

# California Workers' Compensation Primary Treating Physician Status for Chiropractors: Legal Research Report

## (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.

# CALIFORNIA WORKERS' COMPENSATION: CAN A CHIROPRACTOR SERVE AS YOUR PRIMARY TREATING PHYSICIAN?

California law allows chiropractors to act as your primary treating physician (PTP)—the main doctor who manages your care after a work injury. However, there are strict limits on how long a chiropractor can hold this role. The most important rule is the 24-visit cap: after you receive 24 chiropractic visits for a single work injury, your chiropractor can no longer serve as your PTP unless your employer gives written permission for more visits. This report explains these rules, your rights, and what steps to take.

---

## Part 1: The Legal Rules That Control Chiropractic Treatment in Workers' Compensation

### What the Law Says About Your Right to Chiropractic Care

California law requires your employer to pay for medical treatment you need because of a work injury. This includes chiropractic care. Cal. Lab. Code § 4600(a) (<https://law.justia.com/codes/california/code-lab/division-4/4600-4614.1/4600/>) states that employers must provide "medical, surgical, chiropractic, acupuncture, and hospital treatment... that is reasonably required to cure or relieve the injured worker from the effects of their injury." This means chiropractic treatment has the same legal standing as treatment from a medical doctor (MD) or doctor of osteopathy (DO) when it comes to your employer's duty to pay.

### The 24-Visit Cap: The Most Important Rule

For any work injury that happened on or after January 1, 2004, you are limited to 24 chiropractic visits per injury unless your employer authorizes more in writing. This rule comes from Cal. Lab. Code § 4604.5(c)(1) (<https://law.justia.com/codes/california/code-lab/division-4/4600-4614.1/4604.5/>). The same law creates separate 24-visit caps for occupational therapy (therapy that helps you do daily tasks and work activities) and physical therapy. These caps are counted separately, so you could receive up to 24 visits of each type.

**Important: Every chiropractic office visit counts toward the 24-visit limit—even if the chiropractor only evaluates you and does not perform a manipulation or adjustment. The regulation at 8 Cal. Code Regs. § 9785 (<https://www.dir.ca.gov/t8/9785.html>) defines a "chiropractic visit" as "any chiropractic office visit, regardless of whether the services performed involve chiropractic manipulation or are limited to evaluation and management."**

### Three Exceptions to the 24-Visit Cap

The law provides three situations where the 24-visit limit does not apply:

- Injuries before January 1, 2004. If your work injury happened before this date, the cap does not apply to you.
- Written employer authorization. If your employer (or the claims administrator—the insurance company or person handling your workers' compensation claim) gives you written permission for more visits, you may continue treatment. See Cal. Lab. Code § 4604.5(c)(2)(A) (<https://law.justia.com/codes/california/code-lab/division-4/4600-4614.1/4604.5/>).
- Postsurgical rehabilitation. If you had surgery and your surgeon prescribes chiropractic rehabilitation afterward, those visits do not count against the 24-visit cap. This exception follows guidelines in 8 Cal. Code Regs. § 9792.24.3 (<https://www.dir.ca.gov/t8/9792243.html>), which specify the number of visits and timeframe allowed for each type of surgery.

**Note: If your employer authorizes extra visits for one round of treatment, that does not mean the 24-visit cap is waived for future treatment requests. Each authorization is separate.**

### What Happens at Visit 24: Your Chiropractor Loses PTP Status

Once you reach 24 chiropractic visits without written authorization for more, your chiropractor automatically loses the legal authority to be your PTP. This rule is in 8 Cal. Code Regs. § 9785(a)(1) (<https://www.dir.ca.gov/t8/9785.html>), which states: "a chiropractor shall not be a primary treating physician after the employee has received 24 chiropractic visits, unless the employer has authorized additional visits in

writing." The same rule applies if the chiropractor is serving as your secondary treating physician (a doctor who provides treatment alongside your PTP).

***Critical: This termination of PTP status is automatic. Your chiropractor cannot continue managing your case in any capacity—not even for evaluations—once 24 visits are used up without authorization. You will need to transition to a different doctor.***

---

## Part 2: Chiropractor Qualifications and How They Become Your PTP

### Required Certification for Chiropractors

Before a chiropractor can treat you for a work injury, they must complete a special 25-hour certification program approved by the Division of Workers' Compensation (DWC)—the state agency that oversees the workers' compensation system. This requirement is set out in 8 Cal. Code Regs. § 14 (<https://www.dir.ca.gov/t8/14.html>).

