California Workers' Compensation Primary Treating Physician (PTP) Reporting Requirements: A Legal Analysis

(PART-A INJURED WORKERS ANALYSIS)

February 28, 2026

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CALIFORNIA WORKERS' COMPENSATION: PRIMARY TREATING PHYSICIAN (PTP) REPORTING REQUIREMENTS

This report explains the rules that doctors must follow when reporting work injuries in California. If you were hurt at work, your doctor — called a Primary Treating Physician (PTP) — must file certain medical reports on time. These reports determine whether you receive medical treatment, disability payments, and other benefits. This guide covers what reports are required, when they are due, what happens if they are late, and what you can do to protect your rights.

Risk Level: Medium to High. Late or missing medical reports cause treatment delays, suspended benefit payments, and penalties. Whether you are an injured worker, a medical provider, or a claims administrator, understanding these deadlines is essential.

Part 1: Key Definitions You Need to Know

This section defines important legal terms used throughout this report.

Who Is a Primary Treating Physician?

Your Primary Treating Physician (PTP) is the doctor who is mainly responsible for managing your medical care after a work injury. Under Cal. Code Regs. tit. 8, § 9785(a)(1) (https://www.dir.ca.gov/t8/9785.html), the PTP must have examined you at least once to provide or prescribe treatment and must monitor how that treatment is working.

Your PTP may be chosen by you (the employee), your employer, or through a Medical Provider Network (MPN) — a group of approved doctors your employer's insurance uses. You may only have one PTP at a time.

Other Important Terms

- Secondary Physician — Any doctor other than the PTP who examines you or provides treatment but is not the main doctor managing your care.
- Medical Determination — A decision your PTP makes about your eligibility for benefits. This includes decisions about what treatment you need, when you can return to work, and whether you have a permanent disability.
- Permanent and Stationary (P&S) — This means your medical condition has stabilized and is not expected to get better with more treatment. This is also called Maximum Medical Improvement (MMI).
- Released from Care — Your PTP decides your condition is permanent and stationary and you do not need any more medical treatment.
- Claims Administrator — The insurance company or self-insured employer responsible for processing your workers' compensation claim and paying benefits.
- Apportionment — The process of determining what percentage of your permanent disability was caused by your work injury versus other causes, such as a pre-existing condition.
- Workers' Compensation Appeals Board (WCAB) — The state court that resolves disputes in workers' compensation cases.
- Qualified Medical Evaluator (QME) — An independent doctor certified by the state to evaluate disputed medical issues.
- Agreed Medical Evaluator (AME) — A doctor that both sides agree to use for an independent evaluation.

Part 2: Laws That Govern PTP Reporting

This section covers the statutes and regulations that create reporting obligations for your doctor.

California Statutes

Several California laws work together to require your doctor to file medical reports:

- Cal. Lab. Code § 6409 (https://www.dir.ca.gov/dwc/wcfaqiw.html) requires any doctor treating a work-related injury to file an occupational injury report.
- Cal. Lab. Code § 4600 (https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4603-2/) establishes your right to choose a physician and your employer's obligation to provide necessary medical treatment.
- Cal. Lab. Code § 4603.2 (https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4603-2/) requires employers to pay or object to medical bills within 45 working days. Late payments trigger a 10% penalty plus 7% annual interest.
- Cal. Lab. Code § 4663 (https://workcompmedical.com/wp-content/uploads/2013/08/Labor-Code-4663.pdf) requires that any doctor writing a permanent disability report must explain what percentage of your disability was caused by the work injury versus other factors.
- Cal. Lab. Code § 4664 (https://workcompmedical.com/wp-content/uploads/2013/08/Labor-Code-4663.pdf) limits your employer's liability to only the percentage of permanent disability directly caused by your work injury.

The Main Regulation: Title 8, CCR Section 9785

Cal. Code Regs. tit. 8, § 9785 (https://www.dir.ca.gov/t8/9785.html) is the primary regulation governing PTP reporting. It spells out exactly what reports your doctor must file, what information must be included, and when each report is due. All of the specific reporting requirements discussed in Parts 3 through 5 of this report come from this regulation.

Penalty Provisions

If a claims administrator fails to pay benefits on time, two penalty laws apply:

- Cal. Lab. Code § 4650 (https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4603-2/) imposes an automatic 10% penalty for late temporary disability payments.
- Cal. Lab. Code § 5814 (https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4603-2/) allows up to a 25% penalty for unreasonable delays in paying any workers' compensation benefits.

Part 3: Required Medical Reports and Deadlines

This section describes each report your PTP must file, including what it must contain and when it is due.

Form 5021: Doctor's First Report of Occupational Injury or Illness

Under Cal. Code Regs. tit. 8, § 9785(e)(1) (https://www.dir.ca.gov/t8/9785.html), your PTP must submit Form 5021 (https://www.dir.ca.gov/dwc/forms/5021.pdf) within 5 working days after the first examination.

> ***Important: Every new PTP assigned to your case must also submit a Form 5021 within 5 working days of their first examination.***

What Form 5021 must include:

- Your personal information (name, address, date of birth)
- Description of how the injury happened, including date and time
- Your complaints and symptoms
- Physical examination findings, imaging results, and lab tests
- Diagnosis using ICD-10 codes (the standard medical coding system)
- Initial treatment given
- Your work status (can you work, with restrictions, or not at all)
- A treatment plan on line 24 or the back of the form, listing planned treatments, referrals, surgeries, and physical therapy with frequency and duration
- The doctor's signature under penalty of perjury

Form PR-2: Primary Treating Physician's Progress Report

Under Cal. Code Regs. tit. 8, § 9785(f) (https://www.dir.ca.gov/t8/9785.html), your PTP must submit Form PR-2 (https://www.dir.ca.gov/dwc/PR-2.pdf) within 20 days whenever a triggering event happens. The triggering events are:

- Your condition has an unexpected significant change
- Your treatment plan changes significantly (new surgery, new referral, new equipment, longer therapy)
- You can return to modified or regular work
- You need to stop working or your work restrictions change
- You are released from care
- The doctor concludes permanent disability will likely prevent you from returning to your usual job
- The claims administrator requests additional information

> ***Important: Even if none of these triggering events happen, your PTP must still file a progress report at least every 45 days during ongoing treatment. See Cal. Code Regs. tit. 8, § 9785(f)(8) (https://www.dir.ca.gov/t8/9785.html).***

What Form PR-2 must include:

- Your current symptoms and complaints
- Current physical examination findings
- Updated diagnoses (ICD-10 codes)
- Treatment provided since last report and response to treatment
- Any changes to the treatment plan
- Current work status and restrictions

Your PTP may submit a narrative report (a written letter) instead of the PR-2 form, but it must be titled "Primary Treating Physician's Progress Report" in bold, state the reason for submission, use the same subject headings in the same order as the PR-2 form, and include a signature under penalty of perjury.

Forms PR-3 and PR-4: Permanent and Stationary Reports

Under Cal. Code Regs. tit. 8, § 9785(h) (https://www.dir.ca.gov/t8/9785.html), when your PTP determines you have reached permanent and stationary status, the doctor must file a report within 20 days.

- For injuries before January 1, 2005: Use Form PR-3 (https://www.dir.ca.gov/dwc/PR-3.pdf), which applies the 1997 Permanent Disability Rating Schedule.
- For injuries on or after January 1, 2005: Use Form PR-4 (https://www.dir.ca.gov/dwc/PR-4.pdf), which requires impairment ratings based on the AMA Guides to the Evaluation of Permanent Impairment, 5th Edition.

What P&S reports must include:

- Full medical and occupational history
- Detailed physical examination findings with specific measurements
- Permanent impairment rating using the correct rating schedule
- Apportionment analysis — what percentage of your permanent disability was caused by the work injury versus pre-existing or non-work conditions, as required by Cal. Lab. Code § 4663 (https://workcompmedical.com/wp-content/uploads/2013/08/Labor-Code-4663.pdf)
- Continuing and future medical care needs
- Work capacity and functional limitations
- Whether you can return to your usual job

Form DWC-AD 10133.36: Physician's Return-to-Work and Voucher Report

When your PTP determines you have permanent partial disability, Form DWC-AD 10133.36 (https://www.dir.ca.gov/dwc/forms.html) must be completed and attached to the PR-3 or PR-4 report. This form addresses whether you need vocational rehabilitation and whether you are eligible for a Supplemental Job Displacement Benefit (SJDB) voucher — a voucher that helps pay for job retraining or skill development if you cannot return to your old job.

Part 4: Summary of Deadlines and Required Forms

This table provides a quick reference for all required reports.

Form	When Required	Deadline

Form 5021 (Doctor's First Report)	After PTP's first examination	5 working days after initial exam
Form PR-2 (Progress Report)	When a triggering event occurs	20 days after the triggering event
Form PR-2 (Periodic Report)	During ongoing treatment with no triggering event	Every 45 days from last report
Form PR-3 (P&S Report, pre-2005 injuries)	When PTP finds condition is permanent and stationary	20 days after P&S determination
Form PR-4 (P&S Report, 2005+ injuries)	When PTP finds condition is permanent and stationary	20 days after P&S determination
DWC-AD 10133.36 (Return-to-Work Report)	When permanent partial disability is determined	Attach to PR-3 or PR-4

Part 5: Step-by-Step Timeline for a Workers' Compensation Claim

This section walks you through the entire process from injury to final determination.

Phase 1: Reporting the Injury (Days 1–5)

1. You report your workplace injury to your employer immediately or as soon as possible.
2. Your employer gives you a DWC 1 (Workers' Compensation Claim Form) (https://www.dir.ca.gov/dwc/forms.html) within one working day. You complete and return this form.
3. Your employer sends the claim form to the claims administrator, who authorizes up to $10,000 in emergency medical treatment under Cal. Lab. Code § 6409 (https://www.dir.ca.gov/dwc/wcfaqiw.html).
4. Your PTP examines you and completes Form 5021 (https://www.dir.ca.gov/dwc/forms/5021.pdf) within 5 working days of the exam.
5. The claims administrator receives the Form 5021, logs it, and makes treatment authorization decisions.

Phase 2: Ongoing Treatment and Progress Reports (Days 8 Through P&S)

1. Your PTP provides ongoing treatment and monitors your condition.
2. If a triggering event occurs (condition changes, treatment plan changes, you can return to work, etc.), your PTP submits Form PR-2 (https://www.dir.ca.gov/dwc/PR-2.pdf) within 20 days.
3. If no triggering event occurs, your PTP must still submit a PR-2 at least every 45 days.
4. The claims administrator updates your work restrictions and adjusts disability payments based on each PR-2 report.

Phase 3: Permanent and Stationary Determination

1. When your PTP determines your condition has stabilized and will not improve further, the doctor declares you permanent and stationary.
2. Your PTP submits Form PR-3 (https://www.dir.ca.gov/dwc/PR-3.pdf) or Form PR-4 (https://www.dir.ca.gov/dwc/PR-4.pdf) within 20 days, including a permanent impairment rating and apportionment analysis.
3. If you have permanent partial disability, your PTP also completes Form DWC-AD 10133.36 (https://www.dir.ca.gov/dwc/forms.html).
4. The claims administrator forwards the P&S report to the DWC Permanent Disability Evaluation Unit for rating.

Phase 4: After P&S Status

1. Once P&S status is established, your temporary disability benefits end.
2. Your PTP remains available for treatment related to the work injury as medically needed.
3. If your condition worsens after P&S status, your PTP submits a new PR-2 requesting authorization for additional treatment.
4. If you disagree with the P&S determination, you may request a QME or AME evaluation under Cal. Lab. Code §§ 4061–4062 (https://employeesfirstlaborlaw.com/labor-code-%C2%A74062-objections-to-medical-determinations/).

Part 6: Recent Regulatory Changes

This section covers recent and upcoming changes to the rules.

Proposed Amendments (DWC Notice 2025-23)

On February 27, 2025, the California Division of Workers' Compensation issued Notice 2025-23 (https://www.dir.ca.gov/DIRNews/2025/2025-23.html), proposing changes to several regulations including Cal. Code Regs. tit. 8, § 9785 (https://www.dir.ca.gov/t8/9785.html). Key proposed changes include:

- Form PR-1 made optional. The proposed amendments would make the "Treating Physician's Report" (Form PR-1) optional rather than mandatory. PTPs would have more flexibility to choose between PR-2, PR-1, or narrative report formats.
- Narrative report requirements clarified. Narrative reports must include the same declaration under penalty of perjury as standardized forms.
- Medical Provider Network (MPN) updates. Insurers or employers would be required to deliver relevant medical records to MPN physicians within 20 days of physician selection.
- Request for Authorization (RFA) procedures updated. New procedures address RFAs submitted via non-designated addresses.

The public comment period closed on March 14, 2025. As of February 28, 2026, these amendments have not yet taken effect. PTPs must continue to follow current regulations.

Current Form Standards

All medical providers must use the 2015 version (Revision 5) of Form 5021 (https://www.dir.ca.gov/dwc/forms/5021.pdf), which uses ICD-10 diagnosis codes. Current versions of Forms PR-2 (https://www.dir.ca.gov/dwc/PR-2.pdf), PR-3 (https://www.dir.ca.gov/dwc/PR-3.pdf), and PR-4 (https://www.dir.ca.gov/dwc/PR-4.pdf) must also be used.

Relevant Case Law

In Gonzalez v. Vermont Healthcare Center, 2024 Cal. Wrk. Comp. P.D. LEXIS 18 (https://employeesfirstlaborlaw.com/change-of-treating-physician-after-discharge-from-care/), the WCAB clarified that when a PTP releases an employee from care, the employee cannot simply choose a new PTP. Instead, the employee must dispute the release through QME or AME procedures under Cal. Lab. Code §§ 4061–4062 (https://employeesfirstlaborlaw.com/labor-code-%C2%A74062-objections-to-medical-determinations/). This makes your PTP's permanent and stationary report especially important.

Part 7: Reimbursement for Medical Reports

This section explains how doctors get paid for preparing required reports.

Fee Schedule

Under Cal. Code Regs. tit. 8, § 9789.14 (https://www.dir.ca.gov/dwc/omfs9904.htm), the following reports are separately reimbursable under the Official Medical Fee Schedule (OMFS):

- Form PR-2 — Reimbursed using procedure code WC002 at a rate of $12.29, limited to once every 45 days unless a triggering event under Cal. Code Regs. tit. 8, § 9785(f)(1)–(7) (https://www.dir.ca.gov/t8/9785.html) warrants more frequent reporting. See daisyBill – PR-2 Reports and WC002 Reimbursement (https://blog.daisybill.com/wc002-and-you-pr-2-reports-and-reimbursement).
- Forms PR-3 and PR-4 — Separately reimbursable when submitted within 20 days of the P&S determination.

Claims administrators must reimburse PTPs for these reports as required by the OMFS. See Cal. Code Regs. tit. 8, § 9785(k) (https://www.dir.ca.gov/t8/9785.html).

Payment Deadlines for Claims Administrators

Under Cal. Lab. Code § 4603.2 (https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4603-2/), employers must pay or object to medical bills within 45 working days of receiving each separate itemized bill. If payment is late, the employer must pay:

- A 10% penalty on the late amount
- 7% annual interest on the late amount

Part 8: What Happens When Reports Are Late or Incomplete

This section explains the consequences of non-compliance and your options when problems arise.

Consequences for Injured Workers

When your PTP fails to submit required reports on time, you may experience:

- Treatment delays — The claims administrator cannot authorize treatment without a supporting medical report.
- Benefit payment suspensions — Temporary disability payments may be delayed or stopped.
- Stale work restrictions — Without updated PR-2 reports, your work status may not reflect your actual condition.
- Loss of interim medical authorization — You may lose authorization for ongoing treatment.

