Primary Treating Physician Referrals in California Workers' Compensation: Statutory Obligations, Employee Rights, and Dispute Procedures

(PART-A INJURED WORKERS ANALYSIS)

February 28, 2026

The information provided through this AI-powered Analysis is for **general informational and educational purposes only**. It is **not legal advice**, does **not create an attorney-client relationship**, and should not be relied upon as a substitute for advice from a qualified attorney. Laws and legal outcomes vary based on specific facts and jurisdiction. If you need advice tailored to your situation, you should consult directly with an attorney.

(c) 2026 The Law Offices of Fernando Hidalgo, Inc.. Generated by a Legal AI Assistant. Facilitated by The Law Offices of Fernando Hidalgo, Inc.. All rights reserved.

PRIMARY TREATING PHYSICIAN REFERRALS IN CALIFORNIA WORKERS' COMPENSATION: YOUR RIGHTS, OBLIGATIONS, AND DISPUTE PROCEDURES

This report explains how referrals from your Primary Treating Physician (the main doctor managing your work injury) work under California workers' compensation law. It covers what your employer must do, what your doctor must do, and what you can do if you are not getting the medical care you need. A 2019 legal ruling called Pena v. Aqua Systems changed the rules significantly in your favor: your employer cannot require a referral from your main doctor before authorizing you to see a specialist. This report walks you through the law, your rights, and the steps to take when problems arise.

Part 1: Your Right to Medical Treatment Under California Law

This section covers the basic legal rule that your employer must pay for all reasonable medical treatment for your work injury.

The Employer's Duty to Provide Treatment

Under California law, your employer has a legal duty to pay for your medical care when you are hurt at work. California Labor Code § 4600 (https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4600/) requires your employer to provide "medical, surgical, chiropractic, acupuncture, and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches, and apparatuses...that is reasonably required to cure or relieve the injured worker from the effects of their injury." This is not optional — it is a mandatory obligation.

> ***Important: If your employer fails to provide treatment, you may obtain it yourself and your employer must reimburse you. This right is written directly into Labor Code § 4600 (https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4600/).***

What Is a Primary Treating Physician?

Your Primary Treating Physician (PTP) is the one doctor who is mainly responsible for managing your care for your work injury. Under California Code of Regulations Title 8, § 9785(a)(1) (https://www.dir.ca.gov/t8/9785.html), the PTP is defined as "the physician who is primarily responsible for managing the care of an employee, and who has examined the employee at least once for the purpose of rendering or prescribing treatment and has monitored the effect of the treatment thereafter."

Key rules about your PTP:

- You may have only one PTP at a time
- Your PTP may be chosen by your employer, selected by you from an approved list, or designated through a Medical Provider Network (MPN) — a group of doctors your employer has contracted with under Labor Code § 4616 (https://law.justia.com/codes/california/2011/lab/division-4/4616-4616.7/4616/)
- You can change your PTP if your current PTP determines you need continuing or future medical treatment

Pre-Designating Your Own Doctor

You have a powerful right that many workers do not know about. Under Labor Code § 4600(d) (https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4600/), you can pre-designate a personal physician before any injury happens. If you notify your employer in writing before an injury that you have a personal doctor, you may treat with that doctor from day one of your injury — even if that doctor is not in your employer's MPN.

To qualify, the doctor must:

- Be your regular physician licensed in California
- Have previously directed your medical treatment and hold your medical records
- Agree to be pre-designated

Part 2: Your Doctor's Reporting and Referral Duties

This section explains what your PTP must report to your employer's insurance company and when referrals must be documented.

The Doctor's First Report

Within 5 working days of your first examination, your PTP must submit a Doctor's First Report of Occupational Injury or Illness (Form DLSR 5021) to the claims administrator (the person or company that manages your employer's workers' compensation insurance). This report must include planned treatments, any planned referrals to specialists, any planned surgeries or hospitalizations, and any planned physical therapy. Cal. Code Regs. tit. 8, § 9785 (https://www.dir.ca.gov/t8/9785.html) requires this information be documented from the start of your care.

When Your Doctor Must File Progress Reports

Your PTP must file a progress report to the claims administrator within 20 days when certain events happen. Under Cal. Code Regs. tit. 8, § 9785(f) (https://www.dir.ca.gov/t8/9785.html), these triggering events include:

- Your condition changes unexpectedly
- Your treatment plan changes significantly
- A new need arises for referral to or consultation with another physician
- A new need for surgery or hospitalization arises
- There is a change in physical therapy or other treatment methods
- There is a need for medical equipment

Even if nothing changes, your PTP must file a progress report at least every 45 days during ongoing treatment. This prevents your care from continuing without updated medical justification.

How Secondary Doctors Report to Your PTP

A secondary physician is any specialist or other doctor you are referred to for additional care. Under Cal. Code Regs. tit. 8, § 9785(e)(3)-(4) (https://www.dir.ca.gov/t8/9785.html), secondary physicians must report their findings back to your PTP. Your PTP then has 20 days to review those findings, either agree or disagree with them, and send everything to the claims administrator.

> ***Important: If your PTP does not incorporate or respond to a secondary doctor's report within 20 days without good cause, that is a regulatory violation. It can weaken your PTP's credibility and may expose the claims administrator to liability for delayed care.***

Part 3: The Pena Doctrine — You Do Not Need a PTP Referral

This section explains the landmark 2019 ruling that protects your right to see a specialist without waiting for your PTP to write a referral.

What Happened in Pena v. Aqua Systems

In 2019, the Workers' Compensation Appeals Board (WCAB) — the state agency that decides workers' compensation disputes — issued a ruling in Pena v. Aqua Systems (https://dclbv.com/newsletters/2019/q3/ptp-referral-and-rfa-are-not-required/) that changed how referrals work in California. An injured worker named Miguel Pena had a psychiatric doctor confirm he had a work-related psychiatric injury. He requested psychiatric treatment on July 6, 2018, but his employer refused to authorize it until October 25, 2018 — a three-month delay. The employer argued that Pena needed a referral from his PTP first.

The WCAB rejected this argument. The panel stated clearly: "There is no requirement that the applicant's Primary Treating Physician make a referral or submit a Request for Authorization before an employer's obligation to provide treatment activated."

What This Means for You

The Pena ruling established three important rules:

- You can request secondary treatment directly. When you (or your attorney) ask the claims administrator for specialist care for an accepted body part, that request by itself activates your employer's duty under Labor Code § 4600 (https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4600/) to provide treatment. You do not need your PTP to write a referral first.
- Asking to see a specialist is not a "treatment plan." The WCAB explained that choosing a doctor to evaluate you is not the same as requesting a specific medical treatment. The employer cannot use the utilization review process (explained in Part 4) to delay your initial access to a specialist.
- Delays without good reason trigger penalties. Under Labor Code § 5814 (https://employeesfirstlaborlaw.com/labor-code-%C2%A75814-penalties-for-unreasonable-delay-or-denial/), if your employer unreasonably delays providing your medical care, you can receive a penalty of up to 25% of the delayed benefit (or $10,000, whichever is less), plus attorney's fees.

The "Genuine Doubt" Standard

The only acceptable excuse for delaying your secondary treatment is if the employer has genuine medical or legal doubt about whether your injury is work-related or whether the treatment applies to your accepted condition. This doubt must be real and documented. In Pena, the employer never tried to challenge the psychiatric doctor's findings and never conducted further investigation — so the WCAB found the delay was unreasonable and awarded a penalty.

> ***Critical: Your employer cannot simply stay silent or delay. If the employer doubts liability, it must document that doubt in writing. Mere silence or delay is not enough.***

Part 4: Utilization Review and Treatment Authorization

This section explains how your employer reviews medical treatment requests and what happens when treatment is denied.

What Is Utilization Review?

Utilization Review (UR) is a process where your employer reviews a doctor's treatment recommendation to decide if it is medically necessary. Under Labor Code § 4610 (https://law.justia.com/codes/california/2011/lab/division-4/4600-4614.1/4610/), employers may "prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, based in whole or in part on medical necessity to cure and relieve, treatment recommendations by physicians."

To start the UR process, your treating doctor submits a Request for Authorization (RFA) using the official DWC Form RFA to the claims administrator. The claims administrator must respond within specific timeframes under Cal. Code Regs. tit. 8, § 9792.9.1 (https://www.dir.ca.gov/t8/979291.html):

- Standard review: Decision within 5 business days
- Urgent/expedited review: Decision within 72 hours
- Retrospective review (after treatment already given): Decision within 30 days

> ***Important: Only a licensed physician who is qualified in the specific medical area can deny or modify a treatment request. A claims adjuster or non-medical employee cannot make this decision. This rule is in Labor Code § 4610(e) (https://law.justia.com/codes/california/2011/lab/division-4/4600-4614.1/4610/).***

UR Does Not Apply to Choosing a Doctor

The Pena ruling drew an important line. UR applies to a specific course of proposed medical treatment — such as a request for surgery or a series of physical therapy sessions. It does not apply to your request to simply be evaluated by a specialist. The WCAB stated: "the mere selection of a physician to provide medical treatment does not constitute a 'specific course of proposed medical treatment' that would necessitate a Request for Authorization." Once the specialist examines you and proposes a treatment plan, that plan may then go through UR.

When Your Employer Can Defer UR

If your employer is disputing whether your injury is work-related (a liability dispute), it may defer UR under Labor Code § 4610(l) (https://www.sullivanoncomp.com/blog/deferring-utilization-review). However, the employer must send written notice within 5 business days of receiving the RFA. This notice must go to your doctor, to you, and to your attorney (if you have one). The notice must explain the basis for the dispute. If the

employer fails to defer UR properly and also fails to issue a timely UR decision, the treatment may be considered authorized by default.

Part 5: Independent Medical Review — Your Appeal Right

This section explains what to do when utilization review denies your treatment request.

What Is Independent Medical Review?

If UR denies or modifies your treatment, you have the right to request an Independent Medical Review (IMR) under Labor Code § 4610.5 (https://www.dir.ca.gov/dwc/IMR/IMR_FAQs.htm). IMR is conducted by an independent medical professional who has never reviewed your case before. This reviewer makes a final decision about whether the denied treatment is medically necessary.

To request IMR:

1. You must file the DWC Form IMR-1 within 30 days of receiving the UR denial
2. The form must be complete and signed
3. You should include copies of the UR decision and all supporting medical records

The Administrative Director of the Division of Workers' Compensation reviews whether your case qualifies for IMR within 5 to 10 days. If it qualifies, an independent review organization conducts the review.

IMR Decisions Are Hard to Overturn

The IMR determination is presumed correct. You can appeal an IMR decision to the WCAB, but only on very narrow grounds:

- The Administrative Director acted without authority
- The determination was obtained through fraud
- The medical reviewer had a conflict of interest
- There was bias based on a protected characteristic (race, gender, etc.)
- There was a clear and obvious mistake of fact

This high standard means it is very difficult to reverse an IMR decision. That is why it is important to submit strong medical evidence with your original UR request.

Qualified Medical Evaluator Process

When you and your employer disagree about medical questions that UR and IMR cannot resolve — such as whether your injury is work-related or whether you truly need ongoing care — either side can request a Qualified Medical Evaluator (QME) under Labor Code § 4062 (https://employeesfirstlaborlaw.com/labor-code-%C2%A74062-objections-to-medical-determinations/). The QME is an independent doctor who conducts a full evaluation and writes a detailed report. The Division of Workers' Compensation Medical Unit (https://www.dir.ca.gov/dwc/medicalunit/faqiw.html) provides a panel of three qualified evaluators, and the parties select one.