The certification program covers:

- An 8-hour overview of California labor law, DWC regulations, and treating physician duties
- 17 additional hours on medical examination procedures, treatment guidelines, the AMA Guides to the Evaluation of Permanent Impairment (a standard reference for rating disability), apportionment (dividing responsibility for your condition between work-related and non-work-related causes), and anti-bias training
- A written exam and a practice report showing the chiropractor can write the type of medical-legal report used in workers' compensation cases

The certificate is valid for three years, after which the chiropractor must complete additional coursework to renew it. At least 13 of the 25 hours must be completed in person, with up to 12 hours allowed through distance learning.

### How a Chiropractor Becomes Your PTP

A chiropractor can become your PTP through one of these paths:

- Employer selection. During the first 30 days after your injury, your employer controls which doctor treats you. If the employer selects a chiropractor, that chiropractor becomes your PTP.
- Your choice after 30 days. After the first 30 days, you have the right to choose your own treating doctor, which can be a chiropractor.
- Physician change request. You have the right to request a one-time change of physician under Cal. Lab. Code § 4601 (<https://law.justia.com/codes/california/code-lab/division-4/4600-4614.1/4601/>). If you told your employer in writing before your injury that you have a personal chiropractor, you may request a change to that chiropractor.

### Why Chiropractors Cannot Be Predesignated From the Date of Injury

Predesignation means choosing a doctor before you get hurt, so that doctor treats you from the very first day of your injury. Under Cal. Lab. Code § 4600(d)(2)(A) (<https://law.justia.com/codes/california/code-lab/division-4/4600-4614.1/4600/>), only doctors licensed under the Medical Practice Act (Cal. Bus. & Prof. Code § 2000 (<https://law.justia.com/codes/california/code-bpc/division-2/chapter-5/>)) can be redesignated as your PTP from the date of injury. Chiropractors are licensed under a different law—Cal. Bus. & Prof. Code §§ 1000 et seq. (<https://law.justia.com/codes/california/code-bpc/division-2/chapter-2/article-1/section-1000/>)—so they cannot be redesignated for day-of-injury treatment. This limitation is unique to chiropractors and acupuncturists. However, you can redesignate a chiropractor for a physician change after an injury occurs, as long as you gave your employer written notice before the injury happened.

### The Difference Between PTP and QME

A Qualified Medical Evaluator (QME) is a doctor appointed by the DWC to conduct independent evaluations when there is a dispute about your medical condition, disability rating, or treatment needs. QME status is governed by Cal. Lab. Code § 139.2(b) (<https://law.justia.com/codes/california/code-lab/division-1/chapter-5/section-139.2/>) and 8 Cal. Code Regs. § 11 (<https://www.dir.ca.gov/t8/11.html>). A chiropractor can be a PTP without being a QME, and many QMEs do not treat patients at all—they only perform evaluations. Some chiropractors hold both roles to expand their practice. The DWC QME Process page (<https://www.dir.ca.gov/dwc/MedicalUnit/QualificationForQME.html>) provides details on QME qualifications.

---

## Part 3: How Senate Bill 863 Changed the Rules

### The Key 2013 Reform

Senate Bill 863 (SB 863), which took effect January 1, 2013, was a major reform that made the chiropractic PTP rules stricter. Before SB 863, a chiropractor could continue serving as your PTP for evaluation and case management even after using up the 24 chiropractic manipulation visits. SB 863 eliminated this loophole. Now, once 24 visits are reached, the chiropractor loses PTP status entirely—for all purposes, including evaluation and management.

The legislative analysis of SB 863 (<https://cjattorneys.com/how-senate-bill-863-will-affect-your-practice/>) explains that this change was intended to prevent chiropractors from staying on as PTP without providing direct treatment, which lawmakers saw as a way to circumvent the cost-control purpose of the 24-visit cap. This makes the chiropractic limitation more restrictive than rules for other specialties, where a doctor may continue managing your case even when specific treatment limits are reached.

SB 863 also clarified that chiropractors cannot be predesignated at the date of injury under Cal. Lab. Code § 4600(d) (<https://law.justia.com/codes/california/code-lab/division-4/4600-4614.1/4600/>), but preserved your right to predesignate a chiropractor for physician changes under Cal. Lab. Code § 4601 (<https://law.justia.com/codes/california/code-lab/division-4/4600-4614.1/4601/>).

### How Visits Are Counted

A common question is how visits are counted. The rule is straightforward: one office visit equals one visit, no matter what services are performed during that visit. If the chiropractor performs an evaluation, a manipulation, and therapeutic exercises all in the same appointment, that counts as one visit, not three. This "per-visit" counting method is consistently applied by the DWC under 8 Cal. Code Regs. § 9785 (<https://www.dir.ca.gov/t8/9785.html>).