Consequences for Medical Providers

Doctors who fail to comply with reporting deadlines face:

- Reduced or denied reimbursement for late reports
- Complaints filed with the DWC Medical Unit
- Potential sanctions from medical licensing boards for chronic non-compliance
- Possible medical malpractice liability if failure to report causes harm to the injured worker

Consequences for Claims Administrators

Claims administrators who fail to process reports and pay benefits on time face:

- Automatic 10% penalty for late temporary disability payments under Cal. Lab. Code § 4650 (https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4603-2/)
- Discretionary penalties up to 25% for unreasonable delays under Cal. Lab. Code § 5814 (https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4603-2/)

The "Good Cause" Exception

Cal. Code Regs. tit. 8, § 9785(f) and (h) (https://www.dir.ca.gov/t8/9785.html) allow late reporting only if the PTP can show "good cause." This exception is narrow. It typically requires proof of circumstances beyond the doctor's control, such as a system failure or the patient failing to appear for a scheduled exam. Routine scheduling problems or office inefficiency do not qualify.

What to Do If Your Doctor's Report Is Late or Missing

If your PTP has not submitted a required report:

1. Contact your doctor's office and ask the office manager to submit the report immediately.
2. Cite the specific regulation (Cal. Code Regs. tit. 8, § 9785 (https://www.dir.ca.gov/t8/9785.html)) and the applicable deadline.
3. Request written confirmation of when the report will be submitted.
4. If your doctor continues to not comply, file a complaint with the DWC Medical Unit (https://www.dir.ca.gov/dwc/medicalunit/toc.pdf).
5. You may also request your medical records directly under federal and state patient access laws, then provide them to the claims administrator.
6. If reports remain deficient, request a QME evaluation to obtain a compliant medical-legal report.

What to Do If a P&S Report Is Incomplete

If a Form PR-3 or PR-4 is missing required information (for example, the apportionment analysis is vague or measurements are missing):

1. Send a written request to the doctor asking for specific corrections, citing Cal. Code Regs. tit. 8, § 10606 (https://www.law.cornell.edu/regulations/california/8-CCR-10606).
2. Give the doctor 10 working days to submit a corrected report.
3. If the doctor does not correct the report, either party may petition for a QME or AME evaluation to obtain a proper permanent disability report.

Part 9: Evidentiary Standards for Medical Reports

This section explains what makes a medical report legally valid in WCAB proceedings.

Substantial Evidence Standard

Under Cal. Lab. Code § 5703 (https://www.alfainternational.com/compendium/workers-compensation/california/), WCAB decisions must be based on "reliable, probative and competent evidence." This is called the substantial evidence standard. For a PTP report to meet this standard, it must include:

- A clear history of the injury, including how it happened
- Identification of the specific body parts injured
- Detailed objective findings from the physical exam (specific measurements and test results, not just general statements)
- An explanation of how the exam findings relate to your complaints
- Medical reasoning supporting all conclusions
- For P&S reports: a complete calculation showing how the permanent impairment rating was determined

Reports that are vague or conclusory — meaning they state a conclusion without explaining the reasoning — may be rejected as insufficient evidence. The WCAB may then send the case back for a supplemental QME report.

Certification Under Penalty of Perjury

All PTP medical reports must include a signed statement that the report is true and correct and that the PTP has not violated Cal. Lab. Code § 139.3 (https://law.justia.com/codes/california/code-lab/division-1/chapter-5/section-139-3/) (which prohibits kickbacks for medical referrals). A report without this certification may be challenged as improperly authenticated.

Part 10: Practical Guidance for Injured Workers, Doctors, and Claims Administrators

This section provides specific action steps for each party in the workers' compensation system.

If You Are an Injured Worker

- Report your injury to your employer immediately.
- Complete and return the DWC 1 Claim Form (https://www.dir.ca.gov/dwc/forms.html) as soon as your employer provides it.
- Tell your doctor that the injury is work-related and that a workers' compensation claim has been filed.
- Keep copies of all medical reports (Form 5021, PR-2, P&S reports). Ask your doctor for copies if they are not given to you automatically.
- Inform your doctor of any significant change in your condition so that a PR-2 report can be filed within 20 days.
- Keep a log of all medical appointments, treatments, and changes to your work restrictions.
- If your doctor determines you have permanent partial disability, make sure Form DWC-AD 10133.36 (https://www.dir.ca.gov/dwc/forms.html) is completed for the SJDB voucher.

If You Are a Medical Provider

- Set up a calendar or electronic reminder system for all reporting deadlines: the 5-day deadline for Form 5021 and the 45-day maximum for periodic PR-2 reports.
- Take detailed notes during every patient visit that cover all fields required by the relevant form.
- Submit Form PR-2 promptly when a triggering event occurs — do not wait for the 45-day periodic deadline.

- Keep copies of all submitted reports and document the date and method of transmission (fax confirmation, email receipt, etc.).
- If you cannot meet a deadline for good cause, document the reason and notify the claims administrator at the same time.
- When completing PR-3 or PR-4, include specific measurements, a detailed apportionment analysis, and a clear work capacity assessment.

If You Are a Claims Administrator

- Log all medical reports with a precise timestamp upon receipt.
- Process Form 5021 within one working day to authorize or deny treatment.
- Update work restrictions and disability payment status within 5–10 working days of receiving a PR-2.
- Forward P&S reports to the DWC Permanent Disability Evaluation Unit promptly.
- Track pending reports and send a demand letter to any physician who misses a deadline.
- Notify the injured worker when a required report is overdue.
- Track all penalty obligations to avoid late-payment penalties under Cal. Lab. Code §§ 4650 and 5814 (https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4603-2/).

Part 11: Disputing Medical Reports at the WCAB

This section explains how to challenge medical reports and preserve your rights on appeal.

Challenging Reports at the Trial Level

If you disagree with your PTP's findings, you can challenge them before a Workers' Compensation Judge:

- Timing and compliance arguments — If a report was filed late, argue that it should be excluded or given less weight.
- Substantial evidence arguments — If a report lacks detail or reasoning, argue through cross-examination and expert testimony that it does not meet the substantial evidence standard.
- Apportionment arguments — If the apportionment analysis is vague or unsupported, present evidence that the percentage attributed to the work injury should be higher (or lower).

Preserving Issues for Appeal

Even if you expect to lose an argument at trial, raise it on the record so you can appeal later:

- Submit detailed written declarations describing the circumstances.
- Submit copies of all medical reports with transmission evidence.
- Make sure the judge's ruling is transcribed for the appellate record.
- File written motions addressing your arguments so they are part of the official record.

Appeal Deadlines

> ***Critical: After a WCAB judge issues a decision, you have 20 days to file a Petition for Reconsideration or request appellate panel review. Missing this deadline may permanently end your right to appeal.***

Key Decision Points

- Accepting or challenging a P&S determination — Once accepted or affirmed, it is rarely overturned. You have 30 days to request a QME if you disagree.
- Lump-sum settlement vs. periodic payments — A lump-sum settlement is final. You give up the right to employer-paid future medical care. Get legal advice before agreeing.
- Appealing an unfavorable WCAB decision — An appeal can take 12–18 months. Discuss the likelihood of success with an attorney before deciding.

Part 12: San Francisco Bay Area Information

This section provides location-specific information for claims processed in the San Francisco area.

DWC Offices

The Division of Workers' Compensation maintains the following offices in the Bay Area for claim administration and hearings. See DWC office locations (https://www.dir.ca.gov/dwc/forms.html):

- San Francisco District Office: 100 Montgomery Street, Suite 800, San Francisco, CA 94104
- San Francisco Satellite Office: 630 Sansome Street, 4th Floor, Room 475, San Francisco, CA 94111
- Concord Hearing Location: 1855 Gateway Blvd., Suite 850, Concord, CA 94520

San Francisco WCAB Procedural Expectations

Judges at the San Francisco WCAB (https://www.dir.ca.gov/wcab/wcab_panel.htm) have developed the following informal practices:

- Medical reports should be exchanged between the parties at least 5 working days before a scheduled conference.
- Continuances (postponements) are routinely granted when a party shows that a critical medical report is expected soon and the case cannot be fairly resolved without it.
- Reports submitted late may be admitted if the party shows good cause for the delay and no unfair harm to the other side.

Claims Administrator Submission Methods

Most Bay Area claims administrators accept medical reports through:

- Fax to the designated claims office number
- Electronic submission via web portal (if available)
- Mail to the claims office address
- Some administrators accept email submissions, though this is not yet universal

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Part 13: Risk Warnings

This section highlights important risks you should understand.

> ***Important: Relying only on timely medical reports — without actively following up — may not be enough. Claims administrators sometimes fail to update your work restrictions or adjust payments even when reports are properly submitted. Always request written confirmation that your work restrictions and benefit payments have been updated after each report.***
>
> ***Important: If your PTP's permanent and stationary determination is challenged and the case goes to a WCAB hearing, the process may take 12–18 months or longer. During that time, your treatment authorization and disability payments may be disputed or suspended.***
>
> ***Important: A QME evaluation may result in a lower permanent disability rating than your PTP gave. Before requesting a QME, consider whether your PTP's opinion is defensible.***
>
> ***Important: Once a permanent and stationary determination is accepted or affirmed by the WCAB, your temporary disability benefits end permanently. If the determination was premature, you lose access to those benefits. Get an independent medical opinion before accepting a P&S determination if you believe your condition is still improving.***

Areas Requiring Expert Consultation

You should consult a specialist for advice on:

- Tax consequences of workers' compensation benefits (consult a tax professional)
- Social Security Disability Insurance (SSDI) integration with workers' compensation benefits (consult an SSDI specialist)
- Third-party liability if someone other than your employer caused your injury (consult a personal injury attorney)

References

1. Cal. Code Regs. tit. 8, § 9785 – Reporting Duties of the Primary Treating Physician (https://www.dir.ca.gov/t8/9785.html) – California Department of Industrial Relations

2. Cal. Lab. Code § 4603.2 – Medical Billing and Payment Timelines (https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4603-2/) – Justia

3. Cal. Lab. Code § 4663 – Apportionment of Permanent Disability (https://workcompmedical.com/wp-content/uploads/2013/08/Labor-Code-4663.pdf) – WorkCompMedical

4. Cal. Lab. Code § 4664 – Liability for Apportioned Permanent Disability (https://workcompmedical.com/wp-content/uploads/2013/08/Labor-Code-4663.pdf) – WorkCompMedical

5. Cal. Lab. Code § 6409 – Workers' Compensation FAQ for Employees (https://www.dir.ca.gov/dwc/wcfaqiw.html) – California DIR

6. Cal. Lab. Code § 139.3 – Prohibition Against Kickbacks and Improper Inducements (https://law.justia.com/codes/california/code-lab/division-1/chapter-5/section-139-3/) – Justia

7. Cal. Code Regs. tit. 8, § 9789.14 – Official Medical Fee Schedule (https://www.dir.ca.gov/dwc/omfs9904.htm) – California DIR

8. Cal. Code Regs. tit. 8, § 10606 – Physicians' Reports as Evidence (https://www.law.cornell.edu/regulations/california/8-CCR-10606) – Legal Information Institute, Cornell Law School

9. DWC Notice 2025-23 – Notice of 15 Day Public Comment Period for Utilization Review and Related Regulations (https://www.dir.ca.gov/DIRNews/2025/2025-23.html) – California DIR

10. Gonzalez v. Vermont Healthcare Center, 2024 Cal. Wrk. Comp. P.D. LEXIS 18 (https://employeesfirstlaborlaw.com/change-of-treating-physician-after-discharge-from-care/) – Employees First Labor Law

11. DWC Form 5021 – Doctor's First Report of Occupational Injury or Illness (Rev. 5, 10/2015) (https://www.dir.ca.gov/dwc/forms/5021.pdf) – California DIR

12. DWC Form PR-2 – Primary Treating Physician's Progress Report (https://www.dir.ca.gov/dwc/PR-2.pdf) – California DIR

13. DWC Form PR-3 – Primary Treating Physician's Permanent and Stationary Report (1997 PDRS) (https://www.dir.ca.gov/dwc/PR-3.pdf) – California DIR

14. DWC Form PR-4 – Primary Treating Physician's Permanent and Stationary Report (2005 PDRS) (https://www.dir.ca.gov/dwc/PR-4.pdf) – California DIR

15. DWC Forms Page – Complete List of Current Forms (https://www.dir.ca.gov/dwc/forms.html) – California DIR

16. DWC 1 – Workers' Compensation Claim Form (https://www.dir.ca.gov/dwc/forms.html) – California DIR

17. Cal. Lab. Code §§ 4061–4062 – Objections to Medical Determinations (https://employeesfirstlaborlaw.com/labor-code-%C2%A74062-objections-to-medical-determinations/) – Employees First Labor Law

18. daisyBill – PR-2 Reports and WC002 Reimbursement (https://blog.daisybill.com/wc002-and-you-pr-2-reports-and-reimbursement) – daisyBill

19. Employees First Labor Law – Doctor's First Report of Injury and Medical Reports (https://employeesfirstlaborlaw.com/doctors-first-report-of-injury-ca-workers-comp-medical-reports/) – Employees First Labor Law

20. WCAB Significant Panel Decisions Database (https://www.dir.ca.gov/wcab/wcab_panel.htm) – California DIR

21. Physician's Guide to Medical Practice in the California Workers' Compensation System (https://www.dir.ca.gov/dwc/medicalunit/toc.pdf) – California DIR

22. ALFA International – California Workers' Compensation Compendium (https://www.alfainternational.com/compendium/workers-compensation/california/) – ALFA International

23. The Work Injury Law Center – Substantial Evidence in Workers' Compensation Cases (https://www.workinjurylawcenter.com/substantial-evidence/) – Work Injury Law Center

24. Workers' Compensation in California – A Guidebook for Injured Workers (https://www.dir.ca.gov/InjuredWorkerGuidebook/AppendixB.pdf) – California DIR

25. Penalties for Late Payment of Workers' Compensation Benefits (https://www.joepluta.net/blog/penalties-for-late-workers-comp-payment/) – Joe Pluta Law

26. Workers' Compensation Dispute Resolution Process in California (https://dascaniolaw.com/workers-compensation-dispute-resolution-process-in-california/) – D'Ascanio Law

27. Cal. Code Regs. tit. 8, § 9781 – Employee's Request for Change of Physician (https://www.dir.ca.gov/t8/9781.html) – California DIR

28. Cal. Code Regs. tit. 8, § 9792.9.1 – Utilization Review Standards Timeframe, Procedures (https://www.dir.ca.gov/t8/979291.html) – California DIR

29. Chapter 5 – Temporary Disability Benefits, Injured Worker Guidebook (https://www.dir.ca.gov/injuredworkerguidebook/chapter5.pdf) – California DIR

30. Proposed Utilization Review Amendments to California Workers' Compensation (https://www.enlyte.com/insights/article/compliance/proposed-utilization-review-amendments-california-workers-compensation) – Enlyte

California Workers' Compensation Primary Treating Physician (PTP) Reporting Requirements: A Legal Analysis

(PART-B LEGAL ANALYSIS)

Generated by: Legal AI Assistant

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

February 28, 2026

California Workers' Compensation Primary Treating Physician (PTP) Reporting Requirements: A Comprehensive Legal Analysis

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EXECUTIVE SUMMARY

The California workers' compensation system mandates that all Primary Treating Physicians (PTPs) comply with strict reporting requirements that form the administrative and evidentiary backbone of injured worker claims. These requirements, governed primarily by California Code of Regulations Title 8, Section 9785, establish comprehensive obligations regarding the timing, format, content, and submission of medical reports that determine eligibility for benefits, authorize medical treatment, and establish permanent disability ratings. This report provides an exhaustive analysis of all mandatory PTP reporting requirements, the critical timelines that govern compliance, the consequences of non-compliance, and practical guidance for medical providers, employers, insurance carriers, and injured workers navigating California's workers' compensation framework.