The QME can address whether secondary treatment is medically necessary, whether you have reached permanent and stationary status (meaning your condition has stabilized as much as it will), and what future medical care you need. The QME's opinion carries significant weight in settlement talks and at trial.

Part 6: Medical Provider Networks and Specialist Access

This section explains how Medical Provider Networks work and your rights when the network cannot provide the specialist you need.

What Is a Medical Provider Network?

A Medical Provider Network (MPN) is a group of doctors and other medical providers that your employer has set up or contracted with to treat injured workers. Under Labor Code § 4616 (https://law.justia.com/codes/california/2011/lab/division-4/4616-4616.7/4616/), the MPN must include enough

doctors of different types to treat common work injuries based on the kind of work you do and where you work.

Within an MPN, you have the right to choose your PTP from the available network doctors. Under Cal. Code Regs. tit. 8, § 9767.6(e) (https://www.dir.ca.gov/t8/9767_5.html), at any point after your initial evaluation, you may select a different physician from within the MPN.

Access Standards: The Distance Rules

Your employer's MPN must meet minimum distance requirements so you can actually reach your doctors. Under Cal. Code Regs. tit. 8, § 9767.5(a) (https://www.dir.ca.gov/t8/9767_5.html):

- General PTPs and emergency hospitals: At least 3 available primary treating physicians within 30 minutes or 15 miles of your home or workplace
- Specialists: At least 3 available specialists within 60 minutes or 30 miles of your home or workplace

The Murillo Decision: Specialist Access Standards

A 2021 WCAB ruling in Murillo v. Western National Group (https://www.sullivanoncomp.com/blog/mpn-access-standards-if-an-employee-chooses-to-treat-with-a-specialist) clarified an important point. When you want a specialist (such as a pain management doctor) to be your PTP, the MPN must meet the specialist access standard (30 miles/60 minutes), not the general PTP standard (15 miles/30 minutes).

If the MPN cannot provide at least three available specialists of the type you need within these distance limits, the MPN must allow you to see a specialist outside the network at your employer's expense.

Appointment Scheduling Deadlines

Under Cal. Code Regs. tit. 8, § 9767.5(g) (https://www.dir.ca.gov/t8/9767_5.html), the MPN must schedule your first appointment with a specialist within 20 business days of your request through the MPN's medical access assistant. If the access assistant cannot schedule a timely appointment within 10 business days, your employer must let you see an appropriate specialist outside the MPN.

> ***Important: Under Cal. Code Regs. tit. 8, § 9767.5(c) (https://www.dir.ca.gov/t8/9767_5.html), the MPN must have a written policy allowing you to obtain necessary treatment from an appropriate specialist outside the MPN when access standards or timeframes cannot be met. This is an automatic safety valve — you do not need special permission beyond documenting that the MPN could not meet the standard.***

Part 7: Recent Legal Developments — The Rodriguez Decision

This section covers a 2025 court ruling that changed how "ongoing treatment" disputes are handled.

Background: The Patterson Doctrine (2014)

In Patterson v. The Oaks Farm (2014), the WCAB established what became known as the Patterson exception. Under this rule, if your employer had previously authorized an ongoing course of treatment, the employer could not use utilization review to deny that same treatment later unless the employer proved your condition had materially changed. This effectively created permanent authorizations for certain types of care like home health services or continuing physical therapy.

The 2025 Rodriguez Decision

On November 10, 2025, the Second District Court of Appeal issued a published decision in Illinois Midwest Insurance Agency LLC v. WCAB (Rodriguez) (https://www.sullivanoncomp.com/blog/2nd-district-court-of-appeal-rejects-patterson-exception-to-ur/imr) that significantly limited the Patterson doctrine. The court held that there is no statutory basis for an "ongoing treatment" exception to the UR/IMR process. For any dispute about whether treatment is medically necessary, IMR is the sole and exclusive remedy.

The court stated: "the entire statutory framework evinces a clear legislative purpose: to remove medical necessity determinations from the WCAB and courts and to place such decisions exclusively in the hands of medical professionals."

What Rodriguez Means for You

- If your employer previously authorized secondary treatment and now denies it through UR, you must challenge the denial through IMR — not by filing directly with the WCAB
- You cannot rely on a "once authorized, always authorized" argument
- You must pursue IMR appeals promptly when secondary treatment is denied or modified

> ***Note: In footnote 6 of the Rodriguez decision, the court said it was not deciding cases where an employer authorizes treatment and then terminates it without using the UR process, or where the parties agreed to forgo UR/IMR. These situations may still be handled differently.***

Part 8: Continuity of Care When Your Doctor Leaves the MPN

This section explains your rights if the doctor treating your work injury is removed from your employer's Medical Provider Network.

When Continuity of Care Protections Apply

Labor Code § 4616.2 (https://law.justia.com/codes/california/2011/lab/division-4/4616-4616.7/4616/) and Cal. Code Regs. tit. 8, § 9767.10 (https://www.dir.ca.gov/t8/9767_10.html) protect you if your treating doctor is terminated from the MPN. You may be able to continue seeing that doctor if your situation falls into one of these categories:

- Acute condition: Your condition has lasted less than 90 days and treatment will be completed soon
- Serious or chronic condition: Your condition requires at least 90 more days of treatment
- Terminal illness: You have a condition expected to result in death
- Scheduled surgery: A surgery or procedure is recommended and documented to occur within 180 days of the doctor's termination date

What Your Employer Must Do

When your doctor is removed from the MPN, the claims administrator must:

- Notify you in writing about the termination
- Tell you whether you need to select a new doctor
- Explain the continuity of care dispute resolution process

If you believe your case qualifies for a continuity of care exception, you can ask your current doctor to write a report supporting your position. If the doctor agrees you qualify, you may continue treatment while the dispute is resolved through Labor Code § 4062 (https://employeesfirstlaborlaw.com/labor-code-%C2%A74062-objections-to-medical-determinations/) procedures.

The Valdiviezo Case (2025)

In a 2025 WCAB decision, Valdiviezo v. Unknown Defendant (ADJ10885532) (https://www.dir.ca.gov/wcab/Panel-Decisions-2025/CarlosVALDIVIEZO-ADJ10885532.pdf), the judge found that the employer failed to follow continuity of care procedures by improperly deferring utilization review requests from a terminated provider without giving proper notice. The judge awarded a Labor Code § 5814 (https://employeesfirstlaborlaw.com/labor-code-%C2%A75814-penalties-for-unreasonable-delay-or-denial/) penalty for unreasonable delay in treatment.

> ***Critical: Your employer cannot simply remove your doctor from the MPN and stop your treatment without following all required continuity of care steps. Failure to follow these steps can result in penalties.***

Disputing a Release from Care

If your PTP says you are "released from care" — meaning the doctor believes your condition is stable and you need no more treatment — you cannot simply choose a new PTP. However, you can dispute this determination. In Gonzalez v. Vermont Healthcare Center (2024) (https://ieatraining.org/change-of-treating-physician-after-discharge-from-care/), the WCAB clarified that a release from care must be challenged through the full QME process under Labor Code § 4062 (https://employeesfirstlaborlaw.com/labor-code-%C2%A74062-objections-to-medical-determinations/), not through the faster MPN second-opinion process.

Part 9: Penalties for Unreasonable Delays

This section explains the financial penalties your employer faces for delaying or denying your medical care without good reason.

Labor Code § 5814 Penalties

Under Labor Code § 5814 (https://employeesfirstlaborlaw.com/labor-code-%C2%A75814-penalties-for-unreasonable-delay-or-denial/), if your employer unreasonably delays or denies any workers' compensation benefit — including medical treatment — you may receive a penalty of up to 25% of the delayed benefit amount or $10,000, whichever is less. You may also receive attorney's fees under Labor Code § 5814.5.

In the Pena case, a three-month delay in authorizing psychiatric treatment — with no documented reason for the delay — resulted in a 25% penalty on the first psychiatric treatment visit.

How to Protect Yourself

To support a penalty claim, keep detailed records of:

- The date you requested secondary treatment
- All communications with the claims administrator
- The date treatment was finally authorized
- Any periods when treatment was denied or delayed without explanation

The Risk for Employers

For claims administrators, the Pena ruling (https://dclbv.com/newsletters/2019/q3/ptp-referral-and-rfa-are-not-required/) creates a lopsided risk: delaying treatment without documented genuine doubt exposes the employer to penalties and attorney's fees on top of the treatment costs. Authorizing treatment promptly costs only the treatment itself — which the employer is legally required to pay anyway under Labor Code § 4600 (https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4600/).

> ***Important: If your employer has genuine doubt about liability, it must document that doubt in writing and communicate it within 5 business days. Staying silent while delaying your care is not a valid excuse.***

Part 10: Key Timelines and Deadlines

This section provides a quick reference for the most important deadlines in the referral and treatment authorization process.

Doctor Reporting Deadlines

Event	Deadline	Authority
Doctor's First Report after initial exam	5 working days	Cal. Code Regs. tit. 8, § 9785 (https://www.dir.ca.gov/t8/9785.html)
Progress report after triggering event (including new referral)	20 days	Cal. Code Regs. tit. 8, § 9785(f) (https://www.dir.ca.gov/t8/9785.html)
PTP review of secondary provider report	20 days	Cal. Code Regs. tit. 8, § 9785(e)(4) (https://www.dir.ca.gov/t8/9785.html)
Routine progress report during ongoing treatment	45 days from last report	Cal. Code Regs. tit. 8, § 9785(f)(8) (https://www.dir.ca.gov/t8/9785.html)

Employer and Claims Administrator Deadlines

Event	Deadline	Authority
UR decision (standard)	5 business days	Cal. Code Regs. tit. 8, § 9792.9.1 (https://www.dir.ca.gov/t8/979291.html)
UR decision (urgent/expedited)	72 hours	Labor Code § 4610(g)(2) (https://law.justia.com/codes/california/2011/lab/division-4/4600-4614.1/4610/)
Written notice of UR deferral for liability dispute	5 business days	Labor Code § 4610(l) (https://www.sullivanoncomp.com/blog/deferring-utilization-review)

MPN specialist appointment scheduling	20 business days	Cal. Code Regs. tit. 8, § 9767.5(g) (https://www.dir.ca.gov/t8/9767_5.html)
Escalation to out-of-network specialist if MPN cannot schedule	10 business days	Cal. Code Regs. tit. 8, § 9767.5(g) (https://www.dir.ca.gov/t8/9767_5.html)

Employee Deadlines

Event	Deadline	Authority
Request IMR after UR denial	30 days	Labor Code § 4610.5 (https://www.dir.ca.gov/dwc/IMR/IMR_FAQs.htm)
Appeal IMR decision to WCAB	30 days	Labor Code § 4610.5 (https://www.dir.ca.gov/dwc/IMR/IMR_FAQs.htm)

Part 11: Step-by-Step Guide — What to Do If You Need a Specialist

This section gives you practical steps to follow when you need secondary treatment.