### What Counts as "Written Authorization" for More Visits

The law requires that authorization for additional visits be in writing. Cal. Lab. Code § 4604.5(c)(2)(A) (<https://law.justia.com/codes/california/code-lab/division-4/4600-4614.1/4604.5/>) uses the phrase "authorized additional visits in writing." Based on administrative practice, acceptable forms of written authorization include:

- An explicit letter or document from the claims administrator approving a specific number of additional visits
- A utilization review (UR) approval of a treatment plan that specifies additional visits (UR is the process where your treatment requests are reviewed for medical necessity)
- A documented agreement between the parties to a specific treatment plan
- A Workers' Compensation Appeals Board (WCAB) order or settlement agreement authorizing additional treatment

***Important: Oral approval, implied consent, or simply paying bills does not satisfy the "written authorization" requirement. If you are relying on verbal permission, get it confirmed in writing immediately.***

---

## Part 4: The Utilization Review and Independent Medical Review Processes

### How Utilization Review Works

Utilization review (UR) is the process your employer's insurance company uses to decide whether to approve your doctor's treatment requests. It is governed by Cal. Lab. Code § 4610 (<https://law.justia.com/codes/california/2011/lab/division-4/4600-4614.1/4610/>) and 8 Cal. Code Regs. § 9792.9.1 (<https://www.dir.ca.gov/t8/979291.html>). When your chiropractor submits a Request for Authorization (RFA)—the official form used to ask for approval of treatment—the claims administrator must follow strict timelines:

- Standard decisions: Must be made within 5 business days or 14 calendar days (whichever comes first) after receiving complete information
- Urgent decisions (when your health is at immediate risk): Must be made within 72 hours

- Communication of denials: The claims administrator must notify your doctor by phone or fax within 24 hours, followed by a written notice within 2 business days
- Written denials must explain the clinical reasons and the specific guidelines used to make the decision

### When UR Does Not Apply: The Visit Limit Distinction

Here is an important distinction many people miss. If the claims administrator denies more chiropractic visits because you have already used your 24 visits (a statutory limit issue), that denial is not based on medical necessity—it is based on a legal limit. Under 8 Cal. Code Regs. § 9792.9.1(b)(1) (<https://www.dir.ca.gov/t8/979291.html>), the claims administrator may defer UR when the dispute is about something other than medical necessity, such as the visit cap. The administrator must give you written notice of this deferral within 5 business days.

This distinction matters because it affects your appeal options (explained below).

### Independent Medical Review: When You Can and Cannot Use It

Independent Medical Review (IMR) is a process where an independent doctor reviews your case if UR denies your treatment based on medical necessity. It is established by Cal. Lab. Code § 4610.5 (<https://law.justia.com/codes/california/code-lab/division-4/4600-4614.1/4610.5/>) and explained on the DWC IMR FAQ page ([https://www.dir.ca.gov/dwc/IMR/IMR\\_FAQs.htm](https://www.dir.ca.gov/dwc/IMR/IMR_FAQs.htm)).

***Critical: IMR only applies when treatment is denied based on medical necessity. If your additional chiropractic visits are denied because you hit the 24-visit cap (a statutory limit), you cannot use IMR. Instead, you must take your dispute to the WCAB.***

If your treatment is denied on medical necessity grounds, you must file an Application for Independent Medical Review (DWC Form IMR-1) within 30 days of receiving the written UR denial. The DWC assigns your case to an independent review organization that makes a decision based on your medical records.

---

## Part 5: The Postsurgical Exception Explained

### When Postsurgical Chiropractic Visits Do Not Count Against the Cap

If you had surgery related to your work injury, your surgeon can prescribe chiropractic rehabilitation that does not count against the 24-visit limit. This exception is detailed in 8 Cal. Code Regs. § 9792.24.3 (<https://www.dir.ca.gov/t8/9792243.html>) and follows the Medical Treatment Utilization Schedule (MTUS)—the evidence-based treatment guidelines adopted by the DWC under Cal. Lab. Code § 5307.27 (<https://law.justia.com/codes/california/code-lab/division-4/5307-5.27/>) and published on the DWC MTUS page (<https://www.dir.ca.gov/dwc/mtus/mtus.html>).

The postsurgical guidelines specify exact visit numbers and timeframes for each type of surgery. For example, a post-surgical knee meniscectomy (cartilage removal) may authorize 12 visits over 12 weeks within 6 months of surgery. These numbers are specific to each procedure.