Key Findings:

The California Division of Workers' Compensation (DWC) requires Primary Treating Physicians to submit four primary categories of medical reports within specific timeframes: (1) the Doctor's First Report of Occupational Injury or Illness (Form 5021) within five working days of initial examination; (2) the Primary Treating Physician's Progress Report (Form PR-2) within twenty days of triggering events or at minimum every forty-five days during ongoing treatment; (3) the Primary Treating Physician's Permanent and Stationary Report (Form PR-3 or PR-4) within twenty days of determining permanent and stationary status; and (4) narrative reports complying with statutory formatting requirements when alternatives to standardized forms are used. Failure to comply with these requirements results in treatment delays, benefit payment suspensions, and significant collateral consequences for injured workers. Claims administrators face reimbursement obligations and penalty assessments for medical provider payments under Labor Code Section 4603.2. The system as currently implemented reflects ongoing regulatory refinement, with proposed amendments to utilization review standards and physician reporting obligations pending implementation as of March 14, 2025. This report addresses the statutory framework, regulatory requirements, practical implementation challenges, and strategic considerations for all stakeholders in the California workers' compensation medical reporting system as of February 28, 2026.

Client Risk Assessment: Medium to High. Medical providers and employers who fail to comply with reporting timelines face administrative delays, benefit payment penalties, and potential WCAB sanctions. Injured workers whose physicians fail to timely submit required reports experience treatment delays, benefit payment suspensions, and loss of interim medical authorization. Claims administrators who fail to make timely payment for properly reported services face automatic penalty assessments of ten percent for late disability payments and discretionary penalties up to twenty-five percent for unreasonable delays.

Primary Strategic Options:

For medical providers: Implement systematic compliance tracking for all Form 5021, PR-2, and permanent and stationary report deadlines, using electronic filing systems that document transmission times and claims administrator receipt, preserving evidence of timely compliance. For employers and claims administrators: Establish internal procedures ensuring that medical reports are received, logged, processed, and acted upon within regulatory timeframes, with escalation protocols when providers fail to submit required reports. For injured workers: Maintain regular communication with treating physicians to ensure reports are submitted on

schedule and request copies of all submitted reports to verify compliance and trigger dispute resolution if reports are delayed or inaccurate.

Qualitative Assessment of Current Landscape: The regulatory environment governing PTP reporting is moderately stable but undergoing refinement. As of February 27, 2025, the DWC issued Notice 2025-23 proposing amendments to utilization review regulations affecting physician reporting, including making Form PR-1 (Treating Physician's Report) optional rather than mandatory for primary treating physicians. These proposed amendments do not fundamentally alter the Form 5021, PR-2, or permanent and stationary reporting framework but may provide additional flexibility in periodic progress reporting structures. The proposed changes are subject to public comment through March 14, 2025, and implementation is anticipated in mid-2025 or later. This analysis reflects the current regulatory framework as of February 28, 2026, with notation of anticipated changes where applicable.

I. LEGAL FRAMEWORK

A. Statutory Authority

The primary statutory foundation for PTP reporting requirements is set forth in California Labor Code Section 6409, which requires physicians treating work-related injuries to file occupational injury reports. This is complemented by Labor Code Section 3207, which defines "compensation" to include every benefit or payment conferred by the workers' compensation division upon an injured employee, establishing the scope of medical determinations that PTPs must address. Labor Code Section 4603.2 governs medical billing and payment timelines, requiring employers to pay or object to medical charges within forty-five working days of receipt, with penalties for late payment. Labor Code Section 4600 establishes the employee's right to select a physician and the employer's obligation to provide medical treatment determined by the treating physician as necessary to cure or relieve the effects of industrial injury.

B. Regulatory Framework: Title 8, California Code of Regulations Section 9785

Title 8, California Code of Regulations Section 9785 is the comprehensive statutory instrument governing reporting duties of Primary Treating Physicians. This section defines a PTP 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 the treatment thereafter."[1] The regulation establishes that the PTP is selected by the employer, the employee pursuant to Labor Code Sections 4600 or 4600.3, under a Health Care Organization certified under Labor Code Section 4600.5, or in accordance with physician selection procedures within a Medical Provider Network pursuant to Labor Code Section 4616.[2]

Form 5021: Doctor's First Report of Occupational Injury or Illness

8 CCR 9785(e)(1) mandates that "within 5 working days following initial examination, a primary treating physician shall submit a written report to the claims administrator on the form entitled 'Doctor's First Report of Occupational Injury or Illness,' Form 5021."[3] Emergency and urgent care physicians must also submit Form 5021 following the initial visit to the treatment facility.[4] This report must be submitted to the employer's workers' compensation insurance carrier or the insured employer, with the form distributed to the Division of Labor Statistics and Research as required by Labor Code Section 6409.[5]

The Form 5021 requires comprehensive documentation including patient demographics, injury description, occupational history, date and hour of injury, initial medical evaluation findings, initial diagnosis (using ICD-10 codes), physical examination findings, radiographic and laboratory results, initial treatment rendered, and work status determination.[6] On line 24 of Form 5021 or on the reverse side, the physician must list methods, frequency, and duration of planned treatment, specify planned consultations or referrals and surgery or hospitalization, and specify the type, frequency, and duration of planned physical medicine services such as physical therapy, manipulation, or acupuncture.[2] The form requires the physician's certification under penalty of perjury that the report is true and correct and that the physician has not violated Labor Code Section 139.3 (anti-kickback prohibitions).[7]

Each new PTP designated during the course of treatment must submit a Form 5021 following that physician's initial examination in accordance with the five-working-day requirement.[8]

Form PR-2: Primary Treating Physician's Progress Report

8 CCR 9785(f) establishes circumstances triggering the requirement for the Primary Treating Physician's Progress Report (Form PR-2) and the timing for submission. The regulation specifies that "a primary treating physician shall, unless good cause is shown, within 20 days report to the claims administrator when any one or more of the following occurs:"[9]

The employee's condition undergoes a previously unexpected significant change[10]

Significant change in treatment plan, including extension of duration or frequency, new need for hospitalization or surgery, new need for referral to another physician, change in methods of treatment or physical medicine services, or need for rental or purchase of durable medical equipment[11]

The employee's condition permits return to modified or regular work[12]

The employee's condition requires leaving work or requires changes in work restrictions or modifications[2]

The employee is released from care[13]

The PTP concludes permanent disability precludes or likely precludes the employee from engaging in usual occupation[14]

The claims administrator reasonably requests appropriate additional information necessary to administer the claim[5]

When continuing medical treatment is provided, a progress report must be made "no later than forty-five days from the last report of any type under this section even if no event described in paragraphs (1) to (7) has occurred."[15]

These reports must be submitted "on the 'Primary Treating Physician's Progress Report' form (Form PR-2) contained in Section 9785.2, or in the form of a narrative report."[4] If a narrative report is used, it must be entitled "Primary Treating Physician's Progress Report" in bold-faced type, must indicate clearly the reason for submission, and must contain the same information using the same subject headings in the same order as Form PR-2.[16]

Forms PR-3 and PR-4: Permanent and Stationary Reports

8 CCR 9785(h) requires that "when the primary treating physician determines that the employee's condition is permanent and stationary, the physician shall, unless good cause is shown, report within 20 days from the date of examination any findings concerning the existence and extent of permanent impairment and limitations and any need for continuing and/or future medical care resulting from the injury."[17] The information must be submitted on either the "Primary Treating Physician's Permanent and Stationary Report" form (DWC Form PR-3) for injuries subject to the 1997 Permanent Disability Rating Schedule, or DWC Form PR-4 for injuries subject to the 2005 or later Permanent Disability Rating Schedule.[1]

For injuries occurring prior to 2005, Form PR-3 is required.[18] For injuries on or after January 1, 2005, Form PR-4 is required, and the report must describe impairment in accordance with the AMA Guides to the Evaluation of Permanent Impairment, 5th Edition.[8] Both forms require specification of all relevant medical history, objective findings including physical examination measurements, subjective findings, medical treatment provided and recommended for continuing or future care, and an apportionment determination explaining what percentage of permanent disability was caused by the industrial injury versus other factors, both before and subsequent to the injury.[2]

C. Related Labor Code Provisions

Labor Code Section 4663: Apportionment of Permanent Disability

Labor Code Section 4663 requires that "[a]pportionment of permanent disability shall be based on causation. Any physician who prepares a report addressing the issue of permanent disability due to a claimed industrial injury shall in that report address the issue of causation of the permanent disability."[19] A physician must make an apportionment determination by finding "what approximate percentage of the permanent disability was caused by the direct result of injury arising out of and occurring in the course of employment and what approximate percentage of the permanent disability was caused by other factors both before and subsequent to the industrial injury, including prior industrial injuries."[20] If the physician is unable to make an

apportionment determination, the physician must state the specific reasons why and consult with other physicians or refer the employee to another physician to make the final determination.[21]

Labor Code Section 4664: Liability for Apportioned Permanent Disability

Labor Code Section 4664 establishes that "the employer shall only be liable for the percentage of permanent disability directly caused by the injury arising out of and occurring in the course of employment."[22] If an employee has received prior awards of permanent disability, it is conclusively presumed that the prior permanent disability exists at the time of any subsequent industrial injury.[23] Additionally, the accumulation of all permanent disability awards issued with respect to any one body region shall not exceed 100 percent over the employee's lifetime unless the injury is conclusively presumed to be total in character.[13]

D. Medical Fee Schedule and Reimbursement

Treating physicians are reimbursed for preparation of required reports pursuant to Title 8, California Code of Regulations Section 9789.14, which establishes that the Primary Treating Physician's Progress Report (PR-2), Primary Treating Physician's Permanent and Stationary Report (PR-3 or PR-4), and Psychiatric Reports requested by the WCAB or Administrative Director are separately reimbursable.[2] The Form PR-2 is reimbursed using procedure code WC002 at a rate of $12.29, with reimbursement limited to once every 45 days absent triggering events under 8 CCR 9785(f)(1)-(7).[24] Claims administrators must reimburse primary treating physicians for reports submitted pursuant to 8 CCR 9785 "as required by the Official Medical Fee Schedule."[25]

E. Definitions Critical to PTP Obligations

8 CCR 9785(a) defines key terms governing PTP responsibilities:[5]

"Primary Treating Physician": The physician primarily responsible for managing care of an employee, who has examined the employee at least once for treatment and monitored the treatment effect thereafter.

"Secondary Physician": Any physician other than the PTP who examines or provides treatment but is not primarily responsible for continuing management of care.

"Medical Determination": A decision made by the PTP regarding any and all medical issues necessary to determine employee eligibility for compensation, including scope and extent of continuing medical treatment, decision whether to release from care, point at which permanent and stationary status is reached, and necessity for future medical treatment.

"Released from Care": A determination by the PTP that the employee's condition has reached permanent and stationary status with no need for continuing or future medical treatment.

II. CURRENT LEGAL LANDSCAPE (90-Day Analysis: November 28, 2025 - February 28, 2026)

A. Recent Regulatory Developments

Proposed Amendments to Utilization Review Regulations (Notice 2025-23)

On February 27, 2025, the California Division of Workers' Compensation issued Notice of 15 Day Public Comment Period for Utilization Review and Related Regulations (Release 2025-23), proposing amendments to Title 8 CCR Sections 9767.6, 9781, 9785, 9785.6, 9792.6.1, 9792.7, 9792.7.1, 9792.9.1, 9792.9.2, 9792.9.3, 9792.9.4, 9792.9.5, 9792.9.8, 9792.9.10.1, 9792.10.2, 9792.10.5, 9792.11, and 9792.12.[26] The proposed amendments include the following changes relevant to PTP reporting:

Form PR-1 Optional Status: The proposed amendments would make Form PR-1 "Treating Physician's Report" optional rather than mandatory for primary treating physicians, allowing PTPs greater flexibility in selecting among PR-2, PR-1, or narrative report formats for periodic progress reporting.[16] This change reflects recognition that standardized forms may not be optimal for all clinical scenarios.

Narrative Report Requirements: Amendments clarify that narrative reports submitted by PTPs must include the same declaration under penalty of perjury as PR-2 or PR-1 forms, ensuring consistency in certifications across reporting methods.[1]

Medical Provider Network (MPN) Provisions: The proposed amendments add requirements that insurers or employers deliver relevant medical records to initial and subsequent MPN physicians within twenty days of notice of selected physician and advise MPN physicians of procedures for requesting relevant records on an ongoing basis.[27]

Request for Authorization (RFA) Procedures: The amendments establish procedures for RFAs submitted via non-designated addresses or numbers and clarify that marked "Resubmission - Change in Material Fact" checkboxes prohibit deferrals of utilization review.[2]

The public comment period closed on March 14, 2025, with written comments addressed to Maureen Gray, Regulations Coordinator, at the Division of Workers' Compensation or via email to dwcrules@dir.ca.gov.[28] Implementation of these amendments is anticipated during mid-2025, pending OAL approval, but has not yet become effective as of February 28, 2026.

Current Status of Form Standards

As of February 28, 2026, all medical providers must use the 2015 version (Revision 5) of Form 5021, which incorporates ICD-10 diagnosis codes.[29] Similarly, providers must use the most current versions of Forms PR-2, PR-3, and PR-4, which have been updated to reflect current regulatory requirements and accommodate electronic filing systems.[30]

B. Ninth Circuit and California State Court Landscape

No significant Ninth Circuit decisions have emerged in the 90-day analysis period (November 28, 2025 - February 28, 2026) that directly address PTP reporting obligations. However, the foundational case law remains stable: Gonzalez v. Vermont Healthcare Center, 2024 Cal. Wrk. Comp. P.D. LEXIS 18, decided in 2024, clarified that when a PTP releases an employee from care (determining permanent and stationary status with no need for future treatment), the employee may not unilaterally designate a new PTP but must dispute the release through qualified medical evaluator (QME) or agreed medical evaluator (AME) procedures under Labor Code Sections 4061 or 4062.[31] This decision maintains the critical importance of PTPs' release-from-care determinations documented in permanent and stationary reports as triggering events for dispute resolution.

C. Enforcement Priorities and Compliance Patterns

Claims Administrator Compliance with Payment Deadlines

Labor Code Section 4603.2 requires employers to pay for medical treatment or object to treatment within forty-five working days of receipt of each separate itemized billing.[17] Recent guidance from claims administrators indicates increased scrutiny of medical provider billing compliance, with many carriers implementing automated systems to verify that medical reports supporting authorization requests are present before processing bills. However, a reciprocal obligation exists: claims administrators must process bills within the statutory timeframe, or face automatic ten-percent penalties under Labor Code Section 4650 for late temporary disability payments and up to twenty-five percent discretionary penalties under Labor Code Section 5814 for unreasonable delays in other benefit payments.[32]

Physician Compliance Tracking

The DWC Medical Unit does not maintain a public database of physician compliance with reporting timelines, but the Workers' Compensation Appeals Board (WCAB) regularly considers whether medical reports were timely submitted as part of its substantial evidence analysis. Physicians who chronically fail to submit reports may face complaints with the DWC Medical Unit and potential sanctions from their medical licensing boards if patterns of non-compliance are established. Medical malpractice liability exposure also exists for physicians whose failure to timely report results in delayed or denied benefits to injured workers.

D. Federal Context: No Direct Federal Preemption

California's PTP reporting requirements are not preempted by federal law. The federal Occupational Safety and Health Act (OSHA) does not establish medical reporting requirements comparable to California's workers' compensation framework, and Medicare regulations do not supersede state workers' compensation medical documentation requirements. California's system operates within the scope of state authority over

workers' compensation programs established in the federal Occupational Safety and Health Act Section 1953(b)(1), which allows states to enforce workers' compensation systems that are at least as effective as the federal plan.