If Your PTP Will Not Refer You

1. Put your request in writing to the claims administrator — describe the specific specialist you need and why
2. Cite the Pena v. Aqua Systems ruling: no PTP referral is legally required
3. Identify the accepted body part or claimed injury the specialist would treat
4. Include any supporting medical records or diagnostic results

If the Claims Administrator Does Not Respond

1. Follow up in writing within 5 business days
2. Cite the applicable UR deadline (5 business days for standard, 72 hours for urgent)
3. State that you may pursue a Labor Code § 5814 (https://employeesfirstlaborlaw.com/labor-code-%C2%A75814-penalties-for-unreasonable-delay-or-denial/) penalty claim for unreasonable delay
4. Keep copies of all communications

If UR Denies Your Treatment

1. File DWC Form IMR-1 within 30 days of receiving the denial
2. Include the UR decision and all supporting medical documentation
3. Make sure the form is complete and signed
4. Keep a copy for your records

If Your MPN Cannot Provide a Specialist

1. Document your attempts to schedule with an MPN specialist
2. If you cannot schedule within 10 business days or the MPN has fewer than 3 specialists within 30 miles/60 minutes, request out-of-network care in writing
3. Cite Cal. Code Regs. tit. 8, § 9767.5(c) (https://www.dir.ca.gov/t8/9767_5.html) as authority for your request
4. Attach documentation showing your scheduling attempts and the MPN's failure to meet access standards

If Your Doctor Is Removed from the MPN

1. Review whether your condition qualifies for a continuity of care exception (acute, chronic, terminal, or pre-scheduled surgery)
2. Ask your treating doctor to write a report supporting continuity of care
3. If the claims administrator denies continuity, dispute the decision through Labor Code § 4062 (https://employeesfirstlaborlaw.com/labor-code-%C2%A74062-objections-to-medical-determinations/) QME procedures

4. Continue treating with your doctor while the dispute is pending if the doctor agrees

---

Part 12: Guidance for Doctors and Claims Administrators

This section provides practical checklists for medical providers and claims administrators handling referral decisions.

For Primary Treating Physicians

- In your Doctor's First Report (Form DLSR 5021), clearly identify all anticipated referrals with clinical justification
- When a new referral need arises, file a progress report within 20 days specifying the specialist type, clinical reasons, and any specific provider recommendations
- When you receive a secondary provider's report, review it and respond within 20 days — either incorporate the findings or explain your disagreement
- If you decide not to refer for secondary treatment, document your clinical reasoning in detail in the medical record
- If the claims administrator denies treatment you recommended, file an objection and consider requesting IMR

For Secondary Providers

- Send your findings and treatment recommendations to the PTP promptly
- If the PTP does not incorporate your recommendations or forward them to the claims administrator, consider sending your reports directly to the claims administrator with copies to the PTP and the injured worker
- Include clear clinical recommendations about treatment, prognosis, and any additional care needed

For Claims Administrators

- When you receive a secondary treatment request, determine within 24 hours whether genuine doubt exists about liability
- If no genuine doubt exists, authorize treatment or begin UR promptly to avoid § 5814 (https://employeesfirstlaborlaw.com/labor-code-%C2%A75814-penalties-for-unreasonable-delay-or-denial/) penalties
- If you deny treatment, document the specific medical necessity basis and communicate it clearly to the doctor, the worker, and the worker's attorney
- For MPN specialist referrals, verify the network can meet the 30-mile/60-minute access standard; if not, authorize out-of-network care before the worker must request it
- When a provider is terminated from the MPN, follow all continuity of care procedures, including written notice and opportunity to dispute

---

References

1. California Code of Regulations Title 8, § 9785 — Reporting Duties of the Primary Treating Physician (https://www.dir.ca.gov/t8/9785.html)
2. California Labor Code § 4616 — Medical Provider Networks (https://law.justia.com/codes/california/2011/lab/division-4/4616-4616.7/4616/)
3. California Labor Code § 4600 — Right to Medical Treatment (https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4600/)
4. DCLBV — Panel Decision on PTP Referral and RFA Requirements (Pena v. Aqua Systems) (https://dclbv.com/newsletters/2019/q3/ptp-referral-and-rfa-are-not-required/)
5. Sullivan on Comp — Deferring Utilization Review (Labor Code § 4610(l)) (https://www.sullivanoncomp.com/blog/deferring-utilization-review)
6. Employees First Labor Law — Labor Code § 5814: Penalties for Unreasonable Delay or Denial (https://employeesfirstlaborlaw.com/labor-code-%C2%A75814-penalties-for-unreasonable-delay-or-denial/)
7. California Labor Code § 4610 — Utilization Review (https://law.justia.com/codes/california/2011/lab/division-4/4600-4614.1/4610/)

8. Sullivan on Comp — MPN Access Standards for Specialists (Murillo v. Western National Group) (https://www.sullivanoncomp.com/blog/mpn-access-standards-if-an-employee-chooses-to-treat-with-a-specialist)

9. California Code of Regulations Title 8, § 9767.5 — Access Standards (https://www.dir.ca.gov/t8/9767_5.html)

10. DWC — FAQs About Medical Provider Networks (https://www.dir.ca.gov/dwc/mpn/dwcmpnfaq.html)

11. California Code of Regulations Title 8, § 9792.9.1 — Utilization Review Standards (https://www.dir.ca.gov/t8/979291.html)

12. DWC — Independent Medical Review (IMR) FAQs (https://www.dir.ca.gov/dwc/IMR/IMR_FAQs.htm)

13. DWC — FAQs on Utilization Review for Claims Administrators (https://www.dir.ca.gov/dwc/utilizationreview/ur_faq.htm)

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

15. DWC — FAQs on Qualified Medical Evaluators (https://www.dir.ca.gov/dwc/medicalunit/faqiw.html)

16. Sullivan on Comp — 2nd District Court of Appeal Rejects Patterson Exception to UR/IMR (Rodriguez) (https://www.sullivanoncomp.com/blog/2nd-district-court-of-appeal-rejects-patterson-exception-to-ur/imr)

17. California Code of Regulations Title 8, § 9767.10 — Continuity of Care Policy (https://www.dir.ca.gov/t8/9767_10.html)

18. WCAB Panel Decision — Carlos Valdiviezo v. Unknown Defendant (ADJ10885532) (https://www.dir.ca.gov/wcab/Panel-Decisions-2025/CarlosVALDIVIEZO-ADJ10885532.pdf)

19. IEA Training — Change of Treating Physician After Discharge from Care (Gonzalez v. Vermont Healthcare Center) (https://ieatraining.org/change-of-treating-physician-after-discharge-from-care/)

20. Ochoa Calderon — Workers Comp Medical Treatment: A Rights & Authorization Guide (https://ochoacalderon.com/blog/workers-comp-medical-treatment-a-rights-authorization-guide)

21. WCAB Panel Decision — Miguel Pena v. Aqua Systems (ADJ10308959) (https://www.dir.ca.gov/wcab/Panel-Decisions-2022/Miguel-PENA-ADJ10308959.pdf)

22. WCAB Panel Decision — Vidal Murillo v. Western National Group (ADJ12031213) (https://www.dir.ca.gov/wcab/Panel-Decisions-2021/Vidal-MURILLO-ADJ12031213.pdf)

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

24. California Labor Code § 4616.2 — Continuity of Care (https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4616/)

Primary Treating Physician Referrals in California Workers' Compensation: Statutory Obligations, Employee Rights, and Dispute Procedures

(PART-B LEGAL ANALYSIS)

Generated by: Legal AI Assistant

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

February 28, 2026

The information provided through this AI-powered Analysis is for **general informational and educational purposes only**. It is **not legal advice**, does **not create an attorney-client relationship**, and should not be relied upon as a substitute for advice from a qualified attorney.
Laws and legal outcomes vary based on specific facts and jurisdiction. If you need advice tailored to your situation, you should consult directly with an attorney.

(c) 2026 The Law Offices of Fernando Hidalgo, Inc.. Generated by a Legal AI Assistant. Facilitated by The Law Offices of Fernando Hidalgo, Inc.. All rights reserved.

Primary Treating Physician Referrals in California Workers' Compensation: Statutory Obligations, Employee Rights, and Dispute Procedures

Executive Summary

California workers' compensation law establishes a mandatory statutory framework governing Primary Treating Physician (PTP) referral obligations, secondary provider coordination, and dispute resolution mechanisms that balance employer cost management with employee access to necessary medical treatment. This report synthesizes controlling statutory authority, regulatory requirements, and recent case law developments to provide practitioners, injured workers, medical providers, and claims administrators with comprehensive guidance on PTP referral obligations, employee rights to challenge inadequate or delayed referrals, and procedures for resolving disputes. Key Finding: A landmark 2019 WCAB decision in Pena v. Aqua Systems established that employers cannot require a PTP referral or Utilization Review authorization before authorizing secondary treatment when an employee requests such care and no genuine medical or legal doubt exists regarding liability for the injury. This decision fundamentally restructured the referral authorization process and established that unreasonable delays in providing secondary treatment access trigger penalties under Labor Code Section5814. Simultaneously, recent Medical Provider Network (MPN) access standard cases, particularly Murillo v. Western National Group (2021), clarify that when employees seek specialist treatment, different geographic access standards apply, potentially enabling employees to establish entitlement to non-network specialists when an MPN cannot meet specialist access requirements. This report addresses three distinct legal dimensions: (1) PTP statutory and regulatory obligations regarding referral issuance, documentation, and coordination; (2) employee rights to request, obtain, and challenge referral decisions; and (3) procedural mechanisms for resolving disputes through utilization review, independent medical review, qualified medical examiner processes, and the Workers' Compensation Appeals Board. Understanding these interconnected requirements is essential for ensuring timely patient access to appropriate care, maintaining compliance with reporting obligations, and avoiding statutory penalties for unreasonable delays or denials of medical treatment.

I. Statutory and Regulatory Framework Governing PTP Referrals

A. Primary Treating Physician Statutory Definition and Authority

The foundation of California workers' compensation medical treatment governance rests on Labor Code Section 4600, which establishes the employer's fundamental obligation to provide "medical, surgical, chiropractic, acupuncture, and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches, and apparatuses, including orthotic and prosthetic devices and services, that is reasonably required to cure or relieve the injured worker from the effects of their injury" at the employer's expense.[1][4] Critically, Labor Code Section 4600 creates an affirmative duty on the employer, not merely a permission structure; if the employer fails to provide treatment, "the injured worker may obtain it at the employer's expense," meaning the employee can procure treatment and bill the employer for reimbursement.[1][4] This baseline obligation applies to all workers' compensation claims whether managed through Medical Provider Networks, Health Care Organizations, or traditional self-insured or insured arrangements.

The Primary Treating Physician is statutorily defined in California Code of Regulations Title 8, Section 9785(a)(1) 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][1] The PTP may be selected by the employer, chosen by the employee from a list of employer-approved physicians, or designated through procedures established in Medical Provider Networks pursuant to Labor Code Section 4616.[1][1] A critical constraint exists: an employee may have no more than one PTP at any given time, and may designate a new PTP only if the current PTP has determined that there is a need for continuing or future medical treatment.[1][1][1] This limitation prevents employees from unilaterally shopping between multiple treating physicians to circumvent cost controls while preserving the employee's ability to change providers when ongoing care is clinically necessary.

B. Regulatory Framework: Reporting and Coordination Duties

California Code of Regulations Title 8 Section 9785 creates comprehensive reporting and coordination obligations for Primary Treating Physicians that extend substantially beyond initial examination and diagnosis. Within 5 working days following the initial examination, the PTP must submit the "Doctor's First

(c) 2026 The Law Offices of Fernando Hidalgo, Inc.

Report of Occupational Injury or Illness" (Form DLSR 5021) to the claims administrator.[1][1][1] This initial report must specify, on line 24 or the reverse side, "(A) list methods, frequency, and duration of planned treatment(s), (B) specify planned consultations or referrals, surgery or hospitalization and (C) specify the type, frequency and duration of planned physical medicine services (e.g., physical therapy, manipulation, acupuncture)."[1][1] This requirement establishes that planned referrals must be identified and documented at the earliest stage of medical management, not introduced ad hoc as treatment progresses.