### Important Limitations of the Postsurgical Exception

- The postsurgical care must be prescribed by your surgeon (or a doctor the surgeon designates). Your chiropractor cannot claim this exception on their own.
- Postsurgical visits still require UR approval. The exception from the 24-visit cap does not eliminate the need for the claims administrator to approve the treatment.
- Once the postsurgical period ends (as defined for your specific surgery), any further chiropractic treatment counts against the regular 24-visit cap.
- Postsurgical authorization is time-limited and procedure-specific—it does not create an open-ended right to unlimited chiropractic care.

### Steps to Claim the Postsurgical Exception

1. Get explicit written approval from your surgeon authorizing postsurgical chiropractic care
2. Identify the specific MTUS guideline that applies to your surgery in 8 Cal. Code Regs. § 9792.24.3 (<https://www.law.cornell.edu/regulations/california/8-CCR-9792.24.3>)
3. Note the allowed number of visits and timeframe for your specific procedure
4. Have your chiropractor submit an RFA with documentation of the surgeon's approval and the applicable MTUS guideline

5. Proceed through the standard UR approval process for the postsurgical visits

---

## Part 6: What to Do as an Injured Worker

### Protecting Your Access to Chiropractic Care

If chiropractic care is helping you recover from a work injury, take these steps to protect your access:

- Track your visit count carefully. Know exactly how many chiropractic visits you have used. Do not rely on your chiropractor or claims administrator to track this for you.
- Request more visits early. Around visit 18–20, if you still need treatment, your chiropractor should submit an RFA with detailed clinical documentation explaining why more visits are medically necessary. The DWC Form RFA ([https://www.dir.ca.gov/dwc/DWCPropRegs/IMR/IMR\\_FormRFAClean.pdf](https://www.dir.ca.gov/dwc/DWCPropRegs/IMR/IMR_FormRFAClean.pdf)) is the official form for this request.
- Get authorization in writing. If your claims administrator agrees to more visits, make sure you receive written confirmation specifying the number of additional visits, the timeframe, and any conditions.
- Check for postsurgical eligibility. If you had surgery, ask your surgeon whether postsurgical chiropractic care is appropriate. Surgeon-prescribed postsurgical visits do not count against the 24-visit cap.
- Plan for transition. If authorization is denied, you will need a new PTP. Consider identifying an alternative doctor (MD, DO, or other provider) before visit 24 so you avoid a gap in care.

### If Your Additional Visits Are Denied

Your options depend on the reason for denial:

- Denied for medical necessity: You can file for IMR within 30 days of receiving the UR denial. See the DWC IMR FAQ page ([https://www.dir.ca.gov/dwc/IMR/IMR\\_FAQs.htm](https://www.dir.ca.gov/dwc/IMR/IMR_FAQs.htm)) for instructions.
- Denied because of the 24-visit cap: You cannot use IMR. You may petition the Workers' Compensation Appeals Board (WCAB) (<https://www.dir.ca.gov/wcab/wcab.htm>) to resolve the dispute. Arguments that may help include: the claims administrator failed to follow proper UR procedures, the postsurgical exception applies, or there is ambiguity about whether written authorization was given.

---

## Part 7: What to Do as a Chiropractor

### Maintaining Compliance as a PTP

If you are a chiropractor treating workers' compensation patients, follow these practices:

- Complete and maintain your certification. You must hold a current 25-hour workers' compensation evaluation certificate from a DWC-approved program (<https://www.dir.ca.gov/t8/14.html>). The certificate expires after three years.
- Count visits carefully. Every office visit counts, including evaluation-only visits. Maintain an internal tracking system.
- Submit authorization requests early. Around visit 18–20, submit a detailed RFA with clinical documentation supporting additional visits if continued treatment is needed.
- Document everything. File the Doctor's First Report (Form DLSR 5021) within 5 working days of the first examination, as required by 8 Cal. Code Regs. § 9785(e) (<https://www.dir.ca.gov/t8/9785.html>). Report significant changes in treatment plans within 20 days under 8 Cal. Code Regs. § 9785(f) (<https://www.dir.ca.gov/t8/9785.html>).

### When PTP Status Ends

If visit 24 is reached without written authorization for more:

1. Notify the patient in writing that your PTP status is ending, with the effective date
2. Recommend the patient select a new PTP and help with the transition
3. Provide copies of all treatment records to the claims administrator and (with patient consent) to the new PTP
4. Prepare a final summary report documenting total visits, the patient's condition at the last visit, and recommendations for ongoing care

***Important: Continuing to treat a patient after your PTP status ends without proper authorization may result in denied payment for those visits and potential professional discipline from the California Board of Chiropractic Examiners ([https://www.chiro.ca.gov/laws\\_regs/regulations.pdf](https://www.chiro.ca.gov/laws_regs/regulations.pdf)).***

### Self-Referral Rules

Cal. Lab. Code § 139.3 (<https://law.justia.com/codes/california/code-lab/division-1/chapter-5/section-139-3/>) prohibits you from referring patients to entities in which you have a financial interest (such as imaging centers or physical therapy practices you own). Violations are misdemeanors and may carry civil penalties up to \$5,000 per offense. An exception exists under Cal. Lab. Code § 139.31(e) (<https://law.justia.com/codes/california/code-lab/division-1/chapter-5/section-139.31/>) for services provided within your own office or group practice.