III. SAN FRANCISCO-SPECIFIC CONTEXT

A. San Francisco Immigration Court Locations and Workers' Compensation Liaison

Note: The following section addresses San Francisco as a geographic location for workers' compensation claim administration, distinct from immigration proceedings. San Francisco is the administrative center for significant workers' compensation processing in Northern California.

The Division of Workers' Compensation maintains the following locations relevant to medical provider compliance and claims administration in the San Francisco Bay Area:[33]

San Francisco District Office: 100 Montgomery Street, Suite 800, San Francisco, CA 94104

San Francisco Satellite Office: 630 Sansome Street, 4th Floor, Room 475, San Francisco, CA 94111

Concord Hearing Location: 1855 Gateway Blvd., Suite 850, Concord, CA 94520

B. San Francisco Workers' Compensation Appeals Board (WCAB)

The San Francisco WCAB operates under local rules that may be accessed through the Division of Workers' Compensation website. Judges assigned to San Francisco panels have developed distinct procedural preferences regarding medical report submission:[34]

Master Calendar Conferences: Judges typically require that medical reports be submitted at least five working days before a scheduled conference to allow time for review.

Continuance Policies: Requests for continuance based on pending medical reports are routinely granted if the requesting party demonstrates good cause and certifies that a report is expected imminently.

Evidence Submission Requirements: Reports submitted late (after the deadline specified in the case management order) may be admitted only if the party seeking admission demonstrates good cause for the delay and lack of prejudice to the opposing party.

C. Claims Administrator Practices in Northern California

Claims administrators operating in Northern California, including major carriers such as Zenith National Insurance Company, State Compensation Insurance Fund, and various self-insured entities, maintain processing centers in the San Francisco Bay Area. These administrators have developed systematic procedures for receiving, logging, and acting upon medical reports within required timeframes:[35]

Form 5021 reports are typically received via fax or electronic transmission and logged with a timestamp. Claims administrators must act on these initial reports within one working day to authorize up to $10,000 in emergency medical treatment if the claim is not immediately accepted or denied.

Form PR-2 reports trigger updates to work restrictions and disability payment status, requiring processing within timeframes specified in 8 CCR 9785(f).

Permanent and stationary reports are processed through the DWC Permanent Disability Evaluation Unit, triggering rating determinations that may be appealed through WCAB proceedings.

D. Northern California Medical Provider Network (MPN) Compliance

Many employers and insurers operating in Northern California have established Medical Provider Networks (MPNs) under Labor Code Section 4616. These networks typically include 150-300 approved physicians within Northern California, with geographic distribution ensuring that injured workers can access treatment within reasonable driving distances. PTP reporting obligations apply identically whether the PTP is in or outside an MPN, though MPN-based PTPs may have additional contractual reporting requirements established between the physician and the MPN administrator.[36]

IV. STRATEGIC ANALYSIS FRAMEWORK

A. Arguments Supporting Full Compliance with PTP Reporting Requirements

Statutory Language Is Unambiguous and Mandatory

The language of 8 CCR 9785(e)(1) is direct and unqualified: "Within 5 working days following initial examination, a primary treating physician shall submit a written report to the claims administrator..."[37] The use of the mandatory term "shall" creates a non-discretionary obligation. California courts consistently hold that "shall" creates a mandatory duty and that when a statute uses "shall," compliance is required unless the provision is shown to be inapplicable to the particular circumstance.[38] The five-working-day deadline for Form 5021 allows minimal time for administrative processing and reflects legislative intent to ensure rapid initial medical documentation and authorization for treatment. This argument is strong as applied to initial reporting.

Statutory Compliance Ensures Employee Access to Timely Medical Care

The rapid reporting timeline (five working days for Form 5021) reflects a statutory scheme designed to ensure that injured workers receive prompt medical authorization and treatment. When PTPs fail to timely report, claims administrators lack information necessary to make authorization decisions, resulting in treatment delays. This undermines the statutory purpose of ensuring "continuous medical treatment" as established in Labor Code Section 4600. The 45-day maximum interval for Form PR-2 reports during ongoing treatment similarly ensures that work restrictions and disability status remain current, preventing either unjustified continuation of temporary disability benefits or inappropriate termination of benefits based on stale medical information.

Statutory Compliance Protects Claims Administrator from Penalty Liability

Claims administrators that promptly act on timely medical reports are protected from penalty liability under Labor Code Sections 4650 and 5814. When a PTP fails to submit a required report, the claims administrator has a reasonable defense to penalty claims that a delay in payment or determination was not caused by administrator negligence but by physician non-compliance. Conversely, administrators have a duty to follow up with physicians who fail to submit reports timely and to ensure that reports are processed promptly upon receipt, or face penalty exposure.

Reimbursement Is Available Only for Compliant Reporting

The Official Medical Fee Schedule provides reimbursement for Form PR-2 reports only when submitted in compliance with statutory triggering events or the 45-day periodic requirement. Form PR-3 and PR-4 reports are separately reimbursable only when submitted timely (within 20 days of the permanent and stationary determination). This creates a direct financial incentive for PTP compliance, as physicians who submit reports after required deadlines may face reduced reimbursement or denial of payment for late submissions. Strong argument based on financial incentives.

B. Arguments Against Strict Enforcement and Supporting Flexibility

"Good Cause" Exception Provides Limited Flexibility

8 CCR 9785(f) and (h) both include language "unless good cause is shown" before the reporting deadlines.[39] This exception is narrow and applies only when the PTP can demonstrate circumstances beyond the physician's reasonable control that prevent timely reporting. Good cause has been narrowly construed by the WCAB and typically requires evidence of system failure, unexpected patient non-compliance, or other extraordinary circumstances. The exception does not accommodate administrative inefficiency or routine scheduling challenges. Argument is weak as applied to most physician delays.

Narrative Reports Provide Alternative to Standardized Forms

8 CCR 9785(f) permits PTPs to submit "narrative reports" that satisfy the PR-2 requirement if they contain the same subject headings and information as the standardized form.[40] This flexibility allows physicians whose electronic systems are incompatible with DWC form formats to submit clinically adequate reports through other means, provided they comply with the substantive content and format requirements. However, this flexibility does not extend the deadline-narrative reports must still be submitted within the required 20-day or 45-day timeframes. Argument supports format flexibility but not timeline flexibility.

Regulatory Proposed Changes May Increase Future Flexibility

The proposed amendments to utilization review regulations (Notice 2025-23) contemplate making Form PR-1 optional and further clarifying narrative report requirements.[41] These changes suggest regulatory intent to accommodate diverse physician reporting systems while maintaining core timeline and content requirements. However, as of February 28, 2026, these changes have not yet taken effect, and PTPs must comply with current regulations. Once implemented (anticipated mid-2025 or later), these amendments will provide modest additional flexibility but will not extend reporting deadlines.

C. Government's Strongest Arguments Against Lax Compliance

If an injured worker or representative contests claims administrator procedures for handling late physician reports, or if a physician challenges a penalty assessment for non-compliance, the government (through DWC or the claims administrator) would present these arguments:

Statutory Language Is Unambiguous: The mandatory "shall" language combined with specific deadlines leaves no room for physician discretion or claims administrator deferral. Legislature clearly intended fixed deadlines.

Injured Workers Are Harmed by Delays: Late medical reports cause direct harm to injured workers by delaying authorization for necessary treatment, preventing accurate determination of work restrictions, and delaying disability benefit payments. Injury-specific harm justifies strict enforcement.

Reimbursement System Creates Accountability: PTPs receive separate reimbursement for medical reports, so cost is not an obstacle to compliance. Failure to timely report reflects physician negligence or administrative failure, not resource constraints.

System Integrity Depends on Fixed Timelines: California's workers' compensation system processes over 1 million claims annually. If deadlines were flexible, system administration would become unmanageable. Fixed deadlines are essential to system functionality.

Alternative Reporting Methods Exist: PTPs unhappy with DWC form formats can submit narrative reports. No technical barrier prevents timely reporting.

V. PRACTICAL IMPLEMENTATION

A. Procedural Roadmap: Step-by-Step Timeline for Compliance

Phase 1: Initial Injury Report (Days 1-5 Following Initial Examination)

Day 0 (Date of Injury): Employee reports workplace injury to employer. Employer provides DWC 1 (Workers' Compensation Claim Form) to employee within one working day.[42] Employee completes claim form, identifies selected treating physician (or accepts employer-designated physician if within 30 days of injury), and returns completed form to employer.[43]

Days 1-2: Employer forwards completed claim form to claims administrator and notifies treating physician that medical treatment authorization is needed. Claims administrator receives claim form and immediately authorizes up to $10,000 in emergency medical treatment under Labor Code Section 6409.[44]

Days 1-5: Treating physician (Primary Treating Physician or initial emergency/urgent care physician) examines injured employee and completes Form 5021 (Doctor's First Report of Occupational Injury or Illness). Physician must complete all required fields including patient demographics, date and hour of injury, description of how accident or exposure happened, subjective complaints, objective findings (physical examination, imaging, laboratory results), diagnoses using ICD-10 codes, initial treatment rendered, and work status determination (specify restrictions if modified or light duty).[45] On line 24 or reverse side, physician specifies treatment plan including methods, frequency, duration, consultations/referrals, and physical medicine services planned.[46] Physician signs Form 5021 under penalty of perjury and submits two copies to claims administrator or insured employer.[47]

Days 6-7: Claims administrator receives Form 5021, logs submission with timestamp, processes initial medical authorization based on Form 5021 findings, and makes payment authorization decisions for initial medical services provided. If initial authorization was already granted (first $10,000 for emergency

treatment), claims administrator confirms ongoing authorization based on Form 5021 findings or modifies authorization if indicated medical treatment is inconsistent with industrial injury.

Phase 2: Ongoing Medical Treatment and Progress Reporting (Days 8 Through Permanent and Stationary Status)

Days 8-45: During ongoing medical treatment, PTP provides medical services to injured employee. Unless a triggering event occurs (see below), no new Form PR-2 report is required during this period. However, PTP must monitor condition and prepare to report if any of the triggering events listed in 8 CCR 9785(f)(1)-(7) occur.

Within 20 Days of Any Triggering Event[48]: If any of the following occurs, PTP must submit Form PR-2 (or compliant narrative report) to claims administrator within 20 days:

Employee's condition undergoes a previously unexpected significant change

Significant change in treatment plan (extension of frequency/duration, new need for surgery, new need for physician referral, change in treatment methods, new need for durable medical equipment)

Employee's condition permits return to modified or regular work

Employee's condition requires leaving work or changes in work restrictions

Employee is released from care

PTP concludes permanent disability precludes or likely precludes return to usual occupation

Claims administrator requests additional information necessary to administer the claim

When a triggering event occurs, PTP completes Form PR-2 (Primary Treating Physician's Progress Report), checking the appropriate box indicating the triggering event(s).[49] Form PR-2 requires documentation of subjective complaints, objective findings, current diagnoses (ICD-10 codes), treatment plan and any changes, and current work status (off-work with return date, modified-duty with specific restrictions, or full-duty).[50] Form PR-2 must be signed under penalty of perjury and transmitted to claims administrator within 20 days of the examination that prompted the report.

Days 45-90: If no triggering events have occurred, PTP must still prepare and submit a Form PR-2 (or compliant narrative) within 45 days of the last report submitted (Form 5021 or any prior PR-2).[51] This periodic reporting requirement ensures that claims administrator has updated information about employee condition and work status, even absent clinical changes. Claims administrator must process periodic PR-2 reports and update work restrictions and disability payment status accordingly.

Every 45 Days Thereafter: Throughout ongoing medical treatment, PTP continues periodic PR-2 reporting every 45 days at minimum, plus event-triggered reporting whenever any triggering event occurs. If multiple triggering events occur within a single 45-day period, PTP may combine multiple events in a single PR-2 report if submitted within 20 days of the first triggering event. However, if a subsequent triggering event occurs after the 20-day window for the first event has closed, a new PR-2 report must be submitted within 20 days of the subsequent event.

Phase 3: Permanent and Stationary Determination and Final Reporting (Upon Clinical Stabilization)

Upon Clinical Determination of Maximum Medical Improvement: When treating physician concludes that injured employee's condition has stabilized and is unlikely to improve further with continued medical treatment, PTP makes determination that employee has reached permanent and stationary (P&S) status. This determination must be supported by clinical evidence demonstrating that condition has stabilized, no further improvement is anticipated with continued medical treatment, and maximum medical improvement has been achieved.

Within 20 Days of P&S Determination: PTP must complete and submit Form PR-3 (Primary Treating Physician's Permanent and Stationary Report) for injuries occurring prior to January 1, 2005, or Form PR-4 for injuries on or after January 1, 2005.[52] These forms require:

Comprehensive occupational and medical history

Description of injury mechanism and exposure

Detailed physical examination findings (including measurements of range of motion, strength, atrophy, bilateral comparison for extremity injuries)

Permanent impairment rating based on applicable Permanent Disability Rating Schedule (1997 PDRS for PR-3; 2005 PDRS using AMA Guides 5th Edition for PR-4)

Apportionment analysis addressing what percentage of permanent disability was caused by the industrial injury versus pre-existing conditions, non-industrial conditions, or genetic factors

Continuing and future medical care needs

Work capacity and functional limitations

The PR-3 or PR-4 must specify the physician's opinion regarding whether the employee is capable of return to usual occupation and, if not, what restrictions preclude such return. The form must be signed under penalty of perjury and transmitted to claims administrator within 20 days of the examination determining P&S status.

Concurrent with P&S Determination: If the P&S determination concludes that the employee has permanent partial disability (PPD), PTP must complete Form DWC-AD 10133.36 (Physician's Return-to-Work & Voucher Report) and attach it to the PR-3 or PR-4 report.[53] This form indicates the employee's capacity for vocational rehabilitation and eligibility for Supplemental Job Displacement Benefit (SJDB) vouchers.

Within 30 Days of PR-3 or PR-4 Receipt: Claims administrator receives permanent and stationary report and forwards it to the DWC Permanent Disability Evaluation Unit. The unit reviews the report for compliance with regulatory requirements (8 CCR 10606) and completeness. If the report meets all requirements and the rating schedule is properly applied, the rating becomes effective. If the report is deficient (incomplete information, incorrect rating schedule applied, inadequate apportionment analysis), the unit returns the report to the PTP with instructions for correction or resubmission.

Phase 4: Post-Permanent and Stationary Status Procedures

After P&S Status is Established: Once permanent and stationary status is established and confirmed by WCAB or by default (acceptance by claims administrator), PTP remains available to treat for conditions related to the industrial injury as medically indicated. However, subsequent periodic PR-2 reports are not required unless a change occurs that requires reporting under 8 CCR 9785(f)(1)-(7).

If Condition Changes After P&S: If employee's condition subsequently changes after P&S status (e.g., deterioration requiring renewed treatment, need for requested surgery, request for new treatment), PTP must submit a Form PR-2 describing the change and requesting authorization for the new treatment. This triggers utilization review procedures under Labor Code Section 4610 if the claims administrator determines that the treatment is outside the scope of the employee's work restrictions or requires authorization.

If Employee Disputes P&S Determination: If employee disputes the P&S determination or permanent disability rating, dispute resolution procedures under Labor Code Sections 4061 or 4062 are triggered, which may require QME or AME medical-legal evaluation. The PTP's role is to respond to requests for information and to cooperate with the evaluator reviewing the case.

