels throughout the region. WCAB decisions from recent years (2024-2025) have clarified MPN access standards and the burden of proof for workers seeking to challenge MPN restrictions[26][43][48].

Strategic Options and Risk Assessment

Option 1: Assert Pre-Designation if Validly Executed Before Injury

Strengths: If the injured worker can produce evidence of a valid pre-designation executed before the injury and before the MPN was implemented, this provides absolute protection against MPN restrictions. The worker has a clear statutory right to continue with the pre-designated physician. The burden shifts to the employer to disprove the pre-designation's validity.

Weaknesses: Pre-designation requires strict compliance with statutory requirements-written notice before the injury, qualifying health insurance at time of injury, and the physician's agreement. Many injured workers fail to maintain documentation of pre-designation, making it difficult to prove at hearing. Even if the employer failed to provide required pre-designation notices, recent WCAB decisions suggest the worker must still prove the physician would have agreed to the pre-designation.

Risk Level: Low if evidence of valid pre-designation exists; High if relying solely on memory or oral statements without written documentation.

Likelihood of Success: High if evidence is produced; Low if no documentation exists.

Option 2: Invoke Continuity of Care Protections for Ongoing Conditions

Strengths: If the injured worker's condition qualifies as acute (less than 90 days), a serious chronic condition (expected to require ongoing treatment 90+ days), a terminal illness, or involves a scheduled surgery, the worker can continue with the non-MPN treating physician without requiring employer approval. The worker has only to request the physician's report within 20 days and dispute the employer's determination if necessary. If the treating physician agrees the condition meets the criteria, the worker continues treatment.

Weaknesses: The continuity of care period is temporary, lasting only as long as necessary to complete treatment and arrange transfer, but not exceeding 12 months. The injured worker must act within 20 days to request the treating physician's report; failure to meet this deadline forfeits the right to dispute. The employer's determination is presumed valid if the physician's report is not timely filed.

Risk Level: Medium. The timeline is short (20 days), and the right is not permanent. However, if properly invoked, it provides immediate relief.

Likelihood of Success: Medium to High if the condition clearly meets the statutory definition (serious chronic condition or terminal illness) and the worker acts promptly.

Option 3: Challenge the MPN's Access Standards Compliance

Strengths: If the injured worker can demonstrate that the MPN fails to provide the required access-three available physicians in the relevant specialty within 30 miles or 60 minutes for specialists-the MPN may be found non-compliant. This is a factual showing that does not require proof of bad faith or intentional violation, only failure to meet the regulatory minimum. A successful challenge may allow the worker to treat outside the MPN at the employer's expense.

Weaknesses: The burden is on the injured worker to prove access violations. This requires specific evidence about the number of available physicians (not merely listed, but accepting new patients), travel times from the worker's residence and workplace, and the worker's specific specialty needs. The employer can present

evidence of many physicians in the network, even if some are not truly "available." WCAB precedent has established that the worker bears this burden.

Risk Level: High. The factual burden is substantial, and recent WCAB decisions favor employers when abundant in-network providers exist even if some are unwilling to accept new patients.

Likelihood of Success: Low to Medium. Unless the worker can demonstrate a clear shortage of physicians in the relevant specialty and geographic area, courts have been reluctant to find access violations.

Option 4: File a Complaint with the DWC Alleging MPN Noncompliance

Strengths: Filing a complaint with the MPN Contact first (30-day cure period) and then with the DWC triggers an administrative investigation that can result in penalties, suspension, or revocation of the MPN's approval. This remedy is available even if the worker cannot prove the violation at a workers' compensation hearing. The DWC has authority to investigate and take enforcement action independent of individual workers' claims.

Weaknesses: The complaint process is administrative and does not directly authorize medical treatment. Even if a complaint results in an MPN violation finding, the worker still must pursue appropriate legal remedies for their individual claim. The process is slow-30 days for the MPN to cure before escalation to the DWC, then investigative delays.

Risk Level: Low. Filing a complaint has minimal downside and may pressure the MPN to comply.

Likelihood of Success: Moderate. If credible evidence of violation exists, the DWC will investigate. However, whether the violation results in modification of the MPN or revocation depends on severity and the MPN's responsiveness.