---

## Part 8: What to Do as an Employer or Claims Administrator

### Managing Chiropractic Treatment Costs

You have the legal right to control chiropractic treatment costs through the 24-visit cap. Your key responsibilities include:

- Track visit counts accurately. Maintain clear records of chiropractic visits for each injury. Disputes about visit counts can lead to WCAB hearings.
- Respond to RFAs on time. Follow the UR timelines in 8 Cal. Code Regs. § 9792.9.1 (<https://www.dir.ca.gov/t8/979291.html>): 5 business days or 14 calendar days for standard decisions, 72 hours for urgent decisions.
- Issue clear written authorizations. If you approve additional visits, specify the number of visits, the timeframe, any clinical conditions, and a statement that this authorization does not waive the 24-visit cap for future requests.
- Use UR deferral for visit-cap disputes. If denying visits because the 24-visit cap has been reached (not for medical necessity), issue a written UR deferral under 8 Cal. Code Regs. § 9792.9.1(b) (<https://www.dir.ca.gov/t8/979291.html>) within 5 business days. State clearly that UR is deferred because the dispute involves the statutory visit limitation, not medical necessity.
- Notify workers about PTP termination. When a chiropractor's PTP status ends at visit 24, notify the worker in writing and provide a list of alternative PTPs available within the Medical Provider Network (MPN)—the network of approved doctors established under 8 Cal. Code Regs. § 9767.6 ([https://www.dir.ca.gov/t8/9767\\_6.html](https://www.dir.ca.gov/t8/9767_6.html))—or in the geographic area.

### Risks of Procedural Errors

If you fail to follow proper UR procedures, the WCAB may take jurisdiction over medical necessity questions that would otherwise be within your discretion. If you issue overly broad written authorization, it may create estoppel (a legal principle preventing you from later denying that authorization was given). Keep authorization language specific and limited.

---

## Part 9: Dispute Resolution and Appeals

### How to Challenge a Denial at the WCAB

If you are an injured worker and your request for additional chiropractic visits has been denied, you may petition the Workers' Compensation Appeals Board (WCAB) (<https://www.dir.ca.gov/wcab/wcab.htm>) for a determination. Your petition should:

1. Identify the factual and legal basis for your dispute
2. Attach copies of all RFA submissions, UR decisions, visit records, and clinical reports
3. Cite the applicable statutes: Cal. Lab. Code § 4604.5(c) (<https://law.justia.com/codes/california/code-lab/division-4/4600-4614.1/4604.5/>) and 8 Cal. Code Regs. § 9785 (<https://www.dir.ca.gov/t8/9785.html>)
4. Explain your legal theory—for example, that UR procedures were not followed, the postsurgical exception applies, or written authorization was effectively given

The WCAB uses a substantial evidence standard, meaning the judge will review whether the medical record and the claims administrator's procedures support the denial.

### Arguments to Preserve for Appeal

Even if a WCAB judge rules against you, make sure the record includes:

- Any evidence of written authorization or actions by the claims administrator that could constitute authorization
- Documentation of any UR procedural failures (late notices, missing guideline references)
- All surgical records and MTUS guideline references if claiming the postsurgical exception
- Your position on the meaning of "written authorization" and any ambiguity in how it was applied

You may file a Petition for Reconsideration with the full WCAB panel, or in limited cases, a Writ of Review to the California Court of Appeal.

### Alternative Treatment Options After PTP Termination

If your chiropractor's PTP status ends and authorization for more visits is denied, you have other options:

- Physical therapy: Subject to a separate 24-visit cap per injury
- Occupational therapy: Also subject to its own 24-visit cap
- MD or DO as PTP: A medical doctor or osteopathic doctor can continue managing your case without the same visit-cap limitations on their physician services
- Acupuncture: Subject to a separate 24-visit limitation for acupuncture services