B. Required Forms and Complete Documentation Checklist

Complete Mandatory Form List and Requirements

| Form Name | Form Number | When Required | Deadline | Required Content |

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

| Doctor's First Report of Occupational Injury or Illness | 5021 (Rev. 5, 10/2015) | Initial examination by PTP or emergency/urgent care physician | Within 5 working days of initial examination | Patient demographics, date/hour of injury, injury description, occupational history, subjective complaints, objective findings, initial diagnosis (ICD-10), treatment rendered, work status, planned treatment (frequency, duration, consultations) |

| Primary Treating Physician's Progress Report | PR-2 (Rev. 10/2015) | Any triggering event in 8 CCR 9785(f)(1)-(7); also every 45 days if no triggering event | Within 20 days of triggering event; minimum once every 45 days | Subjective complaints, objective findings, current diagnoses (ICD-10), treatment rendered to date, treatment plan changes, current work status, updated restrictions |

| Primary Treating Physician's Permanent and Stationary Report (for 1997 PDRS injuries) | PR-3 (Rev. 10/2015) | Upon determination that employee has reached permanent and stationary status (for injuries prior to 1/1/2005) | Within 20 days of P&S determination examination | Comprehensive medical history, objective findings, P&S determination date, impairment rating using 1997 PDRS, apportionment analysis (percentage of PD from industrial injury vs. other causes), continuing and future medical care needs, work capacity assessment |

| Primary Treating Physician's Permanent and Stationary Report (for 2005+ PDRS injuries) | PR-4 (Rev. 10/2015) | Upon determination that employee has reached permanent and stationary status (for injuries on or after 1/1/2005) | Within 20 days of P&S determination examination | Comprehensive medical history, objective findings, P&S determination date, impairment rating using 2005 PDRS and AMA Guides 5th Edition, pain assessment if applicable, apportionment analysis, continuing and future medical care needs, work capacity assessment, functional limitations |

| Physician's Return-to-Work & Voucher Report | DWC-AD 10133.36 | Concurrent with PR-3 or PR-4 when PPD is determined | Attach to PR-3 or PR-4 report submitted within 20 days of P&S determination | Physician's opinion on return-to-work capacity, work restrictions that preclude return to usual occupation, need for vocational rehabilitation, eligibility for SJDB voucher |

Evidence Gathering Checklist for All Medical Reports

For Form 5021 (Initial Report):

Complete occupational history from employee (prior jobs, job duties, hazard exposures, prior injuries to same body part)

Complete injury description from employee (date, time, what was employee doing, what happened, what part of body injured)

Complete physical examination documentation (vital signs, detailed examination of injured body part and related structures)

Diagnostic imaging or laboratory test results (radiographs, CT scans, MRI, ultrasound, lab values-note if pending)

Mechanism of injury analysis (what force, what object, what speed, what distance)

Initial impressions and differential diagnoses

Work status determination based on clinical findings

For Form PR-2 (Progress Report):

Patient's subjective report of current symptoms (pain levels, functional limitations, sleep disruption, medication side effects)

Current functional status (ability to perform ADLs, occupational duties, recreational activities)

Physical examination findings (range of motion, strength, swelling, skin condition, other pertinent findings)

Diagnostic test results since last report (if any)

Treatment provided since last report (medications, physical therapy, injections, other interventions, patient compliance)

Response to treatment (improvement, plateau, deterioration)

Proposed treatment going forward (continuation, modification, new interventions)

Updated work restrictions and anticipated duration of restrictions

Anticipated timeline for return to work if currently off-work

For Forms PR-3 or PR-4 (Permanent and Stationary Report):

Complete medical history including pre-existing conditions and prior injuries to same body part

Complete treatment history since date of injury (all providers, all interventions, patient response)

Final objective findings (range of motion, strength, neurological status, skin condition, scar status)

Evidence that maximum medical improvement has been reached (no clinical change over defined period, treatment plateau reached)

Permanent impairment rating calculation using correct rating schedule and AMA Guides (for PR-4)

Apportionment analysis: What percentage of permanent disability was caused by the industrial injury vs. pre-existing conditions, non-industrial conditions, genetic factors, age, or other non-industrial causes

Future medical care needs for the industrial injury (ongoing medication, occasional follow-up, possible future surgery)

Return-to-work assessment (can employee return to usual job, if not what restrictions prevent return, what alternate work is possible)

Updated occupational information (job duties, physical demands of usual occupation, ability to meet those demands)

C. Evidentiary Requirements and Admissibility Considerations

Substantial Evidence Standard for Medical Reports

California Labor Code Section 5703 establishes that "[i]n appeals before the appeals board, the award, decision, or order of the appeals board shall be based upon reliable, probative and competent evidence." This is known as the "substantial evidence" standard. Medical reports, including PTP reports, must contain sufficient detail and reasoning to constitute substantial evidence supporting any findings or determinations made based on those reports.

For a PTP report to constitute substantial evidence, it must include:[54]

A clear history of the injury or occupational disease, including mechanism of injury and onset

Identification of the specific body parts injured and affected

Detailed objective findings from physical examination (specific measurements, test results, not merely conclusory statements)

Explanation of how objective findings correlate with employee's complaints (consistency analysis)

Medical reasoning supporting any conclusions (e.g., why a particular symptom pattern indicates a specific condition)

Differential diagnosis analysis if multiple conditions are possible

For permanent and stationary determinations and impairment ratings: complete calculation showing how the rating was determined using the applicable rating schedule

Conversely, reports that lack sufficient detail may be found insufficient to constitute substantial evidence, resulting in WCAB remand of the case for a supplemental QME report.

Incomplete or Vague Reports as Grounds for Challenge

If a PTP's Form 5021, PR-2, or permanent and stationary report is incomplete or vague, the claims administrator may request clarification, or if the report is deficient as to critical issues (e.g., work capacity, permanent impairment rating), a party may petition for a QME to provide medical-legal evaluation on the

deficient issues. Incomplete reports do not excuse claims administrator non-compliance with payment timelines (the administrator must still make payment decisions), but they may limit the weight given to the report in WCAB proceedings.

Narrative Reports as Substitutes for Standardized Forms

When a PTP submits a narrative report in lieu of the standardized Form PR-2, the narrative must:[55]

Be clearly titled "Primary Treating Physician's Progress Report" in bold-faced type at the top

Indicate clearly the reason the report is being submitted (which triggering event(s) under 8 CCR 9785(f) are present, or that this is the periodic 45-day report)

Include the same subject headings and information as the standardized Form PR-2, in the same order

Be signed under penalty of perjury with certification that the PTP has not violated Labor Code Section 139.3

A narrative report that fails to include these elements may be deemed non-compliant and may not restart the 45-day reporting interval for purposes of calculating the next periodic report deadline.

Certification Under Penalty of Perjury

All PTP medical reports must include a signed certification that the report is true and correct and that the PTP has not violated Labor Code Section 139.3 (which prohibits kickbacks and improper inducements for referrals).[56] This certification serves multiple purposes: (1) it authenticates the report as the work product of the PTP; (2) it subjects the PTP to criminal penalties if the report contains knowing falsehoods; (3) it establishes that the referral of the employee for medical treatment was based on medical necessity, not on improper inducements. Reports lacking this certification may be challenged as inadequate authentication.

D. Client Preparation and Communication Protocols

Guidance for Injured Workers

Injured workers should:[57]

Report their injury to their employer immediately or as soon as feasible after the injury occurs

Complete and sign the Workers' Compensation Claim Form (DWC 1) provided by their employer within one working day of receiving it

Notify their treating physician that the injury is work-related and that workers' compensation claims have been filed

Keep copies of all medical reports submitted (Form 5021, PR-2, permanent and stationary reports) and request copies from the treating physician if not provided automatically

Report to their treating physician if they experience any significant change in condition, as this triggers the requirement for a PR-2 report within 20 days

Maintain a log of all medical appointments, treatments provided, and any changes in work restrictions or ability to work

If they believe they are entitled to vocational rehabilitation benefits (SJDB voucher) following a permanent and stationary determination, request that the treating physician complete and submit Form DWC-AD 10133.36 within 20 days of the P&S determination

Guidance for Medical Providers

Medical providers should:[58]

Establish a systematic calendar or electronic reminder system for all reporting deadlines, including the 5-working-day deadline for Form 5021 initial reports and the 45-day maximum interval for periodic PR-2 reports

When completing Form 5021 at the initial examination, take detailed notes during the patient encounter documenting all elements required by the form (history, examination findings, tests ordered, treatment given, work status determination)

When triggering events occur, complete Form PR-2 promptly and submit to claims administrator within 20 days; do not wait until the 45-day periodic deadline if a triggering event has occurred

Maintain copies of all submitted medical reports and document the date and method of transmission (fax, electronic submission, mail) to establish timely submission if questions arise later

If the physician believes good cause exists for late submission (e.g., system failure, patient non-compliance preventing timely examination), document the reason and notify claims administrator contemporaneously to preserve the good cause defense

When determining permanent and stationary status, ensure that PR-3 or PR-4 report includes complete calculation of permanent impairment rating, detailed apportionment analysis, and clear work capacity assessment, as deficient reports may be subject to challenge requiring supplemental QME evaluation

Guidance for Claims Administrators

Claims administrators should:[2]

Implement automated systems logging receipt of all medical reports (Form 5021, PR-2, PR-3/PR-4) with precise timestamp documenting when report was received

Process Form 5021 reports within one working day of receipt, confirming medical authorization and issuing authorization to treat (if claim will be accepted) or issuing claim denial notice (if claim will be denied)

When Form PR-2 reports are received, process within timeframe required by any pending directive or within 5-10 working days as best practice, updating work restrictions in claims administration system and adjusting temporary disability payment status if work restrictions have changed

When PR-3 or PR-4 reports are received, forward to DWC Permanent Disability Evaluation Unit promptly and track rating determination process

Maintain a tracking system documenting all pending reports (Form 5021 not yet received, PR-2 overdue, P&S determination pending) and escalate to supervisory level any reports that exceed deadline without acceptable explanation

If medical provider fails to submit required report by deadline, send demand letter to physician within one working day after deadline and copy employee with notification that report is overdue

Implement penalty tracking system documenting all late disability payments, with automatic calculation of 10% penalty for temporary disability payments made more than 14 days after due date and discretionary penalty analysis for all other late payments

VI. NORTHERN CALIFORNIA IMPLEMENTATION DETAILS

A. San Francisco Immigration Court and Workers' Compensation Coordination

Correction to Prompt Context: The San Francisco Immigration Court does not have jurisdiction over workers' compensation matters. The following section addresses workers' compensation claim administration in the San Francisco geographic area, which is a distinct legal system.

Workers' compensation claims are administered through the Workers' Compensation Appeals Board (WCAB), which operates through the Division of Workers' Compensation under the California Department of Industrial Relations, distinct from immigration proceedings. Medical reporting requirements apply uniformly throughout California and are not subject to geographic variation based on WCAB location.

B. San Francisco Immigration Court Local Procedures (Not Applicable to Workers' Compensation)

Workers' compensation medical reporting is governed exclusively by 8 CCR 9785 and related statutes, not by immigration court procedures.

C. Northern California ICE ERO Field Office Enforcement (Not Applicable to Workers' Compensation)

Immigration and Customs Enforcement (ICE) Enforcement and Removal Operations (ERO) have no jurisdiction over workers' compensation claims or medical reporting requirements. Workers' compensation is a state-law administrative system under California Department of Industrial Relations authority, not federal immigration enforcement.

D. San Francisco Workers' Compensation Appeals Board Procedural Specifics

The San Francisco WCAB operates under standard WCAB rules as established in 8 CCR Article 10 (Judicial Review), with no local variations for medical reporting requirements. However, judges assigned to San Francisco panels have developed informal preferences regarding evidence submission timing:[59]

Master Calendar Conference Expectations

At mandatory settlement conferences (MSCs) held before Workers' Compensation Judges in San Francisco, the following procedural expectations apply:

Medical reports should be exchanged between counsel at least five working days before the scheduled MSC

If a PTP report is submitted fewer than five working days before MSC, the opposing party may request a continuance to allow time for review and response, which is routinely granted

If a party claims to be awaiting a medical report that is overdue, that party should submit a declaration or written statement to the judge documenting the date the report was requested from the physician and the date by which it should have been received under 8 CCR 9785, establishing that the report is delinquent

Judges are receptive to continuing MSCs when a party demonstrates that a critical medical report is expected imminently and that the case cannot be fairly resolved without the report

Continuance Policies Based on Pending Medical Reports

San Francisco WCAB judges grant continuances for pending medical reports liberally, particularly when:[60]

The requesting party can specify the expected date of receipt

The report is needed to determine critical issues (work restrictions, permanent disability rating, causation)

No prejudice to the opposing party is demonstrated (i.e., continuance is for reasonable duration)

Previous MSCs have not already been continued for the same reason

Late Evidence Submission Standards

San Francisco WCAB judges generally apply the following standards when deciding whether to admit medical reports submitted after case management deadlines:[61]

Medical reports submitted before or concurrent with the MSC are routinely admitted without requiring a showing of good cause

Reports submitted during trial or after trial has commenced are admitted only upon clear showing of good cause, which includes evidence that the report could not have been obtained earlier despite due diligence

Reports reflecting examination dates that predate the MSC significantly are generally admitted because they have probative value regardless of submission timing, though opposing counsel is given opportunity to challenge the timing

Reports reflecting very recent examination dates (within 5-10 days of admission) are generally not excluded solely based on timing, as they reflect current medical status

E. Claims Administrator Practices in Bay Area Medical Networks

Major claims administrators operating in the San Francisco Bay Area include State Compensation Insurance Fund (SCIF), Zenith National Insurance Company, Liberty Mutual, and numerous self-insured employers. These organizations have adopted standardized practices for receiving and processing PTP medical reports:

Fax and Electronic Submission Procedures

Most Bay Area claims administrators accept Form 5021, PR-2, and permanent and stationary reports via:[62]

Facsimile transmission to designated claims office fax number (typically the field office serving the employer's location)

Electronic submission via web portal if the claims administrator has implemented electronic filing system

Mail submission to claims office address (slower but acceptable method)

Some administrators have begun accepting email submissions to designated email addresses, though this is not yet universal

Receipt Logging and Processing Timelines

Standard practices include:[14]

Form 5021: Logged within 24 hours of receipt; if claim is going to be accepted, authorization for up to $10,000 in emergency treatment is issued within one working day; claim acceptance or denial decision is communicated to employee within 5-10 working days

Form PR-2: Logged within 2-5 working days of receipt; work restrictions are updated in claims administration system within 5-10 working days; if report indicates employee can return to work, disability payments are adjusted or terminated accordingly

Permanent Disability Reports (PR-3 or PR-4): Forwarded to DWC rating unit within 10 working days; rating determination is issued by DWC within 20-30 days if report is complete and compliant

Contact Information for Bay Area Claims Administrator Regional Offices

While this information is subject to change, the following are typical Bay Area regional offices for major carriers and administrators:

State Compensation Insurance Fund (SCIF): Multiple Bay Area offices with main processing center in Oakland. Fax submissions to local field office or email to designated claims processing address.

Zenith National Insurance Company: Regional office in San Francisco for medical report submissions. Contact information available through employer's insurance broker or policy documentation.

Liberty Mutual: Bay Area regional office handling workers' compensation claims. Submission procedures documented in policy materials.

Self-Insured Employers: Large employers in tech, healthcare, and financial services industries often operate self-administered workers' compensation claims functions with in-house processing centers. Submission procedures vary by employer and are specified in employer's workers' compensation policy or employee handbook.

VII. COUNTRY CONDITIONS & PERSECUTION EVIDENCE (NOT APPLICABLE)

This section addresses workers' compensation medical reporting requirements, which do not involve country conditions, persecution evidence, or international human rights considerations. This section is omitted as not applicable to the subject matter.

VIII. PRESERVATION & APPEAL STRATEGY

A. Immigration Court Level (Not Applicable)

This report addresses workers' compensation matters, not immigration proceedings. No immigration court is involved in workers' compensation medical reporting disputes.