The coordination structure established by Section 9785(e)(3)-(4) requires that "[s]econdary physicians, physical therapists, and other health care providers to whom the employee is referred shall report to the primary treating physician in the manner required by the primary treating physician."[1][1] The PTP is then "responsible for obtaining all of the reports of secondary physicians and shall, unless good cause is shown, within 20 days of receipt of each report incorporate, or comment upon, the findings and opinions of the other physicians in the primary treating physician's report and submit all of the reports to the claims administrator."[1][1][1] This creates a mandatory 20-day deadline for PTP review and response to secondary provider reports, with the PTP bearing responsibility for ensuring completeness of the medical record and coherence of treatment recommendations. Failure to meet this deadline without good cause constitutes regulatory non-compliance that can undermine the PTP's reporting credibility and potentially expose the claims administrator to liability for delayed care if secondary provider findings are not timely incorporated.

C. Triggering Events for Progress Reports and Referral Documentation

Beyond the initial report, Section 9785(f) requires 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: (1) The employee's condition undergoes a previously unexpected significant change; (2) There is any significant change in the treatment plan reported, including, but not limited to, (A) an extension of duration or frequency of treatment, (B) a new need for hospitalization or surgery, (C) a new need for referral to or consultation by another physician, (D) a change in methods of treatment or in required physical medicine services, or (E) a need for rental or purchase of durable medical equipment or orthotic devices."[1][1][1] The explicit inclusion of "a new need for referral to or consultation by another physician" as a triggering event that requires written notice to the claims administrator within 20 days establishes that referral decisions are not informal recommendations but documented medical determinations with fixed reporting deadlines. This structure ensures the claims administrator has timely notice of all secondary treatment requests and can initiate appropriate utilization review or authorization procedures.

Additionally, Section 9785(f)(8) mandates that "when continuing medical treatment is provided, a progress report shall 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."[1][1][1] This 45-day maximum reporting interval creates a safety net ensuring that ongoing referrals and secondary treatment are periodically reviewed and documented, preventing situations where secondary treatment continues indefinitely without current medical justification or updated clinical assessment.

II. The Pena Doctrine: Referral Requests Need Not Require PTP Sponsorship

A. The Seminal Pena v. Aqua Systems Decision (2019)

The 2019 WCAB panel decision in Pena v. Aqua Systems fundamentally restructured California workers' compensation referral practice by establishing that there is no legal requirement that a Primary Treating Physician issue a referral or submit a Request for Authorization (RFA) before an employer's obligation to provide secondary treatment activates.[7] The case involved an applicant with a prior award including future medical care for orthopedic body parts, but who subsequently received a psychiatric Qualified Medical Evaluator (QME) opinion finding a compensable psychiatric injury and authorizing future psychiatric medical care. When the applicant requested psychiatric secondary treatment on July 6, 2018, the defendant refused to authorize it until October 25, 2018-a three-month delay. The applicant then pursued a Labor Code Section 5814 penalty claim for the unreasonable delay.

The WCJ found that the delay constituted an unreasonable delay under Section 5814 and awarded a 25% penalty of the first psychiatric treatment visit. The defendant appealed, arguing that the applicant had not obtained a referral from the Primary Treating Physician and that a Request for Authorization (RFA) from the PTP was therefore required before the defendant's obligation to authorize secondary treatment attached.[7] The WCAB panel rejected this argument categorically, stating that "[t]here is no requirement that the

(c) 2026 The Law Offices of Fernando Hidalgo, Inc.

applicant's Primary Treating Physician make a referral or submit a Request for Authorization before an employer's obligation to provide treatment activated."[7]

Instead, the panel reasoned that "the obligation stems from the basic requirements of Labor Code Section4600 that defendants provide reasonable medical treatment to cure or relieve from the effects of an industrial injury."[7] The panel further noted that while defendants remain entitled and obligated to submit treatment recommendations for an applicant's condition to Utilization Review per Labor Code Section 4610, "the mere selection of a physician to provide medical treatment does not constitute a 'specific course of proposed medical treatment' that would necessitate a Request for Authorization and be subject to Utilization Review."[7] The distinction is critical: requesting access to a secondary physician for evaluation is different from requesting authorization for a specific treatment plan. The WCAB reasoned that "in the absence of any citable authority, the mere selection of a doctor as a secondary treater is not a proposed specific course of treatment, but is simply a request for an opportunity to be seen by the secondary treater, who can then report to the Primary Treating Physician on what treatment, if any, is necessary to cure or relieve from the effects of the secondary condition."[7]

B. The "Genuine Medical or Legal Doubt" Standard

The Pena decision further established that the only satisfactory excuse for delaying or denying secondary treatment access is genuine medical or legal doubt as to liability for the injury or the treatment itself on grounds other than medical necessity.[7] The panel noted that "in the event of a delay of benefits (Section5814 allows a penalty up to the lesser of 25% of the delayed benefit or $10,000.00), the only satisfactory excuse is genuine doubt from a medical or legal standpoint as to liability for benefits."[7] This inverts the typical burden structure: the defendant cannot simply delay and require the applicant to prove entitlement; rather, if the defendant delays, it must affirmatively establish that genuine doubt existed regarding either the work-relatedness of the injury, the applicability of the treatment to an accepted body part, or the basic medical appropriateness of an evaluation by the requested specialist.

Importantly, in Pena itself, the defendant had not attempted to challenge the psychiatric QME's conclusions on causation, nor had it sought to conduct additional discovery before the trial date that might have supported a claim of genuine doubt. The WCAB noted this omission pointedly, suggesting that defendants must affirmatively investigate and document their basis for doubt; mere silence or delay is insufficient.[7] The panel concluded that "defendants did not try to challenge the psychiatric PQME's conclusions on causation or attempt to conduct any further discovery before the October 29, 2018 trial, which may otherwise have supported an argument of genuine doubt of liability by defendants."[7]

C. Implications for Secondary Treatment Authorization

The Pena doctrine has three major implications for claims administration practice: First, when an employee (directly or through an attorney) requests secondary treatment for an accepted body part or claimed injury, the claims administrator cannot condition authorization on receipt of a referral from the PTP. The request itself, if clear and unambiguous regarding the treating physician to be consulted, activates the employer's Section4600 obligation.[7] Second, utilization review of a secondary treatment request may proceed on the basis of medical necessity, but cannot be indefinitely deferred pending a referral that the PTP may be unwilling to issue. If the secondary treatment request describes a specific physician and a reasonable diagnostic or therapeutic purpose, the employer should respond promptly; failure to do so without documented genuine doubt regarding liability exposes the employer to Section5814 penalties.[7] Third, the 20-business day appointment scheduling requirement under CCR Section 9767.5(g) for specialist referrals within an MPN should be measured from when the employee makes the secondary treatment request, not from when a PTP referral is issued.[7]

III. Labor Code Section 4610 Utilization Review Requirements and Their Relationship to Referrals

A. Utilization Review as Distinct from Pre-Authorization

Labor Code Section 4610 establishes a comprehensive utilization review (UR) process by which employers "prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, based in whole or in part on medical necessity to cure and relieve, treatment recommendations by physicians."[11][37][59] However, a critical distinction must be drawn between utilization review of a specific course of proposed medical treatment and utilization review of a request for secondary evaluation. The Pena panel established

(c) 2026 The Law Offices of Fernando Hidalgo, Inc.

that "the mere selection of a physician to provide medical treatment does not constitute a 'specific course of proposed medical treatment' that would necessitate a Request for Authorization."[7]

Thus, an employee's request to be evaluated by a pain management specialist, a neurologist, or a psychiatric specialist is not itself a "specific course of proposed medical treatment" subject to utilization review. Rather, it is a request for access to a physician who will then develop a specific treatment plan. The secondary physician, after examination, may propose treatment that is then subject to utilization review, but the initial request for access to the physician should not be delayed pending UR review.[7] This distinction prevents claims administrators from weaponizing utilization review to delay diagnostic access.

B. Expedited Utilization Review for Urgent Situations

Labor Code Section 4610(g)(2) requires that when treatment is or may become emergent or an urgent need is demonstrated (such as imminent threats to health or ability to regain function), "decisions to approve, modify, delay, or deny requests by physicians prior to, or concurrent with, the provision of medical treatment services to employees shall be made in a timely fashion that is appropriate for the nature of the employee's condition, but not to exceed 72 hours after the receipt of the information reasonably necessary to make the determination."[11] When an employee requests urgent secondary treatment (e.g., immediate psychiatric evaluation following a work-related trauma, or orthopedic specialist evaluation for a potentially serious fracture), the 72-hour deadline applies if the requesting physician certifies the urgency.[11][37][59]

IV. Medical Provider Network Referral Procedures and Access Standards

A. Statutory Framework for MPN Establishment and Physician Requirements

Labor Code Section 4616 establishes the framework permitting employers and insurers to establish Medical Provider Networks (MPNs) for the provision of medical treatment to injured employees.[2][14][15] An MPN must include "physicians primarily engaged in the treatment of occupational injuries and physicians primarily engaged in the treatment of nonoccupational injuries," with a goal of at least 25 percent nonoccupational physicians.[2][14][15] The network "shall include an adequate number and type of physicians...to treat common injuries experienced by injured employees based on the type of occupation or industry in which the employee is engaged, and the geographic area where the employees are employed."[2][14][15]

Within an MPN, injured employees retain the right to choose their Primary Treating Physician from among available network providers. California Code of Regulations Section 9767.6(e) provides that "[a]t any point in time after the initial medical evaluation with an MPN physician, the covered employee may select a physician of his or her choice from within the MPN."[13][13][51] This right extends to designating a new PTP when the original PTP has determined a need for continuing or future medical treatment, as contemplated in Labor Code Section 4600(d)(2).[4]

B. MPN Specialist Access Standards: The 30-Mile/60-Minute Rule

The critical regulatory provision governing specialist access within and outside MPNs is California Code of Regulations Section 9767.5(a), which requires an MPN to "have at least three available physicians of each specialty to treat common injuries experienced by injured employees based on the type of occupation or industry in which the employee is engaged and within the access standards set forth in (1) and (2)."[13][14][13][14] Section 9767.5(a)(1) requires "at least three available primary treating physicians and a hospital for emergency health care services...within 30 minutes or 15 miles of each covered employee's residence or workplace," while Section 9767.5(a)(2) requires "providers of occupational health services and specialists who can treat common injuries experienced by the covered injured employees within 60 minutes or 30 miles of a covered employee's residence or workplace."[13][14][13][14]

A critical distinction emerged from Murillo v. Western National Group (2021): when an injured worker seeks to designate a specialist as their Primary Treating Physician, the MPN must meet the specialist-access standard (30 miles/60 minutes), not the general PTP standard (15 miles/30 minutes).[13][13] The WCAB held that "if the MPN has at least three primary treating physicians of any specialty within the 15-mile/30-minute access standard who are available to undertake the role of PTP, the MPN will have satisfied its obligation to provide medical treatment. But because the applicant wanted to have a pain management physician as his PTP, the MPN must provide an adequate selection of specialists within a 30-mile/60-minute radius of the applicant's residence or workplace, or the MPN must permit him to seek such care outside of the

(c) 2026 The Law Offices of Fernando Hidalgo, Inc.

MPN."[13][13] This holding establishes an important employee right: if an injured worker seeks specialist treatment and the MPN cannot produce three reasonably available specialists at appropriate distance standards, the employee may establish entitlement to non-network specialist care at employer expense.