Option 5: Pursue Second and Third Opinions and MPN IMR

Strengths: Even within the MPN, if the injured worker disputes the diagnosis or treatment, the worker can obtain second and third opinions from other MPN physicians without requiring employer approval. If a second or third opinion physician agrees that treatment outside the MPN is necessary, the worker can pursue an MPN IMR, which may result in authorization for non-MPN care. This process is streamlined and does not require WCAB litigation.

Weaknesses: This strategy does not directly address the problem of the original treating physician being non-MPN. Instead, it uses MPN physicians to validate the need for out-of-network care. If the MPN second and third opinion physicians agree with the original assessment, the process works; if they disagree, the worker has not advanced the position. The MPN IMR process takes time and may not result in approval.

Risk Level: Medium. The strategy requires cooperation from MPN physicians, which cannot be guaranteed.

Likelihood of Success: Medium. Depends on the strength of the clinical case and whether MPN physicians are willing to deviate from the network.

Option 6: Petition the WCAB for Determination that Employer Unlawfully Refused to Provide Care

Strengths: If the injured worker can demonstrate that the employer has actually refused authorization for necessary treatment or neglected to provide required care, a WCAB petition can result in a determination that the MPN restriction is unenforceable in the worker's case. This is a direct remedy that does not require proof of systemic MPN noncompliance, only proof of the employer's actions in the worker's claim.

Weaknesses: The burden is on the worker to prove actual refusal or neglect-not merely the worker's belief that treatment should be provided, but documented evidence (such as denied authorization requests or UR denials that are themselves improper). Recent WCAB precedent has not favored workers on this argument unless they can point to specific, documented denials.

Risk Level: High. The worker must have strong evidence of specific refusals or denials.

Likelihood of Success: Low to Medium. Unless the worker has documentation of wrongful denials, courts have been reluctant to find employer violation.

Northern California Application: Practical Implementation Steps

Step 1: Gather Evidence of Pre-Designation or Original Physician Status

The injured worker should immediately attempt to locate any written pre-designation documents, correspondence with the employer about physician choice, or documentation from the physician's office that the physician was previously treating the worker for non-occupational conditions. This is the strongest evidence and should be prioritized.

Step 2: Determine Whether Continuity of Care Criteria Are Met

The worker should review the nature of the injury and condition to determine if the condition is acute (less than 90 days), a serious chronic condition (requiring ongoing treatment 90+ days), a terminal illness, or involves scheduled surgery within 180 days. If yes, the worker should immediately request a report from the primary treating physician addressing whether these conditions are met and send this request in writing to the claims administrator to create a written record.

Step 3: Document MPN Access Issues

If the worker cannot satisfy continuity of care or pre-designation, the worker should document any access problems: (1) failed attempts to schedule appointments with in-network specialists, including dates and reasons for delays; (2) the distance and travel time from the worker's residence to available in-network providers; (3) the number of truly available physicians in the relevant specialty willing to accept new patients. This evidence should be compiled and preserved for later use.

Step 4: File an MPN Complaint if Violations Are Evident

If the MPN has clearly failed to provide adequate access or violated notice requirements, the worker should send a written complaint to the MPN Contact (with proof of service) detailing the specific violations and the impact on the worker. After 30 days (or if the MPN disputes the complaint), the worker should file a complaint with the DWC on the prescribed form, with a copy to the MPN Contact.

Step 5: Request Second and Third Opinions if Within MPN Framework

If the worker has been restricted to the MPN and the original treating physician is not in the network, the worker should request a second opinion from an MPN physician specializing in the worker's condition. Ensure the request is in writing and identifies the disagreement with the original treatment plan. If the second opinion is unsatisfactory, request a third opinion. If neither the second nor third opinion agrees with restricting the worker to the MPN, file for an MPN IMR.

Step 6: File an Application for Adjudication with the WCAB if Necessary

If the above steps have not resolved the issue, the worker should file an Application for Adjudication of Claim with the WCAB seeking a determination that the worker is entitled to treat outside the MPN. The application should include all evidence gathered in prior steps and should clearly articulate the legal basis for the claim (access standard violation, pre-designation, continuity of care, employer's unlawful refusal of care, or MPN noncompliance).