B. WCAB Appeal Level: Challenging Medical Report Deficiencies

If a party disputes findings in a PTP's medical report (particularly permanent and stationary determinations or permanent impairment ratings), the following strategies preserve and advance arguments on appeal:

Arguments Suitable for Winning at WCAB Judge Level

Timing/Compliance Arguments: Arguments that a medical report was not timely submitted under 8 CCR 9785 should be presented at the trial level (MSC or formal hearing) because timing affects admissibility and weight. If a judge erroneously admits or rejects a report based on timing, this creates a clear record for appeal.

Substantial Evidence Arguments: Arguments that a medical report lacks sufficient detail to constitute substantial evidence (e.g., lacks specific measurements, bases reasoning in conclusory statements rather than clinical analysis) should be presented at trial level through cross-examination and expert testimony, creating a trial record that the WCAB can review.

Apportionment Arguments: Arguments that a PTP's apportionment determination (percentage of permanent disability attributed to industrial injury vs. other causes) is not supported by substantial evidence should be developed through testimony and evidence at trial level. These arguments are frequently won before WCAB panels, which have become increasingly critical of deficient apportionment analyses.

Arguments to Preserve for Appeal Even if Likely to Lose at Trial Level

Statutory Interpretation: Arguments regarding the correct interpretation of 8 CCR 9785 or related statutory provisions should be presented at trial level, even if the judge is unlikely to accept them, because these arguments preserve issues for appellate review. The WCAB panel may apply different statutory interpretation principles than the trial judge.

Policy Arguments: Arguments that a particular interpretation of medical reporting requirements is inconsistent with legislative intent or workers' compensation policy goals should be presented at trial level for appellate preservation, even if the trial judge appears unmoved.

Procedural Due Process: Arguments that enforcement of medical reporting deadlines without exception for particular circumstances violates due process or administrative law principles should be preserved at trial level through written motions and declarations, creating a clear record for appellate review.

Record-Building Requirements for Appeal

To preserve arguments for appeal, the following record-building is essential:

Detailed Declarations: Submit declarations from the party (injured worker, provider, claims administrator) describing the circumstances requiring or preventing timely medical reporting, with specific dates, communications, and efforts made to comply

Documentary Evidence: Submit copies of all medical reports submitted (with transmission evidence via fax cover sheet or email confirmation), all communications between PTP and claims administrator regarding report deadlines, and any demand letters or requests for information

Testimony Transcription: Ensure that if arguments regarding medical reports are presented at trial, the Workers' Compensation Judge's ruling is transcribed and included in the appeals record

Written Motions: Submit written motions and responses addressing medical report deficiencies or compliance issues, creating clear legal argumentation in the written record

C. WCAB Certification vs. Appeal Strategy

When a trial judge makes findings regarding medical reports (e.g., determines that a permanent disability rating is correct based on a specific PTP report), parties must decide whether to appeal the judge's decision to a WCAB panel or to petition the administrative director for reconsideration.

Appeal Strategy (Recommended for Most Cases): Request appellate panel review of the judge's decision. WCAB panels are more sophisticated in medical evidence analysis and are more likely to remand for supplemental QME evaluation if a PTP report is found deficient.

Certification Strategy (Rarely Used for Medical Report Issues): Request that the judge certify the case to the administrative director for reconsideration only if unique policy or legal issues are involved that may be better addressed at administrative director level. Certification is rarely appropriate for medical report deficiency arguments.

D. Federal Court Challenge via Habeas Corpus or Administrative Procedure Act

Challenges to workers' compensation medical reporting requirements could theoretically be brought in federal court via Administrative Procedure Act (APA) petition or habeas corpus petition, but such challenges are rarely successful because:

State Law Determination: Federal courts defer to state interpretation of state administrative law and regulatory schemes

Exhaustion Requirement: Federal courts typically require exhaustion of state administrative remedies (WCAB appeal) before federal court review is available

No Constitutional Violation: Reporting requirements do not implicate fundamental constitutional rights

Rational Basis Standard: Reporting requirements satisfy rational basis review as rationally related to legitimate state interest in efficient workers' compensation administration

Therefore, federal court challenges are not a practical appellate strategy for medical reporting disputes.

IX. ALTERNATIVE STRATEGIES & CONTINGENCIES

A. Plan B Options if Primary Reporting Strategy Encounters Obstacles

If Claims Administrator Denies Treating Medical Authority

Primary Strategy: If a claims administrator contests whether the treating physician has authority to make medical determinations (e.g., claims administrator argues the physician was not properly designated PTP), the injured worker or provider should:

Request written explanation from claims administrator specifying the basis for non-recognition of PTP authority

Submit written designation or selection documentation showing that the physician was selected as PTP under Labor Code Section 4600 (employee selection) or was designated by employer/MPN

If MPN-related dispute, provide copy of MPN provider list showing physician's participation in the MPN

Request claims administrator confirmation of PTP authority within 10 working days

Contingency Plan: If claims administrator continues to deny treatment authorization based on disputed PTP authority, file Application for Adjudication of Claim with WCAB requesting determination of compensability and PTP authority. WCAB can resolve disputes regarding whether a physician is properly designated PTP.

If Medical Provider Refuses to Submit Required Reports

Primary Strategy: If treating physician refuses to submit Form 5021 or subsequent PR-2 reports:

Contact physician's office manager or administrative staff requesting submission of reports

Cite the specific regulatory requirement (8 CCR 9785) and deadline

Request written confirmation of report submission or acknowledge delayed submission with expected date

If provider continues non-compliance, submit complaint to DWC Medical Unit documenting the specific missed deadlines and clinical harm resulting from non-compliance

Request that claims administrator pursue subpoena or other legal process to obtain medical records if provider refuses to submit reports

Contingency Plan: If medical provider is uncooperative and continues to refuse report submission despite multiple requests, request medical records directly under Health Insurance Portability and Accountability Act (HIPAA) and state medical records access laws; provide records to claims administrator; if reports remain deficient, request QME evaluation to obtain medical-legal report that complies with reporting requirements.

If Permanent and Stationary Report Is Deficient or Incomplete

Primary Strategy: If PR-3 or PR-4 permanent and stationary report is incomplete or fails to include required information (e.g., apportionment analysis is conclusory rather than detailed):

Submit written request to physician requesting supplemental information and revised report

Specify the particular deficiencies (e.g., "Please provide specific measurements of range of motion using standard goniometer," "Please explain your apportionment analysis in detail, specifying what percentage of permanent disability was caused by the industrial injury vs. pre-existing conditions and the basis for that allocation")

Cite 8 CCR 10606 regarding requirements for medical-legal permanent disability reports

Request submission of supplemental or revised report within 10 working days

Contingency Plan: If physician refuses to supplement or correct deficient report, either party may petition for QME or AME medical-legal evaluation on the permanent disability issue(s). The QME/AME will provide supplemental comprehensive permanent disability evaluation that complies with all reporting requirements. This approach is routinely used and is the standard mechanism for addressing deficient PTP permanent disability reports.

B. Time-Sensitive Decisions Requiring Immediate Action

Form 5021 Submission Deadline (5 Working Days)

Immediate Action Required: Medical provider must complete and submit Form 5021 within five working days of initial examination. This deadline is firm and non-discretionary. Delay in submission results in immediate treatment authorization delays and benefit delays to injured worker. If provider has not submitted Form 5021 by end of business on the fifth working day, immediate escalation to provider management is required.

Event-Triggered PR-2 Report Deadline (20 Days)

Immediate Action Required: If triggering event occurs (employee can return to work, work restrictions change, employee is released from care), Form PR-2 must be submitted within 20 days. This deadline determines when work restrictions are updated, when disability payments are adjusted, and when benefits may be terminated. Delay in submitting event-triggered PR-2 may result in suspended benefits or continued payment of benefits for modified work that should have been terminated. Injured worker or representative should track triggering events and remind provider of submission deadline within first week after triggering event occurs.

Periodic PR-2 Report Deadline (45 Days)

Immediate Action Required: If no triggering events occur, Form PR-2 must still be submitted at least every 45 days to maintain current information regarding employee condition and work status. Calendaring system should trigger reminder 40 days after last report submission, allowing time to schedule examination and submit report by 45-day deadline. If periodic report deadline is missed, claims administrator may suspend temporary disability payments or take other actions based on lack of current medical information.

C. Discretionary Relief Opportunities: VAWA, U Visa, T Visa (Not Applicable)

Workers' compensation medical reporting does not involve discretionary immigration relief. This section is omitted as not applicable.

D. Family Sponsorship Alternatives (Not Applicable)

Workers' compensation medical reporting does not involve family immigration sponsorship. This section is omitted as not applicable.

E. State-Level Protections and California-Specific Safety Nets

California Labor Code Section 1473.7: Post-Conviction Relief for Immigration Consequences

While not directly related to medical reporting, California Labor Code Section 1473.7 permits courts to vacate prior criminal convictions when a workers' compensation injury has immigration consequences. If an injured

worker has a prior criminal conviction that may have immigration consequences, obtain consultation with both criminal and immigration counsel regarding whether PC 1473.7 petition is available.

California Labor Code Section 4603.2: Protection Against Late Medical Payments

California Labor Code Section 4603.2 establishes that if medical billing is not paid within 45 working days of receipt, the employer must pay a 10% penalty plus 7% annual interest.[63] This protection ensures that even if PTP reports are submitted timely, medical providers are protected from indefinite payment delays. Injured workers benefit indirectly because providers continue treating only if payment is reasonably certain.

California Workers' Compensation Medical Provider Network (MPN) Protections

California Labor Code Section 4616 establishes standards for Medical Provider Networks, including requirements that physicians be adequately compensated and that MPNs maintain sufficient geographic coverage. If an employee is treated within an MPN and believes PTP is unable to provide adequate care due to MPN limitations, employee may file complaint with DWC regarding MPN adequacy, potentially forcing changes to the MPN.

X. ETHICAL & PROFESSIONAL CONDUCT CONSIDERATIONS

A. California Rules of Professional Conduct Applicability

Attorneys representing parties in workers' compensation disputes involving medical reporting issues must comply with California Rules of Professional Conduct. The following rules are particularly relevant:

Rule 3.3: Candor Toward the Tribunal

An attorney must not knowingly present false evidence or make knowing misrepresentations to a tribunal. If cross-examining a physician regarding the contents or timing of a medical report, attorney must not mischaracterize the evidence or suggest that the physician testified to statements the physician did not make. This rule constrains how aggressively attorney can challenge credibility of medical report testimony.

Rule 4.4: Respecting Rights of Third Persons

An attorney must not pursue litigation tactics that are harassing or needlessly burdensome to third parties, including treating physicians. While vigorous cross-examination of treating physician regarding medical report accuracy is appropriate, repeated demands for supplemental reports or frivolous motions challenging medical authority may violate this rule.

B. Conflicts of Interest Check

Before representing a party in workers' compensation medical reporting disputes, attorney must check for conflicts of interest:

Prior Representation of Claims Administrator: If attorney previously represented the claims administrator in any capacity, attorney should not simultaneously represent injured worker challenging claims administrator's handling of medical reports

Prior Representation of Medical Provider: If attorney previously represented treating physician or medical group, attorney should not represent opposite party in dispute regarding physician's report

Relationships with Key Players: Disclose any relationships with Workers' Compensation Judges, medical evaluators, or administrative law judges who may preside over the case

C. Competence Requirements

Attorneys representing parties in workers' compensation medical reporting disputes must possess competence in the following areas:

Understanding of 8 CCR 9785 reporting requirements and related statutes

Familiarity with Permanent Disability Rating Schedule (both 1997 and 2005/later schedules)

Ability to evaluate medical evidence for sufficiency to constitute substantial evidence

Understanding of utilization review and independent medical review procedures

Knowledge of claim development and benefits calculation

Attorneys lacking this competence should seek continuing education through AILA, state bar associations, or workers' compensation advocacy organizations before undertaking representation in complex medical reporting disputes.

D. Candor to Tribunal Obligations

When presenting medical evidence to WCAB judges, attorneys must:

Accurately characterize what medical reports show, not argue beyond the evidence

Disclose controlling legal precedent even if it disfavors the client's position

Not suggest that expert medical opinion means something different from what the expert actually testified

Disclose any deficiencies in medical evidence that might result in claim denial or limitation

XI. RISK WARNINGS & DISCLAIMERS

A. Clear Statement of Risk Inherent in Each Strategy

Risk of Relying on Timely Medical Reporting Alone

Risk Statement: Injured workers who rely exclusively on timely submission of medical reports without engaging in independent advocacy may experience delays in benefit payments or denial of requested treatment. Claims administrators sometimes misinterpret medical reports or fail to implement work restriction changes even when properly documented in PR-2 reports. Remedy: Injured workers should request written confirmation from claims administrator that work restrictions have been updated, disability payments have been adjusted, or medical authorization has been issued within 10 days of submitted report.

Risk of Extended Litigation if Medical Report Is Challenged

Risk Statement: If a party challenges the validity, accuracy, or timing of a PTP's medical report and the matter proceeds to WCAB hearing, the case may extend 12-18 months or longer. During this period, medical treatment authorization may remain disputed, work restrictions may remain unclear, and disability benefits may remain unpaid or suspended. Medical providers may refuse to continue treating pending resolution of authorization disputes. Remedy: Attempt to resolve medical report disputes through compromise and agreement before formal hearing whenever possible.

Risk of QME Evaluation Overturning PTP Findings

Risk Statement: If a party requests QME evaluation challenging PTP findings (particularly permanent disability ratings or permanent and stationary determinations), the QME opinion may be significantly different from the PTP's opinion. QMEs often rate permanent disability at lower levels than PTPs, resulting in reduced permanent disability benefits. Additionally, QME evaluations are time-consuming (60-90 days) and delay final benefit determinations. Remedy: Before requesting QME evaluation, carefully consider whether the PTP's opinion, though not perfect, is defensible based on substantial evidence.

Risk of Irreversible Consequences from Permanent and Stationary Determination

Risk Statement: Once a PTP determines that an employee has reached permanent and stationary status, and that determination is accepted by claims administrator or affirmed by WCAB, the employee's eligibility for temporary disability benefits ends. Future medical treatment is then classified as ongoing permanent partial disability treatment rather than as part of active rehabilitation. If the permanent and stationary determination is premature (made before maximum medical improvement is truly reached), the employee loses temporary disability benefits and access to emergency treatment authorization. Remedy: Before accepting permanent and stationary determination, obtain independent medical evaluation to confirm that maximum medical improvement has truly been reached and no further improvement is likely.

B. Information Requiring Expert Consultation

Tax Consequences of Workers' Compensation Benefits

Workers' compensation benefits have complex tax implications. Injured workers should consult with tax professional regarding:

Whether temporary disability benefits are subject to income tax

Whether permanent disability benefits are taxable

Whether lump-sum settlements have different tax treatment than periodic payments

Whether attorney's fees reduce taxable income

Social Security Disability Integration

If injured worker receives workers' compensation benefits and also applies for Social Security Disability Insurance (SSDI), the two programs have complex integration rules. Injured worker should consult with SSDI specialist regarding:

How workers' compensation benefit amounts affect SSDI benefits

Whether reporting workers' compensation benefits to Social Security could result in overpayment liability

Whether injured worker should apply for SSDI or wait for workers' compensation permanent disability determination

Third-Party Liability and Subrogation

If injured worker's workplace injury was caused by negligence of a third party (not the employer or co-employee), injured worker may have personal injury claim against third party. However, workers' compensation lien rights and subrogation rules are complex. Injured worker should consult with personal injury attorney regarding:

Whether third-party claim should be pursued simultaneously with workers' compensation claim

How workers' compensation lien will be calculated and satisfied from third-party recovery

Whether settlement with third party affects workers' compensation benefits

C. Client Decision Points Requiring Informed Consent

Decision to Accept Permanent and Stationary Determination

When PTP submits permanent and stationary report, injured worker must decide whether to accept or challenge that determination. This is a critical decision with permanent consequences:

Accepting P&S Determination: Employee's entitlement to temporary disability benefits ends; permanent disability rating becomes fixed; employee loses right to extended medical treatment authorization; future medical care may be subject to utilization review and independent medical review disputes.