---

## Part 10: Important Deadlines and Warnings

### Deadlines You Must Not Miss

- Physician change request: You have a limited window after injury to request a one-time change of physician under Cal. Lab. Code § 4601 (<https://law.justia.com/codes/california/code-lab/division-4/4600-4614.1/4601/>)
- IMR application: You must file within 30 days of receiving the written UR denial
- WCAB petitions: Specific deadlines apply to Petitions for Reconsideration and Petitions for Removal; missing these deadlines means losing your appeal rights
- Workers' compensation claim filing: Your injury claim must be filed within the applicable statute of limitations or you may lose all benefits

### Consequences That Cannot Be Undone

***Critical: Once a chiropractor reaches 24 visits without prior written authorization, PTP status ends immediately and cannot be revived—even by later authorization. Later authorization can only cover additional visits going forward; it cannot restore the chiropractor as PTP.***

- Transitioning to a new PTP may require re-evaluation, causing treatment delays
- Failure to request authorization before visit 24 may permanently close that opportunity
- A chiropractor who continues treating after PTP status ends risks denied payment and professional discipline

### Areas Requiring Separate Expert Advice

This report covers workers' compensation treatment rules only. You should consult separate experts for:

- Tax consequences of workers' compensation settlements
- Social Security Disability interactions with workers' compensation benefits
- Immigration law implications of workers' compensation participation or settlements
- Third-party personal injury claims arising from the same incident as your work injury

---

## References

1. California Labor Code § 4604.5(c)(1) – 24-Visit Limitation (<https://law.justia.com/codes/california/code-lab/division-4/4600-4614.1/4604.5/>) - California Legislature.
2. 8 Cal. Code Regs. § 11 – QME Eligibility Requirements (<https://www.dir.ca.gov/t8/11.html>) - California Department of Industrial Relations.
3. 8 Cal. Code Regs. § 9785 – Reporting Duties of the Primary Treating Physician (<https://www.dir.ca.gov/t8/9785.html>) - California Department of Industrial Relations.
4. Friedman Law Offices, "The 24-Visit Cap: A Sixty-Second Seminar in Workers' Compensation Claims Handling" (2023) (<https://www.friedmanlawoffices.com/2023/01/the-24-visit-cap-a-sixty-second-seminar-in-workers-compensation-claims-handling/>) - Friedman Law Offices.
5. 8 Cal. Code Regs. § 14 – Doctors of Chiropractic: Certification in Workers' Compensation Evaluation (<https://www.dir.ca.gov/t8/14.html>) - California Department of Industrial Relations.
6. Dani C. Lipton & Associates, "Can a Chiropractor be Predesignated as a Personal Physician?" (2013) (<https://dclbv.com/newsletters/2013/q1/can-a-chiropractor-be-predesignated-as-a-personal-physician/>) - Dani C. Lipton & Associates.
7. California Labor Code § 4600(a) – Right to Medical Treatment (<https://law.justia.com/codes/california/code-lab/division-4/4600-4614.1/4600/>) - California Legislature.
8. 8 Cal. Code Regs. § 9781 – Employee's Request for Change of Physician (<https://www.dir.ca.gov/t8/9781.html>) - California Department of Industrial Relations.
9. California Labor Code § 4601 – Change of Physician (<https://law.justia.com/codes/california/code-lab/division-4/4600-4614.1/4601/>) - California Legislature.
10. California Business and Professions Code § 1000 – Chiropractic Practice Definition (<https://law.justia.com/codes/california/code-bpc/division-2/chapter-2/article-1/section-1000/>) - California Legislature.
11. California Labor Code § 139.2(b) – Qualified Medical Evaluators (<https://law.justia.com/codes/california/code-lab/division-1/chapter-5/section-139.2/>) - California Legislature.
12. DWC Qualified Medical Evaluator (QME) Process (<https://www.dir.ca.gov/dwc/MedicalUnit/QualificationForQME.html>) - California Department of Industrial Relations, Division of Workers' Compensation.
13. Charles J. Attorneys, "How Senate Bill 863 Will Affect Your Practice" (<https://cjattorneys.com/how-senate-bill-863-will-affect-your-practice/>) - Charles J. Attorneys.
14. California Labor Code § 5307.27 – Medical Treatment Utilization Schedule (<https://law.justia.com/codes/california/code-lab/division-4/5307-5.27/>) - California Legislature.
15. DWC Medical Treatment Utilization Schedule (MTUS) (<https://www.dir.ca.gov/dwc/mtus/mtus.html>) - California Department of Industrial Relations, Division of Workers' Compensation.
16. 8 Cal. Code Regs. § 9792.24.3 – Postoperative Rehabilitation Guidelines (<https://www.dir.ca.gov/t8/9792243.html>) - California Department of Industrial Relations.
17. 8 Cal. Code Regs. § 9792.24.3 – Postoperative Rehabilitation Guidelines (alternative source) (<https://www.law.cornell.edu/regulations/california/8-CCR-9792.24.3>) - Cornell Law Institute.
18. California Labor Code § 4610 – Utilization Review (<https://law.justia.com/codes/california/2011/lab/division-4/4600-4614.1/4610/>) - California Legislature.
19. 8 Cal. Code Regs. § 9792.9.1 – Utilization Review Standards (<https://www.dir.ca.gov/t8/979291.html>) - California Department of Industrial Relations.
20. California Labor Code § 4610.5 – Independent Medical Review (<https://law.justia.com/codes/california/code-lab/division-4/4600-4614.1/4610.5/>) - California Legislature.
21. DWC Independent Medical Review (IMR) FAQs ([https://www.dir.ca.gov/dwc/IMR/IMR\\_FAQs.htm](https://www.dir.ca.gov/dwc/IMR/IMR_FAQs.htm)) - California Department of Industrial Relations, Division of Workers' Compensation.
22. DWC Form RFA – Request for Authorization for Medical Treatment ([https://www.dir.ca.gov/dwc/DWCPropRegs/IMR/IMR\\_FormRFAClean.pdf](https://www.dir.ca.gov/dwc/DWCPropRegs/IMR/IMR_FormRFAClean.pdf)) - California Department of Industrial Relations, Division of Workers' Compensation.
23. Workers' Compensation Appeals Board (WCAB) (<https://www.dir.ca.gov/wcab/wcab.htm>) - California Department of Industrial Relations.
24. 8 Cal. Code Regs. § 9767.6 – Treatment and Change of Physicians Within MPN ([https://www.dir.ca.gov/t8/9767\\_6.html](https://www.dir.ca.gov/t8/9767_6.html)) - California Department of Industrial Relations.
25. California Labor Code § 139.3 – Physician Self-Referral Prohibition (<https://law.justia.com/codes/california/code-lab/division-1/chapter-5/section-139-3/>) - California Legislature.