Preservation of Rights and Appellate Considerations

Record-Building at Trial Level

Even if the injured worker is unsuccessful at the Administrative Law Judge level in establishing the right to out-of-network treatment, the worker should ensure that arguments are preserved for appeal to the WCAB en banc or to potential court review. The record should include all evidence of pre-designation, access violations, continuity of care criteria, and the employer's actions in restricting care.

Interlocutory Appeals and Stays of Removal

If the MPN restriction threatens to prevent necessary medical treatment, the worker may request a stay of the MPN transfer or a temporary restraining order pending resolution of the merits. This is an exceptional remedy but may be available if the worker demonstrates irreparable harm from the MPN restriction.

Federal and State Level Protections

Injured workers in Northern California also have protections under the California Workers' Compensation Exclusivity Rule, which bars civil suits against employers for workers' compensation injuries but protects workers' statutory rights[54]. Additionally, California's Anti-Retaliation Statute (Labor Code Section 132a) protects workers who assert their workers' compensation rights from employer retaliation[55][58].

Recent Legal Developments and 2025-2026 Changes

January 2026 MTUS Update

The Division of Workers' Compensation issued a notice on February 27, 2026, regarding a proposed evidence-based update and adoption to the Medical Treatment Utilization Schedule[16]. This update may affect what treatment is considered "medically necessary" and could impact MPN decisions to deny or modify treatment. Injured workers should monitor this development as it may provide additional grounds to challenge UR or MPN denials.

2026 Utilization Review Regulatory Updates

Effective April 1, 2026, California implemented updated UR regulations that modified the authorization form requirements, timeline extensions for UR plan review, and penalties for UR non-compliance[37]. These changes may benefit injured workers by reducing UR delays and increasing accountability for claims administrators' authorization decisions. The updated regulations specify that only physician reviewers may deny treatment based on medical necessity, reducing the risk of non-physician denials[37].

WCAB En Banc Decisions on MPN Issues

The 2025 WCAB En Banc decisions address electronic witness testimony and replacement QME panels but do not directly address MPN access standards[29]. However, lower WCAB panels continue to refine the burden of proof in MPN disputes, with recent decisions emphasizing that injured workers must prove specific access violations or refusals rather than merely asserting that the MPN is inadequate.

Cost Considerations and Attorney Representation

Contingency Fee Structure for Workers' Compensation Claims

Workers' compensation attorneys in California typically represent injured workers on a contingency fee basis, meaning the worker pays no upfront costs and the attorney receives a percentage of the recovered benefits[65][67]. In California, attorney fees are typically capped at 10-15% of the award, though complex cases may involve higher percentages with approval[65][67]. Fees must be approved by the workers' compensation judge or appeals board.

For MPN disputes specifically, an attorney can recover fees even if the worker is only partially successful in establishing the right to out-of-network treatment, as any additional medical benefits obtained represent a recovery[65][67].

Free Legal Assistance Resources

Injured workers in Northern California with low incomes may access free legal assistance through: (1) Legal Aid at Work[63], which provides free services to low-income workers; (2) the California State Bar's free legal help resources[60]; (3) the DWC's Information and Assistance Unit[61][64], which provides free guidance (though not attorney representation); and (4) workers' rights organizations focusing on occupational safety and health.

Conclusion and Recommendations

An injured worker whose Primary Treating Physician is not included in the employer's Medical Provider Network faces substantial challenges but retains multiple legal remedies depending on the specific circumstances. The strongest positions involve: (1) proof of a valid pre-designation executed before injury, (2) meeting continuity of care criteria for ongoing medical conditions, (3) demonstrating MPN failure to meet access standards, and (4) proving that specific treatment denials violated the employer's obligation to provide reasonably required care.

The injured worker should immediately assess whether pre-designation or continuity of care criteria apply, as these provide the quickest relief. If neither applies, the worker should gather evidence of MPN access

violations and file administrative complaints with the DWC. Throughout the process, the worker should seek representation from a qualified workers' compensation attorney who can navigate the complex procedural requirements, manage deadlines, and present evidence effectively.

The regulatory and statutory framework strongly emphasizes that injured workers receive necessary medical treatment, but enforcement of these protections requires assertive action by workers and their representatives. The DWC has enforcement authority to discipline non-compliant MPNs, and the WCAB has authority to overturn MPN restrictions when statutory requirements are violated. However, courts place the burden on injured workers to prove violations through clear evidence rather than speculation.

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