C. MPN Specialist Referral Procedures and Timeframes

When an employee seeks specialist treatment within an MPN, California Code of Regulations Section 9767.5(g) establishes that "the MPN applicant shall ensure that an initial appointment with a specialist in an appropriate referred specialty is available within 20 business days of a covered employee's reasonable requests for an appointment through an MPN medical access assistant."[13][14][14] However, Section 9767.5(g) applies only when the MPN Medical Access Assistant is scheduling an appointment with a specialist based on a referral from a PTP, not when scheduling an appointment with a specialist as a primary treating physician.[13][13] If "an MPN medical access assistant is unable to schedule a timely medical appointment with an appropriate specialist within ten business days of an employee's request, the employer shall permit the employee to obtain necessary treatment with an appropriate specialist outside of the MPN."[13][14][14]

Additionally, CCR Section 9767.5(c) establishes critical employee protections: "If a covered employee is not able to obtain from an MPN physician reasonable and necessary medical treatment within the applicable access standards in subdivisions (a) or (b) and the required time frames in subdivisions (f) and (g), then the MPN shall have a written policy permitting the covered employee to obtain necessary treatment for that injury from an appropriate specialist outside the MPN within a reasonable geographic area."[13][14][14] This provision creates an automatic escape valve from MPN limitations when access standards cannot be met, preventing the MPN structure from becoming a de facto barrier to necessary medical care.

V. Employee Rights to Request Secondary Treatment and Physician Designations

A. Affirmative Right to Request Secondary Treatment

While the Pena doctrine establishes that employees need not wait for PTP referrals, employees possess an affirmative right under Labor Code Section 4600 to request secondary treatment "at the employer's expense" if the primary treating physician refuses or neglects to provide it.[1][4] More fundamentally, Labor Code Section 4600(c) provides that "unless the employer or the employer's insurer has established or contracted with a medical provider network as provided for in Section 4616, after 30 days from the date the injury is reported, the employee may be treated by a physician of the employee's own choice or at a facility of the employee's own choice within a reasonable geographic area."[4] This creates a baseline freedom-of-choice protection that applies absent a validly established MPN.

Within an MPN, employee choice is restricted to network providers unless the MPN violates access standards or unless the employee can establish grounds for extra-network treatment under CCR Section 9767.5(c).[13][14] However, the employee retains the right to select among available network providers and to request referrals to specialists within the network framework. Critically, the employee can request a referral without the primary treating physician's sponsorship: Pena establishes that a direct request to the claims administrator for secondary treatment access activates the employer's Section4600 obligation.[7]

B. Pre-Designation of Personal Physician

Labor Code Section 4600(d) establishes a powerful employee tool that many workers underutilize: the right to pre-designate a personal physician before an injury occurs.[4] Section 4600(d)(1) provides that "if an employee has notified the employee's employer in writing prior to the date of injury that the employee has a personal physician, the employee shall have the right to be treated by that physician from the date of injury if the employee has health care coverage for nonoccupational injuries or illnesses on the date of injury in a plan, policy, or fund."[4]

To qualify as a valid pre-designated personal physician, the physician must meet three conditions: "(A) Be the employee's regular physician and surgeon, licensed pursuant to Chapter 5...of Division 2 of the Business and Professions Code. (B) Be the employee's primary care physician and has previously directed the medical treatment of the employee, and who retains the employee's medical records, including the employee's medical history....(C) The physician agrees to be predesignated."[4] Once properly pre-designated, the employee's personal physician may serve as the PTP from the date of injury, even if that physician is not in the employer's

(c) 2026 The Law Offices of Fernando Hidalgo, Inc.

MPN.[4] This represents an employee's strongest strategic position regarding physician choice and should be systematically encouraged in safety briefings and employee information materials.

C. Dispute Resolution When PTP Refuses Referral

If the PTP refuses to issue a referral to a secondary physician and the claims administrator denies authorization based on absence of a referral, the employee has multiple remedies. First, the employee can request utilization review directly, arguing that the secondary treatment is medically necessary for an accepted body part and that the employer's Section4600 obligation is not conditioned on a PTP referral.[7] Second, if utilization review denies the request, the employee can pursue Independent Medical Review (IMR) under Labor Code Section 4610.5, though IMR is available only if the UR decision was based on a finding of non-medical necessity.[48]

Third, if the employee and claims administrator are in genuine dispute about whether secondary treatment is needed, the employee can request a Qualified Medical Evaluator (QME) evaluation under Labor Code Section 4062, which addresses medical necessity disputes not resolved through UR/IMR.[25][27] The QME will render an opinion on whether the secondary treatment is medically necessary, and the QME's opinion is entitled to considerable deference (absent clear and convincing evidence to the contrary on appeal).[46]

Fourth, under Labor Code Section 5814, if the claims administrator unreasonably delays providing the secondary treatment, the employee may petition for a penalty of up to 25% of the delayed benefit amount (or $10,000, whichever is less), plus attorney's fees under Section 5814.5.[9][9] The Pena decision establishes that a three-month delay in authorizing secondary treatment, when no genuine doubt regarding liability existed, warrants a Section5814 penalty.[7]

VI. PTP Reporting Obligations Regarding Secondary Treatment Decisions

A. Documentation Requirements When Declining Secondary Treatment

While Pena establishes that PTPs are not gatekeepers for secondary treatment access, PTPs retain obligations to document their clinical reasoning when they recommend against additional secondary treatment. When a PTP declines to recommend secondary treatment for a condition presented by the employee, the PTP should include reasoned clinical justification in the medical record explaining why the secondary evaluation is unnecessary or contraindicated. This documentation serves multiple purposes: it evidences the PTP's clinical judgment, supports the PTP's position if the employee later challenges the decision through IMR or QME procedures, and preserves the administrative record for WCAB review if the issue later becomes contested.

The lack of such documentation may suggest to a workers' compensation judge that the PTP was improperly influenced by cost considerations rather than clinical judgment-a permissible judicial inference that weakens the PTP's credibility.[7] Conversely, contemporaneous, detailed clinical notes explaining why secondary treatment is not indicated strengthen the PTP's position if the case proceeds to litigation.

B. Timely Reporting of Secondary Treatment Recommendations

When the PTP does recommend secondary treatment, Section 9785(f)(2)(C) requires written notification to the claims administrator within 20 days of the decision, as "a new need for referral to or consultation by another physician" is explicitly listed as a triggering event requiring a progress report.[1][1][1] This report should identify the specialty or type of physician requested, the clinical indications for the referral, the anticipated duration of secondary treatment, and any specific provider recommendations. The more detailed and clinically specific the referral documentation, the less opportunity for claims administrators to delay authorization based on claimed need for clarification.

C. Incorporation of Secondary Provider Reports

When secondary providers report back to the PTP with their findings and treatment recommendations, Section 9785(e)(4) imposes a mandatory 20-day deadline for the PTP to "incorporate, or comment upon, the findings and opinions of the other physicians in the primary treating physician's report and submit all of the reports to the claims administrator."[1][1][1] This requirement serves a critical quality assurance function: it prevents secondary provider opinions from languishing unreviewed in the medical record and requires the PTP to engage clinically with potentially divergent medical views.

(c) 2026 The Law Offices of Fernando Hidalgo, Inc.

If the secondary provider recommends treatment that the PTP disagrees with, the PTP must still report this disagreement to the claims administrator with clinical justification. The presence of disputed medical opinions in the record may trigger utilization review disputes or downstream QME procedures, but it prevents information asymmetries where the claims administrator remains unaware of clinical recommendations because the PTP suppressed them.

VII. Utilization Review and Request for Authorization (RFA) Procedures

A. When RFA Submission Is Required

Utilization Review (UR) applies when a specific course of proposed medical treatment is recommended.[37][59][61] The California Code of Regulations Section 9792.9.1 establishes detailed procedural requirements for UR: the treating physician must submit a Request for Authorization (DWC Form RFA) to the claims administrator, which must be accompanied by supporting documentation (the Doctor's First Report, a Treating Physician's Progress Report, or an equivalent narrative report) substantiating the requested treatment.[36][37][38]

Notably, the RFA itself is not separately reimbursable; it is submitted as part of the treating physician's communication to the claims administrator.[36][37] The claims administrator must respond to the RFA within specified timeframes: prospective or concurrent UR decisions must be made within 5 business days of receipt of the completed RFA, or within 72 hours if expedited review is certified as necessary.[37][5][38]

B. Deference to PTP Treatment Recommendations

A significant procedural protection applies to PTPs: Labor Code Section 4610 requires that UR decisions be based on medical necessity according to the Medical Treatment Utilization Schedule (MTUS) adopted by the Administrative Director, or (prior to MTUS adoption) the recommended standards of the American College of Occupational and Environmental Medicine.[11][37][38][59] Critically, Section 4610(e) provides that "[n]o person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, when these services are within the scope of the physician's practice, may modify, delay, or deny requests for authorization of medical treatment."[11][37][38]

This requirement-that only licensed physicians competent in the specific clinical area can deny treatment-serves as a significant protection against cost-driven denials by claims adjusters or utilization review organizations without appropriate medical expertise. When a PTP recommends secondary treatment within the PTP's scope of practice, the UR decision must be made by a physician with comparable or greater expertise in that clinical area.

C. Deferred UR for Liability Disputes

An important exception to the standard UR timeline applies when the claims administrator is disputing liability for the injury or the treatment itself on grounds other than medical necessity. Labor Code Section 4610(l) provides that "utilization review of a treatment recommendation shall not be required while the employer is disputing liability for injury or treatment of the condition for which treatment is recommended pursuant to Section 4062."[8] Similarly, CCR Section 9792.9.1(b) permits the claims administrator to defer UR "if the claims administrator disputes liability for either the occupational injury for which the treatment is recommended or the recommended treatment itself on grounds other than medical necessity."[8][37][39]

However, the claims administrator must issue written notice of intent to defer UR no later than five business days from receipt of the RFA, and this notice must go to the requesting physician, the injured worker, and the injured worker's attorney (if represented).[8][37][39] The notice must specify the basis for the liability dispute with reasonable clarity. If the claims administrator fails to timely defer UR and fails to issue a timely UR decision, the UR decision becomes untimely and may be found invalid-a circumstance that can result in treatment being deemed authorized by operation of law or at minimum create litigation over whether the treatment should be provided pending resolution of the underlying liability dispute.[45]

VIII. Recent Developments: The Rodriguez Decision and Patterson's Evolution

A. The 2019 Patterson Doctrine

(c) 2026 The Law Offices of Fernando Hidalgo, Inc.

In Patterson v. The Oaks Farm (2014), a significant WCAB panel decision, the appeals board established what became known as the "Patterson exception" to utilization review procedures: when an employer had previously authorized a course of ongoing treatment, the employer could not use utilization review to deny or modify the same treatment in a subsequent request unless the employer could prove a material change in the applicant's condition or circumstances.[55][58][55] This doctrine effectively removed certain "ongoing" or "continuous" medical treatment from the UR/IMR process and returned jurisdiction to the WCAB to determine medical necessity based on PTP opinions.

The Patterson doctrine had substantial practical effects: it prevented claims administrators from repeatedly denying previously authorized treatments, forced employers to demonstrate concrete changes in patient status before seeking to discontinue care, and created de facto permanent authorizations for certain types of ongoing care (home health services, continuing physical therapy, etc.).[55][58][55]

B. The 2025 Rodriguez Decision Limiting Patterson

However, on November 10, 2025, the Second District Court of Appeal issued a published decision in Illinois Midwest Insurance Agency LLC v. WCAB (Rodriguez) that substantially limited Patterson's applicability. The Rodriguez court held that there is no statutory basis for an "ongoing treatment" exception to the UR/IMR process, and that for any dispute over medical necessity arising from a UR decision, IMR is the sole and exclusive remedy.[58] The court reasoned that "the entire statutory framework evinces a clear legislative purpose: to remove medical necessity determinations from the WCAB and courts and to place such decisions exclusively in the hands of medical professionals."[58]

Importantly, in footnote 6 of Rodriguez, the court limited its holding to "the specific facts before it-a UR denial of a new request for treatment for a specific duration"-and explicitly stated that it was not deciding whether a different analysis applies when, for example, an employer authorizes treatment, and subsequently terminates the treatment without using the UR process, or when the parties stipulate to the terms of treatment and agree to forgo the UR/IMR procedure.[58] This caveat leaves open the possibility that certain circumstances (de facto authorizations, stipulated treatments, or situations where an employer previously accepted liability for ongoing care) might still warrant WCAB jurisdiction outside the UR/IMR framework.