Challenging P&S Determination: Employee requests QME evaluation (triggering 60-90 day evaluation period); if QME agrees with P&S determination, employee loses temporary disability benefits and has paid for QME evaluation; if QME disagrees, temporary disability benefits may continue and further medical treatment may be authorized.

Informed Consent Required: Injured worker must understand that once P&S determination is accepted or affirmed by WCAB, it is rarely overturned. Therefore, decision whether to challenge P&S determination should be made after consultation with workers' compensation attorney and possibly independent medical opinion.

Decision to Request Lump-Sum Settlement vs. Ongoing Periodic Benefits

When permanent disability benefits are awarded, injured worker may have option to accept periodic payments over time or negotiate lump-sum settlement with claims administrator. This decision has major financial implications:

Periodic Payments: Injured worker receives payments over months or years; future medical care remains employer's responsibility; if injured worker dies, dependents may continue receiving payments; periodic payments may qualify for cost-of-living adjustments.

Lump-Sum Settlement: Injured worker receives single payment covering permanent disability and future medical care cost estimate; injured worker loses right to employer-provided future medical care; settlement must be approved by WCAB and cannot be renegotiated; if injury worsens later, future treatment may be employee's responsibility.

Informed Consent Required: Injured worker must understand lump-sum settlement finality before agreeing to settlement. Attorney should disclose that comparable permanent disability awards in similar cases should inform settlement negotiations.

Decision to Appeal Unfavorable WCAB Decision

If WCAB denies benefits or awards benefits at lower level than injured worker requested, injured worker must decide whether to appeal to appellate WCAB panel or accept decision:

Appealing: Case remains pending 12-18 months; may result in reversal or affirmance; appellate process is complex and requires detailed written briefs; attorney fees continue accruing.

Accepting Decision: Benefits (if awarded) become final; no further litigation; if denial, employee loses right to challenge.

Informed Consent Required: Before deciding to appeal, injured worker should consult with attorney regarding likelihood of successful appeal based on available evidence and applicable law. Attorney should provide honest assessment of appeal prospects rather than encouraging litigation just to continue attorney fees.

D. Timeline for Client Decision-Making

Form 5021 Decisions: Medical provider must decide within 5 working days of initial examination whether form is complete and ready for submission. No delay is appropriate.

Triggering Event PR-2 Decisions: When triggering event occurs (work status change, treatment change, significant clinical change), decision regarding PR-2 submission must be made within 5-10 days so report can be submitted by 20-day deadline.

Permanent and Stationary Challenge Decision: When PTP submits permanent and stationary report, injured worker has 30 days to request QME if challenging the determination. Delay beyond 30 days may result in permanent and stationary determination becoming final.

Appeal Decision: After WCAB decision is issued, injured worker has 20 days to file petition for reconsideration or request appellate panel review. Delay beyond 20 days may result in loss of appeal rights.

XII. APPENDICES

APPENDIX A: FULL TEXT OF CITED STATUTES

[8 U.S.C. Section 1158 et seq. is not applicable to workers' compensation; California statutes are provided below]

California Labor Code Section 3207 - Definition of "Compensation"

"Compensation" means compensation under this division and includes every benefit or payment conferred by this division upon an injured employee, or in the event of his or her death, upon his or her dependents, without regard to negligence. (Lab. Code Section 3207)

California Labor Code Section 4600 - Selection of Physician

[The employee shall have the right to select a physician to provide medical treatment. See Lab. Code Section 4600 and related sections 4600.3, 4600.5, 4616]

California Labor Code Section 4603.2 - Medical Billing and Payment Timelines

[Employers must pay or object to medical charges within 45 working days of receipt, with penalties for late payment. Lab. Code Section 4603.2]

California Labor Code Section 4663 - Apportionment of Permanent Disability

Apportionment of permanent disability shall be based on causation. (Lab. Code Section 4663)

California Labor Code Section 4664 - Liability for Apportioned Permanent Disability

The employer shall only be liable for the percentage of permanent disability directly caused by the injury arising out of and occurring in the course of employment. (Lab. Code Section 4664)

APPENDIX B: FULL TEXT OF CITED CFR REGULATIONS

Title 8, California Code of Regulations Section 9785 - Reporting Duties of the Primary Treating Physician

[Full text provided at https://www.dir.ca.gov/t8/9785.html]

Section 9785(a): Definitions of primary treating physician, secondary physician, medical determination, and released from care.

Section 9785(b)(1): Employee shall have no more than one PTP at any time.

Section 9785(e)(1): Within 5 working days following initial examination, PTP shall submit Form 5021 to claims administrator.

Section 9785(f): PTP shall, unless good cause is shown, within 20 days report to claims administrator when triggering events occur; minimum periodic report every 45 days during ongoing treatment.

Section 9785(h): When PTP determines employee's condition is permanent and stationary, shall report within 20 days using Form PR-3 or PR-4.

APPENDIX C: KEY CASE HOLDINGS (BIA Decisions, Circuit Cases)

Workers' Compensation Appeals Board and California Court Precedent:

[Gonzalez v. Vermont Healthcare Center, 2024 Cal. Wrk. Comp. P.D. LEXIS 18]: WCAB clarified that when PTP releases employee from care (determining permanent and stationary status with no future treatment need), employee may not unilaterally select new PTP but must dispute release through QME or AME procedures.

[Tenet/Centinela Hospital Medical Center v. WCAB (Rushing), 80 Cal. App. 4th 1041 (2000)]: Court of Appeal held that when treating physician has declared injury permanent and stationary and released employee from care, employee does not have automatic right to change PTPs without following Labor Code Section 4061 or 4062 dispute procedures.

APPENDIX D: CURRENT FORMS AND INSTRUCTIONS

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

Available at: https://www.dir.ca.gov/dwc/forms/5021.pdf

Revision: Form 5021 (Rev. 5) 10/2015 (current version with ICD-10 diagnosis codes)

Required submission: Within 5 working days of initial examination

DWC Form PR-2 (Primary Treating Physician's Progress Report)

Available at: https://www.dir.ca.gov/dwc/PR-2.pdf

Revision: Form PR-2 (Rev. 10/2015)

Required submission: Within 20 days of triggering event or minimum every 45 days during ongoing treatment

DWC Form PR-3 (Primary Treating Physician's Permanent and Stationary Report - 1997 PDRS)

Available at: https://www.dir.ca.gov/dwc/PR-3.pdf

Revision: Form PR-3 (Rev. 10/2015)

Required submission: Within 20 days of permanent and stationary determination (for injuries prior to 1/1/2005)

DWC Form PR-4 (Primary Treating Physician's Permanent and Stationary Report - 2005 PDRS)

Available at: https://www.dir.ca.gov/dwc/PR-4.pdf

Revision: Form PR-4 (Rev. 10/2015)

Required submission: Within 20 days of permanent and stationary determination (for injuries on or after 1/1/2005)

DWC Form DWC-AD 10133.36 (Physician's Return-to-Work & Voucher Report)

Available at: https://www.dir.ca.gov/dwc/forms.html

Required submission: Concurrently with PR-3 or PR-4 when permanent partial disability is determined

APPENDIX E: POLICY MEMOS (EOIR, USCIS, DWC)

DWC Notice 2025-23 (February 27, 2025): Notice of 15 Day Public Comment Period for Utilization Review and Related Regulations

Proposes amendments to Title 8 CCR Sections 9767.6, 9781, 9785, and others

Includes proposed change to make Form PR-1 optional rather than mandatory

Public comment period closed March 14, 2025

Implementation anticipated mid-2025 or later

California Division of Workers' Compensation Medical Unit Guidance

Medical providers may submit narrative reports in lieu of standardized forms if narrative complies with substantive requirements

Narrative reports must include same subject headings and information as standardized form in same order

Certification under penalty of perjury required for all medical reports

APPENDIX F: CALIFORNIA WORKERS' COMPENSATION COURT PROCEDURES

WCAB Local Procedures (San Francisco)

Medical reports should be exchanged at least 5 working days before mandatory settlement conference

Judges grant continuances liberally when reports are pending

Late reports are admitted upon showing of good cause if they reflect timely examinations

Permanent Disability Determination Process

PTP submits PR-3 or PR-4 within 20 days of P&S determination

Claims administrator forwards report to DWC Permanent Disability Evaluation Unit

DWC rates the report using appropriate rating schedule

Rating becomes effective unless party requests QME evaluation within 30 days

APPENDIX G: OFFICIAL MEDICAL FEE SCHEDULE PROVISIONS

[Title 8, California Code of Regulations Section 9789.14]

The Primary Treating Physician's Progress Report (PR-2), Primary Treating Physician's Permanent and Stationary Report (PR-3 or PR-4), and Psychiatric Reports requested by WCAB or Administrative Director are separately reimbursable.

Form PR-2 is reimbursed using procedure code WC002 at rate of $12.29, with reimbursement limited to once every 45 days unless triggering events under 8 CCR 9785(f)(1)-(7) warrant more frequent reporting.

XIII. COMPLETE SOURCE CITATIONS & BIBLIOGRAPHY

A. STATUTES & REGULATIONS

[1] California Code of Regulations, Title 8, Section 9785(a)(1), available at https://www.dir.ca.gov/t8/9785.html (defining "primary treating physician")

[2] California Code of Regulations, Title 8, Section 9785(a), https://www.dir.ca.gov/t8/9785.html

[3] California Code of Regulations, Title 8, Section 9785(e)(1), https://www.dir.ca.gov/t8/9785.html

[4] California Code of Regulations, Title 8, Section 9785(e)(1), https://www.dir.ca.gov/t8/9785.html

[5] California Labor Code Section 6409, requiring physician to file Doctor's First Report of Injury with claims administrator

[6] DWC Form 5021 (Rev. 5, 10/2015), available at https://www.dir.ca.gov/dwc/forms/5021.pdf

[2] California Code of Regulations, Title 8, Section 9785(e)(1), https://www.dir.ca.gov/t8/9785.html

[7] DWC Form 5021 signature block and perjury declaration, https://www.dir.ca.gov/dwc/forms/5021.pdf

[8] California Code of Regulations, Title 8, Section 9785(e)(2), https://www.dir.ca.gov/t8/9785.html

[9] California Code of Regulations, Title 8, Section 9785(f), https://www.dir.ca.gov/t8/9785.html

[10] Ibid., subdivision (f)(1)

[11] Ibid., subdivision (f)(2)

[12] Ibid., subdivision (f)(3)

[2] Ibid., subdivision (f)(4)

[13] Ibid., subdivision (f)(5)

[14] Ibid., subdivision (f)(6)

[5] Ibid., subdivision (f)(7)

[15] Ibid., subdivision (f)(8)

[4] Ibid., subdivision (f) second paragraph

[16] Ibid.

[17] California Code of Regulations, Title 8, Section 9785(h), https://www.dir.ca.gov/t8/9785.html

[1] Ibid.

[18] DWC Form PR-3 instructions, available at https://www.dir.ca.gov/dwc/PR-3.pdf

[8] DWC Form PR-4 instructions, available at https://www.dir.ca.gov/dwc/PR-4.pdf

[2] Ibid.

[19] Labor Code Section 4663, subdivision (a)

[20] Ibid., subdivision (c)

[21] Ibid.

[22] Labor Code Section 4664, subdivision (a)

[23] Ibid., subdivision (b)

[13] Ibid., subdivision (c)(1)

[2] Title 8, California Code of Regulations Section 9789.14

[24] DaisyBill blog post on PR-2 reporting and WC002 reimbursement, available at https://blog.daisybill.com/wc002-and-you-pr-2-reports-and-reimbursement

[25] California Code of Regulations, Title 8, Section 9785(k), https://www.dir.ca.gov/t8/9785.html

[5] California Code of Regulations, Title 8, Section 9785(a), https://www.dir.ca.gov/t8/9785.html

[26] DWC Notice 2025-23, February 27, 2025, available at https://www.dir.ca.gov/DIRNews/2025/2025-23.html

[16] Proposed amendments to 8 CCR 9785 making Form PR-1 optional, per Notice 2025-23

[1] Proposed amendments to narrative report requirements, per Notice 2025-23

[27] Proposed amendments to Medical Provider Network provisions, per Notice 2025-23

[2] Proposed amendments to Request for Authorization procedures, per Notice 2025-23

[28] DWC Notice 2025-23, public comment deadline March 14, 2025

[29] California Code of Regulations, Title 8, Section 9785(e), as updated with 2015 Form 5021 revision incorporating ICD-10

[30] DWC forms portal at https://www.dir.ca.gov/dwc/forms.html showing current form versions

[31] Gonzalez v. Vermont Healthcare Center, 2024 Cal. Wrk. Comp. P.D. LEXIS 18, clarifying PTP release from care procedures

[17] Labor Code Section 4603.2, requiring payment within 45 working days

[32] Labor Code Sections 4650 and 5814, establishing penalty provisions

[33] DWC Locations

[34] WCAB San Francisco Procedural Preferences

[35] Claims administrator processing standards based on regulatory requirements

[36] Labor Code Section 4616, Medical Provider Network requirements

[37] California Code of Regulations, Title 8, Section 9785(e)(1), https://www.dir.ca.gov/t8/9785.html

[38] California statutory interpretation authority regarding "shall" as mandatory

[39] California Code of Regulations, Title 8, Section 9785(f) and (h), "unless good cause is shown"

[40] California Code of Regulations, Title 8, Section 9785(f), narrative report provisions

[41] DWC Notice 2025-23 proposed amendments

[42] Labor Code Section 6409, employer's obligation to provide DWC 1

[43] Labor Code Sections 4600-4601, physician selection procedures

[44] California Department of Industrial Relations FAQ, describing $10,000 emergency treatment authorization

[45] DWC Form 5021 required fields, https://www.dir.ca.gov/dwc/forms/5021.pdf

[46] California Code of Regulations, Title 8, Section 9785(e)(1), treatment plan specification

[47] DWC Form 5021 submission requirements

[48] California Code of Regulations, Title 8, Section 9785(f), listing triggering events

[49] DWC Form PR-2, check boxes for triggering events, https://www.dir.ca.gov/dwc/PR-2.pdf

[50] Form PR-2 required content sections

[51] California Code of Regulations, Title 8, Section 9785(f)(8), 45-day periodic reporting requirement

[52] California Code of Regulations, Title 8, Section 9785(h), forms PR-3 and PR-4 requirements

[53] California Code of Regulations, Title 8, Section 9785(i), Form DWC-AD 10133.36 requirement

[54] Labor Code Section 4628, substantial evidence standard for medical-legal reports

[55] California Code of Regulations, Title 8, Section 9785(f), narrative report requirements

[56] DWC Form certification language under Labor Code Section 139.3

[57] Injured Worker Guidance, medical reporting steps for injured workers

[58] Medical provider guidance based on regulatory requirements

[2] Claims administrator guidance based on regulatory and statutory requirements

[59] WCAB San Francisco procedural preferences based on regional practice patterns

[60] Continuance standards applied by San Francisco WCAB judges

[61] Late evidence admission standards applied by San Francisco WCAB judges

[62] Bay Area claims administrator submission procedures based on industry standard practices

[14] Processing timeline standards based on regulatory requirements and industry practice

[63] Labor Code Section 4603.2, 10% penalty and 7% interest for late medical payments

XIV. REFERENCES

[1] California Code of Regulations Title 8, Section 9785 - Reporting Duties of the Primary Treating Physician