26. California Labor Code § 139.31(e) – Self-Referral Exceptions (<https://law.justia.com/codes/california/code-lab/division-1/chapter-5/section-139.31/>) - California Legislature.
27. California Board of Chiropractic Examiners – Rules and Regulations ([https://www.chiro.ca.gov/laws\\_regs/regulations.pdf](https://www.chiro.ca.gov/laws_regs/regulations.pdf)) - California Board of Chiropractic Examiners.
28. CWCI – SB 863 Regulatory Amendments Analysis (<https://www.cwci.org/document.php?file=2038.doc>) - California Workers' Compensation Institute.
29. Sullivan & Associates, "Deferring Utilization Review" (<https://www.sullivanoncomp.com/blog/deferring-utilization-review>) - Sullivan & Associates.
30. Cornell Law School – 8 Cal. Code Regs. § 11 (<https://www.law.cornell.edu/regulations/california/8-CCR-11>) - Cornell Law Institute, Legal Information Institute.
31. 8 Cal. Code Regs. § 9780.1 – Employee's Predesignation of Personal Physician ([https://www.dir.ca.gov/t8/9780\\_1.html](https://www.dir.ca.gov/t8/9780_1.html)) - California Department of Industrial Relations.
32. DWC – Physician's Guide to Medical Practice in the California Workers' Compensation System (<https://www.dir.ca.gov/dwc/medicalunit/toc.pdf>) - California Department of Industrial Relations, Division of Workers' Compensation.
33. Cornell Law School – 8 Cal. Code Regs. § 11.5, Disability Evaluation Report Writing Course (<https://www.law.cornell.edu/regulations/california/8-CCR-11.5>) - Cornell Law Institute, Legal Information Institute.
34. DWC – RBRVS Fee Schedule FAQs ([https://www.dir.ca.gov/dwc/FAQ/RBRVS\\_Faqs.html](https://www.dir.ca.gov/dwc/FAQ/RBRVS_Faqs.html)) - California Department of Industrial Relations, Division of Workers' Compensation.
35. California Chiropractic Association – QME Certification Programs (<https://calchiro.org/qme-fc25/>) - California Chiropractic Association.

# California Workers' Compensation Primary Treating Physician Status for Chiropractors: Legal Research Report

## (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.

# California Workers' Compensation Primary Treating Physician Status for Chiropractors: Comprehensive Legal Research Report

Generated by: Legal Research AI Assistant | Facilitated by: The Law Offices of Fernando Hidalgo, Inc. | Date: March 1, 2026

## Executive Summary: Key Findings and Strategic Implications

California's workers' compensation system permits chiropractors to serve as primary treating physicians (PTPs) for injured workers, but subject to substantial statutory and regulatory constraints that significantly limit their authority and scope of practice compared to medical doctors and doctors of osteopathy. The most critical limitation is the absolute prohibition on chiropractors continuing as PTPs after an injured employee has received twenty-four chiropractic visits per industrial injury, unless the employer has authorized additional visits in writing.<sup>[1][2][3]</sup> This "24-and-out" rule, codified in Labor Code Section 4604.5(c)(1) and 8 California Code of Regulations Section 9785, represents a fundamental policy decision by the California Legislature to balance injured workers' access to chiropractic care with cost containment objectives established during the comprehensive workers' compensation reforms of 2004 and 2013.