C. Implications for Referral Practice

The Rodriguez decision's impact on referral practice is nuanced. First, if an employer authorizes secondary treatment through UR/IMR, and the secondary provider thereafter recommends continued access or expanded services, a subsequent UR denial is not immune from challenge merely because the treatment is "ongoing." The applicant must pursue IMR, not a direct WCAB hearing.[58] Second, the decision reinforces that employers retain the right to conduct utilization review of secondary treatment requests based on medical necessity, and employees cannot simply invoke a "once authorized, always authorized" principle.[58] Third, employees must be vigilant about pursuing timely IMR appeals when secondary treatment is denied or modified; failure to do so forecloses WCAB review on medical necessity grounds.

IX. Continuity of Care and Transfer of Providers

A. Statutory Protections When a Provider Leaves an MPN

Labor Code Section 4616.2 and California Code of Regulations Section 9767.10 establish protective procedures when a treating physician leaves or is terminated from an MPN and the injured employee has received ongoing or substantial treatment from that provider. The statute recognizes certain circumstances under which injured employees may continue treatment with a terminated provider despite MPN termination: (1) acute conditions with less than 90 days' duration where treatment will be completed; (2) serious or chronic conditions requiring at least 90 days for completion of treatment; (3) terminal illnesses; or (4) surgeries or procedures recommended and documented to occur within 180 days of the provider's contract termination date.[54][56]

When a provider is terminated from an MPN, the claims administrator must notify the injured employee of the termination and whether the employee will be required to select a new provider.[54][56] If the terminated provider agrees to continue treating and the employee disputes the claims administrator's determination that the case does not fall within continuity of care exceptions, the employee can request that the current treating physician provide a report addressing whether the employee's condition falls within any continuity of care

(c) 2026 The Law Offices of Fernando Hidalgo, Inc.

exception.[54][56] If the treating physician agrees the employee qualifies for continuity of care, the employee may continue treating with the terminated provider until the matter is formally resolved through the procedures of Labor Code Section 4062.[54][56]

A recent 2025 WCAB decision, Valdiviezo v. unknown defendant (ADJ10885532), illustrates the importance of these protections.[35] The WCJ found that the defendant failed to comply with the continuity of care policy by improperly deferring utilization review requests from a terminated provider without providing proper notice to the injured worker of the continuity of care dispute resolution procedure. The WCJ awarded a Labor Code Section 5814 penalty for the unreasonable delay in treatment, establishing that failure to follow continuity of care procedures can result in statutory penalties even when the underlying question of whether the employee qualifies for continuity might be legitimately disputed.[35]

B. Right to Dispute Release from Care

A critical employee right that frequently intersects with referral issues is the right to dispute a PTP's determination that the employee is "released from care"-meaning the PTP has determined the employee has reached permanent and stationary status with no need for continuing or future medical treatment.[42][44] If a PTP releases an employee from care, the employee cannot immediately designate a new PTP under Labor Code Section 4600, because the regulatory requirement is that the current PTP must have determined a need for continuing or future treatment.[4][42] However, if the employee disputes the release from care, the dispute must be resolved under Labor Code Section 4062 procedures (QME evaluation).[42]

In Gonzalez v. Vermont Healthcare Center (2024), the WCAB clarified that a release from care is not a "diagnosis" or "treatment recommendation" for purposes of invoking the faster MPN second-opinion and MPN Independent Medical Review processes under Labor Code SectionSection 4616.3 and 4616.4.[42] Instead, disputes over whether an employee has truly reached permanent and stationary status must proceed through the full QME procedure, which is more time-intensive but provides a more comprehensive medical evaluation.[42]

X. Strategic Analysis and Comparative Risk Assessment

A. Claims Administrator Perspective: Balancing Cost Control and Liability

For claims administrators managing workers' compensation files, referral decisions present a recurring tension between cost containment and liability exposure. The Pena doctrine creates asymmetric risks: delaying secondary treatment access without documented genuine doubt regarding liability exposes the employer to Section5814 penalties (25% of delayed benefits plus attorney's fees under Section 5814.5), while authorizing secondary treatment promptly results only in the treatment costs themselves, which are statutory obligations under Section 4600 regardless.

Strategically, this risk asymmetry suggests that claims administrators should adopt a presumption of authorization for secondary treatment requests that identify: (1) a specific treating physician; (2) a reasonable connection to an accepted body part or claimed injury; and (3) a general indication that appears related to work-relatedness. If genuine doubt exists regarding liability, the claims administrator should document this explicitly in written correspondence to the applicant, PTP, and requesting physician within 5 business days of the secondary treatment request.[8] If no genuine doubt exists, authorization should be issued promptly to avoid Section5814 exposure.

For specialist referrals within an MPN, the claims administrator should confirm that the MPN can meet the 30-mile/60-minute access standard established by CCR Section 9767.5(a)(2).[13][13] If the MPN cannot identify three available specialists at the required distance within 10 business days, the employer should permit the employee to seek non-network specialist care rather than face a potential Section5814 penalty or WCAB order granting extra-network treatment.[13][14]

B. Injured Worker Perspective: Strategic Levers for Accessing Care

For injured workers, understanding these procedural dynamics creates several strategic opportunities. First, if the PTP is unwilling to recommend a specific secondary treatment but the employee believes it is medically necessary, the employee should request the secondary treatment directly from the claims administrator, citing Pena for the proposition that no PTP referral is required.[7] This converts a medical dispute (between

(c) 2026 The Law Offices of Fernando Hidalgo, Inc.

employee and PTP) into an administrative dispute (between employee/claims administrator regarding medical necessity), which can be resolved through UR/IMR/QME rather than remaining stalled by PTP resistance.

Second, if an MPN cannot provide timely specialist access, the employee should document this fact and request extra-network specialist care pursuant to CCR Section 9767.5(c).[13][14] The regulatory requirement that MPNs have written policies permitting extra-network care when access standards cannot be met creates an automatic escape valve that employees can invoke by showing they have attempted to schedule within the MPN and encountered unacceptable delays.

Third, if the PTP is not responsive to referral requests or secondary provider reports, the employee should use Labor Code Section 5814 leverage by threatening a penalty petition for unreasonable delay of necessary medical treatment. Even if the case does not ultimately proceed to trial on the Section5814 claim, the leverage of potential penalties often encourages prompt authorization or resolution.[9][9]

Fourth, when a PTP relationship becomes adversarial regarding secondary treatment, the employee should prioritize exploring whether pre-designation of a personal physician remains available, or whether the employee can request designation of a new PTP under the regulatory procedures in Section 9785(b)(2) by emphasizing that the existing PTP's refusal to recommend necessary secondary treatment demonstrates need for continuing or future medical treatment that justifies a new PTP selection.[1][1]

C. Medical Provider Perspective: Documentation and Timely Communication

For treating physicians (both PTPs and secondary providers), the procedural framework creates important documentation obligations. PTPs should issue contemporaneous written progress reports identifying referral recommendations and clinical indications within 20 days of identifying the need for secondary consultation.[1][1][1] Secondary providers should ensure that their reports reach the PTP promptly and include clear clinical recommendations regarding treatment, prognosis, and need for additional intervention.[1][1][1]

When secondary providers recognize that the PTP is not incorporating their recommendations or forwarding them to the claims administrator, secondary providers should consider sending independent progress reports directly to the claims administrator with copies to the PTP and applicant, ensuring that their clinical opinions are part of the administrative record.[1][1][1] This creates a documented trail showing that the employer/claims administrator received secondary provider input and cannot later claim ignorance of medical recommendations.

XI. Dispute Resolution Framework and Procedural Pathways

A. Utilization Review and Independent Medical Review

When a PTP or secondary provider recommends treatment and the claims administrator believes it is not medically necessary, the claims administrator initiates utilization review (UR) under Labor Code Section 4610 and CCR Section 9792.9.1.[11][37][38][59][39] The UR decision must be rendered within 5 business days for prospective/concurrent review or 30 days for retrospective review.[37][5][38][39] If the UR reviewer denies or modifies the treatment, the applicant can request Independent Medical Review (IMR) under Labor Code Section 4610.5 by filing the DWC Form IMR-1 within 30 days of receiving the UR decision.[46][48]

IMR is conducted by an independent medical professional who has not previously reviewed the case and who renders a final determination on medical necessity.[46][48] The IMR determination is presumed correct, and appeals are limited to narrow grounds: the AD acted without authority, the determination was procured by fraud, the medical reviewer had a material conflict of interest, bias based on protected characteristics, or a plainly erroneous mistake of fact.[46][48] This highly deferential standard makes IMR determinations difficult to overturn even at the WCAB level.

B. Qualified Medical Evaluator (QME) Procedures

When applicant and employer disagree about medical necessity or diagnosis of an accepted body part, and the dispute is not resolved through UR/IMR, either party can request a Qualified Medical Evaluator (QME) panel pursuant to Labor Code Section 4062.[25][27][66] The QME process is more time-intensive than UR/IMR: the Medical Unit issues a panel of three or five qualified evaluators, parties select one evaluator, and the evaluator conducts an independent comprehensive medical-legal evaluation.[25][27][66] The QME report

(c) 2026 The Law Offices of Fernando Hidalgo, Inc.

includes medical opinions on diagnosis, causation (where relevant), permanent disability, future medical care needs, and other medical issues.[25][27]

For referral disputes specifically, the QME can address whether secondary treatment is medically necessary for an accepted body part, whether the applicant has truly reached permanent and stationary status and can be released from care, and whether specific secondary providers are appropriate for treating identified conditions.[25][27][66] The QME report carries substantial weight in both WCAB litigation and settlement negotiations.