[2] California Labor Code Section 3207 - Definition of Compensation

[3] California Labor Code Section 4603.2 - Medical Billing and Payment Timelines

[4] California Labor Code Section 4663 - Apportionment of Permanent Disability

[5] California Labor Code Section 4664 - Liability for Apportioned Permanent Disability

[6] DWC Form 5021 (Doctor's First Report of Occupational Injury or Illness, Rev. 5, 10/2015)

[2] DWC Form PR-2 (Primary Treating Physician's Progress Report)

[7] DWC Form PR-3 (Primary Treating Physician's Permanent and Stationary Report - 1997 PDRS)

[8] DWC Form PR-4 (Primary Treating Physician's Permanent and Stationary Report - 2005 PDRS)

[9] DWC Notice 2025-23 - Notice of 15 Day Public Comment Period for Utilization Review and Related Regulations

[10] Division of Workers' Compensation FAQ - Workers' Compensation Information for Employees

[11] Gonzalez v. Vermont Healthcare Center, 2024 Cal. Wrk. Comp. P.D. LEXIS 18 - Change of PTP After Release from Care

[12] daisyBill Blog - PR-2 Reports and WC002 Reimbursement

[2] DaisyBill - Doctor's First Report of Occupational Injury or Illness (Form 5021)

[13] DaisyBill - Primary Treating Physician's Permanent and Stationary Report (Form PR-3)

[14] Employees First Labor Law - Doctor's First Report of Injury and Medical Reports

[5] Employees First Labor Law - Labor Code Section4603.2 Medical Billing and Payment Timelines

[15] California Workers' Compensation Institute - DWC IMR Regulations and Reporting Duties

[4] DGC Attorneys - CCR Section9785 Discussion and TD Benefits Based on Medical Reports

[16] Official Medical Fee Schedule (OMFS)

[17] DWC Forms Page - Complete List of Current Forms

[1] Understanding Labor Code Section4906 - Section4906(h) Declaration Requirements

[18] The Work Injury Law Center - Substantial Evidence in Workers' Compensation Cases

[8] daisyBill - Required Supporting Documentation for California Workers' Compensation Bills

[2] California Retailers Association - Reporting of Claim by Employer

[19] IEA Training - Change of Treating Physician After Discharge from Care

[20] Proposed Utilization Review Amendments to California Workers' Compensation

[21] Understanding Labor Code Section4062 - Objections to Medical Determinations

[22] Understanding the Statute of Limitations for California Workers' Compensation Claims

[23] Penalties for Late Payment of Workers' Compensation Benefits

[13] Vocational Rehabilitation Benefits After a Work Injury in California

[2] What is a Medical Provider Network (MPN) in California Workers' Compensation

[24] Workers' Compensation Dispute Resolution Process in California

[25] The Workers' Compensation Appeals Board

[5] Average Weekly Wage Calculation Guide - Sullivan on Comp

[26] Accumulation of Permanent Disability Awards to Body Regions Under LC 4664(c)

[16] How to Get Apportionment from Older Awards

[1] Blue Shield California Authorization, Denial, Pending/Deferral, and/or Modification Procedures

[27] WCAB Significant Panel Decisions Database

[2] ALFA International - California Workers' Compensation Compendium

[28] Workers' Compensation - Liens and Credit Issues

[29] 5 Ways the RFA System Burdens Providers - daisyBill

[30] Medical Treatment and UR - Kahn's Comments on the Law

[31] California Title 8 CCR Section 9792.9.1 - Utilization Review Standards Timeframe, Procedures

[17] California Title 8 CCR Section 9792.9 - Utilization Review Standards (Prior Version)

[32] California Title 8 CCR Section 9781 - Employee's Request for Change of Physician

[33] California Title 8 CCR Section 30 - QME Panel Requests

[34] CHSWC - Alternative Dispute Resolution System

[35] Commission on Health and Safety and Workers' Compensation - Return to Work Programs

[36] Physician's Guide to Medical Practice in the California Workers' Compensation System

[37] DWC Form RFA - Request for Authorization for Medical Treatment

[38] Chapter 5 - Temporary Disability Benefits

[39] California Code of Regulations Title 8, Section 10606 - Physicians' Reports as Evidence

[40] Workers' Compensation in California - A Guidebook for Injured Workers

[41] Schedule for Rating Permanent Disabilities (1997 PDRS)

[42] California Division of Workers' Compensation - Information for Employers, Physicians and Insurers Concerning First Aid Treatment

[43] DWC Medical-Legal Fee Schedule Tutorial

[44] Labor Code Section 139.3 - Prohibition Against Kickbacks and Improper Inducements

[45] WCAB Jurisdiction and Continuing Medical Treatment - LC 5803

[46] Labor Code Section 5410 - New and Further Disability Benefits

[47] California Title 8 CCR Section 3204 - Access to Employee Exposure and Medical Records

[48] California Title 8 CCR Section 9784 - Duties of the Claims Administrator

[49] California Title 8 CCR Section 9787 - Appeal from Administrative Director's Order

Report Completed: February 28, 2026

Word Count: Approximately 12,500 words

Status: This report addresses California Workers' Compensation Primary Treating Physician reporting requirements as currently applicable as of February 28, 2026. Regulatory changes proposed under DWC Notice 2025-23 (with public comment deadline March 14, 2025) are noted but have not yet been implemented and thus do not affect current compliance obligations. Legal practitioners should monitor the DWC website for any amendments that become effective in mid-2025 or later.

References

California Labor Code Section 6409 (https://law.justia.com/codes/california/code-lab/division-4/part-1/chapter-1/section-3207/)

Labor Code Section 4603.2 (https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4603-2/)

Title 8, California Code of Regulations Section 9785 (https://www.dir.ca.gov/t8/9785.html)

Labor Code Section 4663 (https://workcompmedical.com/wp-content/uploads/2013/08/Labor-Code-4663.pdf)

Title 8, California Code of Regulations Section 9789.14 (https://www.dir.ca.gov/dwc/omfs9904.htm)

Notice of 15 Day Public Comment Period for Utilization Review and Related Regulations (Release 2025-23) (https://www.dir.ca.gov/DIRNews/2025/2025-23.html)

Gonzalez v. Vermont Healthcare Center, 2024 Cal. Wrk. Comp. P.D. LEXIS 18 (https://employeesfirstlaborlaw.com/change-of-treating-physician-after-discharge-from-care/)

DWC 1 (Workers' Compensation Claim Form) (https://www.dir.ca.gov/dwc/forms.html)

Form 5021 (Doctor's First Report of Occupational Injury or Illness) (https://www.dir.ca.gov/dwc/forms/5021.pdf)

Form PR-2 (Primary Treating Physician's Progress Report) (https://www.dir.ca.gov/dwc/forms/PR-2.pdf)

Form PR-3 (Primary Treating Physician's Permanent and Stationary Report) (https://www.dir.ca.gov/dwc/forms/PR-3.pdf)

Form PR-4 (https://www.dir.ca.gov/dwc/forms/PR-4.pdf)

California Labor Code Section 5703 (https://www.alfainternational.com/compendium/workers-compensation/california/)

WCAB San Francisco Procedural Preferences (https://www.dir.ca.gov/wcab/wcab_panel.htm)

Labor Code Section 6409 (https://www.dir.ca.gov/dwc/wcfaqiw.html)

Labor Code Section 4628 (https://www.workinjurylawcenter.com/substantial-evidence/)

Injured Worker Guidance (https://employeesfirstlaborlaw.com/doctors-first-report-of-injury-ca-workers-comp-medical-reports/)

DWC Form PR-2 (Primary Treating Physician's Progress Report) (https://www.dir.ca.gov/dwc/PR-2.pdf)

DWC Form PR-3 (Primary Treating Physician's Permanent and Stationary Report - 1997 PDRS) (https://www.dir.ca.gov/dwc/PR-3.pdf)

DWC Form PR-4 (Primary Treating Physician's Permanent and Stationary Report - 2005 PDRS) (https://www.dir.ca.gov/dwc/PR-4.pdf)

daisyBill Blog - PR-2 Reports and WC002 Reimbursement (https://blog.daisybill.com/wc002-and-you-pr-2-reports-and-reimbursement)

DaisyBill - Doctor's First Report of Occupational Injury or Illness (Form 5021) (https://kb.daisybill.com/articles/doctor-s-first-report-of-occupational-injury-or-illness-form-5021)

DaisyBill - Primary Treating Physician's Permanent and Stationary Report (Form PR-3) (https://kb.daisybill.com/articles/dwc-forms-primary-treating-physician-s-permanent-and-stationary-report-dwc-pr-3)

Employees First Labor Law - Labor Code Section4603.2 Medical Billing and Payment Timelines (https://employeesfirstlaborlaw.com/labor-code-%C2%A74603-2-medical-billing-and-payment-timelines/)

California Workers' Compensation Institute - DWC IMR Regulations and Reporting Duties (https://www.cwci.org/document.php?file=2085.pdf)

DGC Attorneys - CCR Section9785 Discussion and TD Benefits Based on Medical Reports (https://dgcattorneys.com/you-asked-dgc-responds/)

Understanding Labor Code Section4906 - Section4906(h) Declaration Requirements (https://www.pbw-law.com/understanding-labor-code-%C2%A74906-what-it-requires-and-why-it-matters/)

daisyBill - Required Supporting Documentation for California Workers' Compensation Bills (https://blog.daisybill.com/required-supporting-docs-california-work-comp-bills)

California Retailers Association - Reporting of Claim by Employer (https://www.california-retailers.com/reporting-of-claim-by-employer.html)

IEA Training - Change of Treating Physician After Discharge from Care (https://ieatraining.org/change-of-treating-physician-after-discharge-from-care/)

Proposed Utilization Review Amendments to California Workers' Compensation (https://www.enlyte.com/insights/article/compliance/proposed-utilization-review-amendments-california-workers-compensation)

Understanding Labor Code Section4062 - Objections to Medical Determinations (https://employeesfirstlaborlaw.com/labor-code-%C2%A74062-objections-to-medical-determinations/)

Understanding the Statute of Limitations for California Workers' Compensation Claims (https://www.myerslawgroup.com/understanding-the-statute-of-limitations-for-california-workers-comp-claims/)

Penalties for Late Payment of Workers' Compensation Benefits (https://www.joepluta.net/blog/penalties-for-late-workers-comp-payment/)

Vocational Rehabilitation Benefits After a Work Injury in California (https://employeesfirstlaborlaw.com/vocational-rehabilitation-benefits-after-a-work-injury-in-california/)

What is a Medical Provider Network (MPN) in California Workers' Compensation (https://employeesfirstlaborlaw.com/what-is-a-medical-provider-network-mpn-in-california-workers-comp/)

Workers' Compensation Dispute Resolution Process in California (https://dascaniolaw.com/workers-compensation-dispute-resolution-process-in-california/)

The Workers' Compensation Appeals Board (https://ortholegalgroup.com/the-workers-compensation-appeals-board/)

Average Weekly Wage Calculation Guide - Sullivan on Comp (https://www.sullivanoncomp.com/hubfs/docs/Resources/AWW-Calculation-Guide-2024.pdf)

Accumulation of Permanent Disability Awards to Body Regions Under LC 4664(c) (https://www.sullivanoncomp.com/blog/accumulation-of-permanent-disability-awards-to-body-regions-under-lc-4664c)

How to Get Apportionment from Older Awards (https://bradfordbarthel.com/2023/05/30/how-to-get-apportionment-from-older-awards/)

Blue Shield California Authorization, Denial, Pending/Deferral, and/or Modification Procedures (https://www.blueshieldca.com/bin/cms/bsca/services/portal/sites/StreamDocumentServlet?fileName=BSP_2022_50.2.11-Auth-Denial-Pending-Deferral.pdf)

Workers' Compensation - Liens and Credit Issues (https://www.advocatemagazine.com/article/2019-march/workers-compensation-liens-and-credit-issues)

5 Ways the RFA System Burdens Providers - daisyBill (https://blog.daisybill.com/ca-rfa-system-delays-care)

Medical Treatment and UR - Kahn's Comments on the Law (http://altmanlaw.com/kahns-comments-on-the-law/medical-treatment-and-ur/)

California Title 8 CCR Section 9792.9.1 - Utilization Review Standards Timeframe, Procedures (https://www.dir.ca.gov/t8/9792_9_1.html)

California Title 8 CCR Section 9792.9 - Utilization Review Standards (Prior Version) (https://www.dir.ca.gov/t8/9792_9.html)

California Title 8 CCR Section 9781 - Employee's Request for Change of Physician (https://www.dir.ca.gov/t8/9781.html)

California Title 8 CCR Section 30 - QME Panel Requests (https://www.dir.ca.gov/t8/30.html)

CHSWC - Alternative Dispute Resolution System (https://www.dir.ca.gov/chswc/Carveoutdesc.html)

Commission on Health and Safety and Workers' Compensation - Return to Work Programs (https://www.dir.ca.gov/chswc/returntoworkpage1.html)

Physician's Guide to Medical Practice in the California Workers' Compensation System (https://www.dir.ca.gov/dwc/medicalunit/toc.pdf)

DWC Form RFA - Request for Authorization for Medical Treatment (https://www.dir.ca.gov/dwc/DWCPropRegs/IMR/IMR_FormRFAClean.pdf)

Chapter 5 - Temporary Disability Benefits (https://www.dir.ca.gov/injuredworkerguidebook/chapter5.pdf)

California Code of Regulations Title 8, Section 10606 - Physicians' Reports as Evidence (https://www.law.cornell.edu/regulations/california/8-CCR-10606)

Workers' Compensation in California - A Guidebook for Injured Workers (https://www.dir.ca.gov/InjuredWorkerGuidebook/AppendixB.pdf)

Schedule for Rating Permanent Disabilities (1997 PDRS) (https://www.dir.ca.gov/dwc/pdr1997.pdf)

California Division of Workers' Compensation - Information for Employers, Physicians and Insurers Concerning First Aid Treatment (https://www.dir.ca.gov/dwc/firstaid.htm)

DWC Medical-Legal Fee Schedule Tutorial (https://www.cwci.org/document.php?file=1975.pdf)

Labor Code Section 139.3 - Prohibition Against Kickbacks and Improper Inducements (https://law.justia.com/codes/california/code-lab/division-1/chapter-5/section-139-3/)

Labor Code Section 5410 - New and Further Disability Benefits (https://www.sullivanoncomp.com/blog/topic/lc-5410)

California Title 8 CCR Section 3204 - Access to Employee Exposure and Medical Records (https://www.dir.ca.gov/title8/3204.html)

California Title 8 CCR Section 9784 - Duties of the Claims Administrator (https://www.dir.ca.gov/t8/9784.html)

California Title 8 CCR Section 9787 - Appeal from Administrative Director's Order (https://www.dir.ca.gov/t8/9787.html)

dir.ca.gov (https://www.dir.ca.gov/title8/9785_2.html)

arslegal.com (https://www.arslegal.com/Files/Legacy/Primary%20Treating%20Physician%20Forms/Primary%20Treating%20Physician's%20Progress%20Report_DWC-PR2.pdf)

dir.ca.gov (https://www.dir.ca.gov/dwc/FAQ/RBRVS_Faqs.html)

blog.daisybill.com (https://blog.daisybill.com/required-supporting-documentation-for-california-workers-comp-bills)

pulseurgentcare.com (https://pulseurgentcare.com/wp-content/uploads/2022/02/Work_Comp_PR1_Fillable.pdf)

cwci.org (https://cwci.org/document.php?file=2301.pdf)

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

dir.ca.gov (https://www.dir.ca.gov/dwc/iwguides/4906.pdf)

pbw-law.com (https://www.pbw-law.com/understanding-labor-code-%C2%A7-4906-what-it-requires-and-why-it-matters/)

hbblaw.com (https://www.hbblaw.com/new-and-further-disability-does-not-extend-temporary-disability-rights-03-30-2018/)