C. WCAB Trial and Burden of Proof Standards

If secondary treatment disputes proceed to WCAB trial without being resolved through UR/IMR/QME processes, the burden of proof depends on the issue framing. If the applicant claims the employer refused or neglected to provide medical treatment in violation of Labor Code Section 4600, the applicant bears the burden of proving refusal or neglect by substantial evidence.[7][60] However, if the employer authorizes secondary treatment and a dispute then arises about whether the secondary treatment is medically necessary or appropriate, the burden shifts: the WCAB's recent jurisprudence suggests that once treatment is authorized, the employer bears the burden of proving material change in circumstances before terminating the treatment through UR.[55][58][55]

XII. Procedural Implementation and Timeline Management

A. Initial Medical Management Phase (Days 0-30)

Upon receipt of a work-related injury claim, the employer must provide the injured employee with notice of the workers' compensation system, information about their rights, and identification of any MPN the employer has established.[2][14][17] Within 5 working days of the employee's initial medical examination, the treating physician must file the Doctor's First Report (Form DLSR 5021), which must identify any planned referrals or consultations anticipated at that early stage.[1][1][50][52]

The employer has 14 days from notice of the claim to either accept or begin investigating the injury. If accepting the claim, the employer must authorize all necessary medical treatment to cure or relieve the effects of the injury, including secondary treatment if indicated.[1][4][53] If the injury is accepted and the employee is in an MPN, the employer must provide written notice of the MPN and information about accessing the network.[2][14][17][18]

B. Active Treatment Phase (Days 30-180+)

As treatment progresses and secondary treatment becomes appropriate, the following timeline applies: Upon identification of secondary treatment need (by PTP, employee, or secondary provider recommendation): the PTP should file a progress report (PR-2 form or narrative equivalent) within 20 days identifying the referral recommendation and clinical indications.[1][1][1] Within 5 business days of receiving a Request for Authorization (RFA) for the secondary treatment: the claims administrator should either approve the treatment, approve it with conditions, deny it with written explanation of medical necessity basis, or (if legitimate liability doubt exists) issue a written deferral of UR pending resolution of the liability dispute.[8][37][5]

If UR denies the treatment, the applicant has 30 days to request IMR by filing the DWC Form IMR-1 with the Administrative Director.[46][48] If IMR is requested, the Administrative Director determines within 5-10 days whether the case is eligible for IMR, and if eligible, assigns the case to an independent medical review organization.[46][48] The IMRO conducts IMR within 5-10 days for expedited cases or longer for regular cases, and issues a final determination that is presumed correct absent fraud, conflict of interest, or clear error.[46][48]

If the applicant disputes the IMR determination, the applicant can file a petition with the WCAB within 30 days, but the grounds for appeal are narrow and the clear and convincing evidence standard favors the IMRO determination.[46][48]

C. Permanent and Stationary Phase and Continuity of Care

(c) 2026 The Law Offices of Fernando Hidalgo, Inc.

When the PTP determines the applicant has reached permanent and stationary status, the PTP must file a report (Form PR-3) within 20 days indicating the employee's impairment rating, permanent disability, and any need for continuing or future medical care.[1][1][1] If the applicant disputes the release from care, the applicant must pursue a QME evaluation under Labor Code Section 4062 rather than the faster MPN second-opinion process.[42]

If the applicant's treating physician leaves the MPN, the continuity of care procedures in CCR Section 9767.10 apply, requiring notice to the applicant and opportunity to dispute whether the applicant falls within a continuity of care exception.[54][56]

XIII. Evidentiary Considerations and Record Building

A. Documentation Standards for Referral Decisions

To establish a strong record for referral decision-making, treating physicians and claims administrators should ensure: PTP documentation includes specific clinical indicators necessitating secondary consultation (diagnostic uncertainty, need for specialist opinion, treatment planning), not merely general statements that "a consult was needed."[1][1][1] Claims administrator responses to referral requests should cite the specific basis for any delay or denial (UR under way, liability being investigated, generic doubts are insufficient; genuine medical or legal doubt must be documented).[8][37] Secondary provider reports should be tracked and documented as received, and any delays in PTP incorporation should be explained in the PTP's subsequent progress report.[1][1][1]

B. Building Evidentiary Support for Secondary Treatment Medical Necessity

If secondary treatment is denied and the applicant pursues UR/IMR/QME, the applicant's ability to demonstrate medical necessity depends on evidentiary support. Useful evidence includes: prior medical records documenting symptoms or conditions indicating secondary treatment appropriateness; peer-reviewed literature or practice guidelines suggesting the secondary treatment is indicated; expert declarations from other treating providers indicating medical necessity; diagnostic test results (imaging, laboratory findings, functional capacity evaluations) supporting the need for specialist evaluation; testimony from the treating physician regarding medical reasoning and treatment planning rationale; and expert QME opinions favoring medical necessity, if obtained.

XIV. Risk Management: Penalties and Collateral Consequences

A. Labor Code Section 5814 Penalties for Unreasonable Delay

As established in Pena, unreasonable delay in providing secondary treatment access can trigger Labor Code Section 5814 penalties of up to 25% of the delayed benefit amount (or $10,000, whichever is less) plus attorney's fees under Section 5814.5.[7][9][9] The Pena case involved a three-month delay without documented genuine doubt, and resulted in a 25% penalty award.[7] To minimize Section5814 exposure, claims administrators should: document any genuine doubt regarding liability or medical necessity within 5 business days of a secondary treatment request; respond to RFAs within applicable timeframes (5 business days for prospective UR, 72 hours for expedited); and authorize treatment when no legitimate basis for delay exists, recognizing that treatment costs are inevitable statutory obligations while delay penalties represent additional unrecoverable expenses.[7][8][5]

B. Collateral Damage to Claim Relationship and Settlement Leverage

Beyond statutory penalties, unreasonable denial or delay of secondary treatment damages the claims relationship and often shifts settlement leverage unfavorably. When an injured worker perceives that the employer is blocking necessary medical care, the worker's willingness to settle the case diminishes, and attorneys become more aggressive in litigation strategy. Conversely, prompt authorization of appropriate secondary treatment often facilitates faster recovery, earlier achievement of permanent and stationary status, and more tractable settlement negotiations.

XV. Conclusion and Practitioner Guidance

A. Synthesis of Key Principles

(c) 2026 The Law Offices of Fernando Hidalgo, Inc.

California workers' compensation law establishes that Primary Treating Physicians are coordinators and advocates for comprehensive medical care, not gatekeepers who control access to medical treatment. The Pena doctrine (2019) fundamentally rejected prior assumptions that referrals were required for secondary treatment access, establishing instead that employees can request secondary treatment directly and that employers must authorize reasonable access to secondary physicians unless genuine doubt regarding liability or medical necessity exists. Simultaneously, utilization review remains the appropriate mechanism for determining whether specific treatment plans are medically necessary, and employers retain the right to challenge medical necessity of proposed secondary treatment through UR/IMR/QME procedures.

For Medical Provider Networks, the access standard distinction between general PTPs (30 minutes/15 miles) and specialists (60 minutes/30 miles) has proven critical: if an MPN cannot produce three available specialists at required distances, employees may establish entitlement to non-network specialist care without having to prove the MPN is structurally inadequate for general orthopedic or other routine services. Recent decisions like Rodriguez (2025) have narrowed the scope of "ongoing treatment" exceptions to UR/IMR procedures, requiring applicants to pursue IMR as the exclusive remedy for UR denials of continued medical treatment rather than bringing WCAB claims on medical necessity grounds.

For injured workers, understanding these principles creates multiple strategic opportunities: directly requesting secondary treatment without awaiting PTP sponsorship (Pena); documenting MPN access standard failures to trigger automatic entitlement to non-network care (CCR Section 9767.5(c)); leveraging Section5814 penalty exposure to encourage prompt treatment authorization; and preserving pre-designation of personal physicians to escape MPN restrictions before injury.

For claims administrators, the optimal strategy involves accepting the statutory Section4600 obligation to provide medical treatment as inevitable and irrevocable, recognizing that prompt authorization of secondary treatment eliminates delay penalties, reduces litigation risk, and typically improves overall claim outcomes through faster recovery and earlier permanent and stationary status determination.

B. Practical Checklist for Claims Administrators

Upon receiving a secondary treatment request (by employee, attorney, or treating physician): Within 24 hours, determine whether the request identifies a specific physician, whether that physician's specialty is appropriate for the accepted body part or claimed injury, and whether any genuine medical or legal doubt exists regarding liability. If no genuine doubt, issue authorization or begin UR process.

If conducting utilization review: Submit RFA to qualified physician-reviewer competent in the clinical specialty at issue; ensure UR decision is rendered within applicable timeframe (5 business days for standard, 72 hours for expedited); communicate decision promptly to physician, employee, and attorney (if represented).

If denying secondary treatment: Document the specific basis for denial (not medically necessary under MTUS/ACOEM, not related to accepted body part, etc.) and communicate this reasoning clearly to all parties. Anticipate that applicant will pursue IMR or QME and ensure the denial rationale is defensible.

If secondary treatment request is delayed due to liability dispute: Issue written deferral of UR within 5 business days specifying the liability dispute basis; track the liability dispute resolution; resume UR process upon resolution of liability question.

For MPN cases involving specialist referrals: Verify that MPN can provide three available specialists within 30-mile/60-minute access standard; if not, proactively authorize extra-network specialist access before employee must request it.

When a treating provider is terminated from MPN: Follow continuity of care procedures in full; provide written notice; offer applicant opportunity to dispute whether case qualifies for continuity of care exception; resolve any dispute through Labor Code Section 4062 procedures, not through unilateral claims administrator determination.

C. Practical Checklist for Treating Physicians (PTPs)

(c) 2026 The Law Offices of Fernando Hidalgo, Inc.

In initial Doctor's First Report (Form DLSR 5021): Clearly identify any anticipated referrals or specialist consultations; provide clinical justification (diagnostic uncertainty, complexity requiring specialist input, etc.); specify anticipated frequency and duration of secondary treatment.

When identifying need for secondary treatment during treatment course: File progress report (PR-2 form or narrative) within 20 days of identifying the need; specify the specialty/type of physician; provide clinical indications; include any specific provider recommendations if known.

Upon receipt of secondary provider reports: Within 20 days, review the report and provide written response: either concur with secondary provider's findings and incorporate into treatment plan, or explain disagreement with clinical reasoning. Submit secondary provider reports along with your response to claims administrator.

When refusing to recommend secondary treatment: Document clinical reasoning explaining why secondary consultation is not indicated; recognize that this documentation may be scrutinized in later litigation if employee obtains care elsewhere and disputes the refusal.

When claims administrator denies secondary treatment you recommended: File an objection through proper channels (request reconsideration of UR decision, request IMR if applicable, consider QME if needed); support your recommendation with clinical evidence; recognize that your PTP opinion carries weight in subsequent dispute resolution.

D. Practical Checklist for Injured Workers and Their Attorneys

If PTP refuses secondary treatment: Request the treatment directly from claims administrator in writing; cite Pena v. Aqua Systems for the principle that no PTP referral is required; specifically reference the accepted body part and symptoms motivating the request; provide clinical justification if possible (prior medical records, literature, expert opinions).

If claims administrator delays response to secondary treatment request: Follow up within 5 business days with written demand for response; cite applicable UR timelines (5 business days standard, 72 hours expedited); threaten Section5814 penalty claim for unreasonable delay if response is not provided.

If UR denies secondary treatment: Request Independent Medical Review (IMR) within 30 days using DWC Form IMR-1; ensure the form is complete and signed; include copies of the UR decision and all supporting medical documentation.

For MPN access standard issues: Document attempts to schedule with MPN specialist; if unable to schedule within 10 business days (or if MPN cannot identify three available specialists within 30 miles/60 minutes), request extra-network specialist access under CCR Section 9767.5(c); put request in writing with documentation of access standard failure.

If provider is terminated from MPN: Review continuity of care policy; if you believe your case qualifies for continuity (acute condition not yet resolved, chronic condition requiring extended treatment, upcoming surgery, etc.), request written report from treating physician supporting continuity of care exception; dispute claims administrator's determination through Labor Code Section 4062 if needed.

Preserve Section5814 penalty claims: Maintain detailed records of dates when secondary treatment was requested, dates of communications with claims administrator, dates when treatment was finally authorized, and any periods during which treatment access was denied or delayed without justification. These records are essential for calculating penalty amounts and supporting frivolous appeal arguments.

References

[1] California Code of Regulations Title 8, Section 9785 - Reporting Duties of the Primary Treating Physician (https://www.dir.ca.gov/t8/9785.html)

[2] California Labor Code Section 4616 - Medical Provider Networks (https://law.justia.com/codes/california/2011/lab/division-4/4616-4616.7/4616/)

[3] California Department of Industrial Relations - CSUSM Instructions for Predesignation of Personal Physician (https://www.csusm.edu/shs/documents/predesignation1.pdf)

(c) 2026 The Law Offices of Fernando Hidalgo, Inc.

[4] California Labor Code Section 4600 - Right to Medical Treatment (https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4600/)

[5] Ochoa Calderon - Workers Comp Medical Treatment: A Rights & Authorization Guide (https://ochoacalderon.com/blog/workers-comp-medical-treatment-a-rights-authorization-guide)

[6] California Workers' Compensation Institute - Memo on PTP Referral Requirements (https://www.cwci.org/document.php?file=1314.doc)

[7] DCLBV - Panel Decision on PTP Referral and RFA Requirements (Pena v. Aqua Systems) (https://dclbv.com/newsletters/2019/q3/ptp-referral-and-rfa-are-not-required/)

[8] Sullivan on Comp - Deferring Utilization Review (Labor Code Section 4610(l)) (https://www.sullivanoncomp.com/blog/deferring-utilization-review)

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

[10] WCAB Panel Decision - Miguel Pena v. Aqua Systems (ADJ10308959) (https://www.dir.ca.gov/wcab/Panel-Decisions-2022/Miguel-PENA-ADJ10308959.pdf)

[11] California Labor Code Section 4610 - Utilization Review (https://law.justia.com/codes/california/2011/lab/division-4/4600-4614.1/4610/)

[12] Boxer & Gerson - The Penalty Box: Part One (5814 Penalties) (https://www.boxerlaw.com/workerscompzone/the-penalty-box-part-one/)

[13] Sullivan on Comp - MPN Access Standards for Specialists (Murillo v. Western National Group) (https://www.sullivanoncomp.com/blog/mpn-access-standards-if-an-employee-chooses-to-treat-with-a-specialist)

[14] California Code of Regulations Title 8, Section 9767.5 - Access Standards (https://www.dir.ca.gov/t8/9767_5.html)

[15] California Labor Code Section 4616 (2025) on Justia (https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4616/)

[16] PRISM MPN - Complete Written Employee Notification (https://prismmpn.prismrisk.gov/downloads/1163%20MPN%20Complete%20Written%20Employee%20Notification-%20English.pdf)

[17] DWC - FAQs About Medical Provider Networks (https://www.dir.ca.gov/dwc/mpn/dwc_mpn_faq.html)

[18] Work Comp Simplified - Medical Provider Networks in California Workers' Compensation (https://www.workcompsimplified.com/medical-provider-networks-in-california-workers-compensation-what-injured-workers-need-to-know/)

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

[19] Form PR-2 "Primary Treating Physician's Progress Report" (https://www.dir.ca.gov/t8/9785_2.html)

[20] Sullivan on Comp - September 2021 Case Law Update (Baker v. County of Sacramento) (https://www.sullivanoncomp.com/hubfs/docs/Podcast%20Slides/2021-09-case-law-update-slides.pdf)

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

[22] Cornell Law - Cal. Code Regs. Tit. 8, Section 9785.2.1 (https://www.law.cornell.edu/regulations/california/8-CCR-9785.2.1)

[23] WCAB Panel Decision - Vidal Murillo v. Western National Group (ADJ12031213) (https://www.dir.ca.gov/wcab/Panel-Decisions-2021/Vidal-MURILLO-ADJ12031213.pdf)

(c) 2026 The Law Offices of Fernando Hidalgo, Inc.

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

[25] Employees First Labor Law - Labor Code Section 4062: Objections to Medical Determinations (https://employeesfirstlaborlaw.com/labor-code-%C2%A74062-objections-to-medical-determinations/)

[26] RJY Law - Bracy v. State of California: Statute of Limitations and Unequivocal Denial (https://www.rjylaw.com/timely-denials-and-thorough-investigations-a-key-takeaway-from-bracy-v-state-of-california-2024-cal-wrk-comp-p-d-lexis-355-wcab-panel-decision-october-15-2024/)

[27] DWC - FAQs on Qualified Medical Evaluators (https://www.dir.ca.gov/dwc/medicalunit/faqiw.html)

[28] Bradford Barthel - Elayne Valdez v. Warehouse Demo Services (Non-MPN Treatment Admissibility) (https://bradfordbarthel.com/2011/09/01/elayne-valdez-v-warehouse-demo-services/)

[29] WCAB En Banc Decisions (https://www.dir.ca.gov/wcab/wcab_enbanc.htm)

[1] Fisher Phillips - Workplace Medical Restrictions and Crossover Obligations (https://www.fisherphillips.com/a/web/iyrxbCcKW1mvJyncHf8eMW/workplace-medical-restrictions-and-crossover-obligations-between-work-comp-and-feha-amanda-manukian-and-anet-drapalski.pdf)

[30] WorkCompCentral - The PTP, Secondary Treater, and Pre-Authorization (https://ww3.workcompcentral.com/columns/show/id/q45q04r654532z49o25goa)

[31] Boxer & Gerson - A Big Yawn? (Labor Code Section 4605 Consulting Physicians) (https://www.boxerlaw.com/workerscompzone/a-big-yawn/)

[32] DaisyBill - E/M: Not the PTP? How to Bill for Required Reports (https://blog.daisybill.com/california-evaluation-management-reports-workers-comp)

[33] WCAB Panel Decision - Carlos Valdiviezo v. Unknown Defendant (ADJ10885532) - Continuity of Care and Section5814 Penalties (https://www.dir.ca.gov/wcab/Panel-Decisions-2025/CarlosVALDIVIEZO-ADJ10885532.pdf)

[34] DWC - DWC Form RFA Instructions (https://www.dir.ca.gov/dwc/DWCPropRegs/IMR/IMR_FormRFAClean.pdf)

[35] California Code of Regulations Title 8, Section 9792.9.1 - Utilization Review Standards (https://www.dir.ca.gov/t8/9792_9_1.html)

[36] WCAB Panel Decision - Daniel Habtes v. Unknown Defendant (ADJ16041060) - UR Timing and RFA Completeness (https://www.dir.ca.gov/wcab/Panel-Decisions-2025/Daniel-HABTES-ADJ16041060.pdf)

[37] DWC - Independent Medical Review (IMR) FAQs (https://www.dir.ca.gov/dwc/IMR/IMR_FAQs.htm)

[5] DWC - Independent Medical Review (IMR) Overview (https://www.dir.ca.gov/dwc/imr.htm)

[38] DWC - FAQs on Utilization Review for Claims Administrators (https://www.dir.ca.gov/dwc/utilizationreview/ur_faq.htm)

[39] 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)

[40] PI Law - How To Manage A Delayed California Workers' Compensation Decision (https://www.pi.law/blog/how-to-manage-a-delayed-california-workers-compensation-decision/)

[13] California Code of Regulations Title 8, Section 9767.10 - Continuity of Care Policy (https://www.dir.ca.gov/t8/9767_10.html)

[34] California Code of Regulations Title 8, Section 9767.5 (Second Source) (https://www.dir.ca.gov/t8/9767_5.html)

(c) 2026 The Law Offices of Fernando Hidalgo, Inc.

[41] WCAB Panel Decision - Ray Gutierrez v. Unknown Defendant (ADJ18067229) - Patterson Doctrine and Material Change in Circumstances (https://www.dir.ca.gov/wcab/Panel-Decisions-2025/Ray-GUTIERREZ-ADJ18067229.pdf)

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

[43] Electronic Medical Billing and Payment Companion Guide (https://www.dir.ca.gov/wcab/Panel-Decisions-2025/CarlosVALDIVIEZO-ADJ10885532.pdf)

[44] CWCI - DWC IMR Regulations (https://www.cwci.org/document.php?file=2085.pdf)

[45] California Labor Code Section 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/)

[46] Employees First Labor Law - Labor Code Section 4603.2: Medical Billing and Payment Timelines (https://employeesfirstlaborlaw.com/labor-code-%C2%A74603-2-medical-billing-and-payment-timelines/)

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

[47] Daily Journal - Rodriguez v. WCAB: Court of Appeal Rejects Patterson Exception (https://www.dailyjournal.com/mcle/1781-court-of-appeal-restores-sanity-to-workers-comp-treatment-authorizations)

[48] Sullivan on Comp - 2nd District Court of Appeal Rejects Patterson Exception to UR/IMR (https://www.sullivanoncomp.com/blog/2nd-district-court-of-appeal-rejects-patterson-exception-to-ur/imr)

[49] Sullivan on Comp - Requesting Consulting Physicians Within an MPN (https://www.sullivanoncomp.com/blog/topic/lc-4616-3)

[50] Sullivan Attorneys - Requesting Consulting Physicians Within an MPN (Second Source) (https://www.sullivanoncomp.com/blog/requesting-consulting-physicians-mpn)

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

[51] California Code of Regulations Title 8, Section 9792.9 - Utilization Review Standards (Second Source) (https://www.dir.ca.gov/t8/9792_9.html)

[52] Employees First Labor Law - Labor Code Section 4610: Utilization Review (UR) - Workers Comp (https://employeesfirstlaborlaw.com/labor-code-%C2%A74610-utilization-review-ur-workers-comp/)

[53] Bradford Barthel - Panel Decision Clarifies Burdens of Proof in MPN Disputes (https://bradfordbarthel.com/2023/06/20/panel-decision-clarifies-burdens-of-proof-in-mpn-disputes/)

[54] PRISM MPN - Continuity of Care Policy (https://prismmpn.prismrisk.gov/downloads/1163%20MPN%20Continuity%20of%20Care%20Policy-%20English.pdf)

[14] CWCI - AB 1465 and Medical Provider Networks (https://cwci.org/document.php?file=4858.pdf)

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

[56] California Code of Regulations Title 8, Section 9767.3 - Application for a Medical Provider Network Plan (https://www.dir.ca.gov/t8/9767_3.html)

[57] County Connection - RFP #2024-MA-04 Workers' Compensation Claims Administration (https://countyconnection.com/wp-content/uploads/2024/12/FINAL_CCCTA-WC-TPA-RFP_120924.pdf)

[58] WorkCompCentral - Employer Controlled Medical Treatment (https://ww3.workcompcentral.com/columns/show/id/w208a06q1090351de59z35)

[1] CWCI - Title 8 Regulations (https://www.cwci.org/document.php?file=2452.doc)

(c) 2026 The Law Offices of Fernando Hidalgo, Inc.

[59] WCAB - En Banc Decisions (Second Source) (https://www.dir.ca.gov/wcab/wcab_enbanc.htm)

[60] DaisyBill - E/M: Not the PTP? How to Bill for Required Reports (Second Source) (https://blog.daisybill.com/california-evaluation-management-reports-workers-comp)

[32] California Code of Regulations Title 8, Section 9792.9 (Third Source) (https://www.dir.ca.gov/t8/9792_9.html)

[61] CWCI - Utilization Review and Independent Medical Review Regulations (https://www.cwci.org/document.php?file=2301.pdf)

[55] California Code of Regulations Title 8, Section 30 - QME Panel Requests (https://www.dir.ca.gov/t8/30.html)

[2] DWC - e-Billing (https://www.dir.ca.gov/dwc/ebilling/ebilling.html)

[62] California Code of Regulations Title 8, Section 9792.8 - Utilization Review Standards (https://www.dir.ca.gov/t8/9792_8.html)

[63] Employees First Labor Law - Labor Code Section 4061: Permanent Disability Disputes (https://employeesfirstlaborlaw.com/labor-code-%C2%A74061-permanent-disability-disputes-workers-comp/)

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

End of Report

Word Count: 10,847 words

Date Prepared: February 28, 2026

Prepared by: Legal AI Assistant | Facilitated by: The Law Offices of Fernando Hidalgo, Inc.

(c) 2026 The Law Offices of Fernando Hidalgo, Inc.