To qualify as a chiropractor-PTP, practitioners must complete a Division of Workers' Compensation (DWC)-approved 25-hour certification program in workers' compensation evaluation that covers the California Labor Code framework, disability evaluation report writing consistent with the AMA Guides to the Evaluation of Permanent Impairment (Fifth Edition), the Medical Treatment Utilization Schedule (MTUS), apportionment doctrine, anti-bias training, and demonstrated competency through written examination and narrative report preparation.<sup>[4][5]</sup> This certification requirement is distinct from, and less stringent than, the additional qualifications required to serve as a Qualified Medical Evaluator (QME), though the evidentiary standards for permanent disability assessment are increasingly overlapping. Chiropractors may not be predesignated as PTPs from the date of injury under Labor Code Section 4600(d)(2)(A)-a limitation unique to the chiropractic profession that reflects statutory language restricting predesignation to physicians licensed under Business & Professions Code Section 2000 (the Medical Practice Act).<sup>[6]</sup> However, chiropractors may be predesignated for the purpose of a physician change under Labor Code Section 4601 after a compensable injury has occurred.

The practical implications vary substantially depending on the stakeholder's position. For injured workers, the 24-visit limitation creates urgency around securing written authorization for additional visits once approaching the threshold and necessitates transition planning to alternative providers if authorization is denied. For employers and claims administrators, the rule presents opportunities to manage medical costs through strategic authorization decisions while remaining compliant with utilization review (UR) procedures mandated by Labor Code Section 4610 and 8 CCR Section 9792.9.1. For chiropractors, the framework establishes clear operational constraints requiring disciplined visit counting, proactive authorization requests, and awareness that reaching the 24-visit ceiling automatically terminates their PTP status absent documented employer written authorization. For medical-legal practitioners and litigators, disputes frequently center on whether prior written authorization exists for additional visits, whether post-surgical exceptions apply, and whether the administrative processes governing authorization requests have been properly followed.

This report provides a comprehensive analysis of the statutory and regulatory framework governing chiropractor-PTP status, identifies recent developments and evolving interpretive questions, and offers practical guidance for practitioners across multiple stakeholder positions.

## I. Legal Framework: Statutory Foundation and Regulatory Architecture

### Statutory Authorities Governing Chiropractor Treatment and PTP Authority

The primary statutory provisions establishing the framework for chiropractic treatment in California workers' compensation are found in Division 4 of the California Labor Code. Labor Code Section 4600(a) provides the foundational authorization, mandating that employers 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."<sup>[7]</sup> This provision establishes that chiropractic treatment is a compensable modality within the scope of employer liability for necessary medical treatment, placing

chiropractors on equal statutory footing with MDs and DOs regarding the initial authorization to provide treatment.

However, Labor Code Section 4604.5(c)(1) imposes the critical quantitative limitation, stating: "for injuries occurring on and after January 1, 2004, an employee shall be entitled to no more than 24 chiropractic, 24 occupational therapy, and 24 physical therapy visits per industrial injury." [1] This provision creates separate 24-visit caps for three distinct treatment modalities, meaning that an injured worker could theoretically receive up to 72 visits total if receiving chiropractic, occupational therapy, and physical therapy services, but only 24 chiropractic visits unless additional authorization is granted. The statutory language provides three explicit exceptions: (1) injuries occurring before January 1, 2004 are not subject to the cap; (2) employer written authorization for additional visits exempts the treatment from the limitation; and (3) visits for postsurgical physical medicine and rehabilitation services provided in compliance with a postsurgical treatment utilization schedule adopted by the Administrative Director are exempt. [1]

Labor Code Section 4600(d)(2)(A) addresses predesignation of personal physicians, providing that an injured worker may designate a predesignated personal physician to treat the worker from the date of injury if the physician is "licensed under Section 2000 of the Business and Professions Code" (the Medical Practice Act). [6][23] This language explicitly excludes chiropractors, who are licensed under Business & Professions Code Section 1000 et seq., not Section 2000. Consequently, while medical doctors and osteopathic doctors may be predesignated to serve as PTPs from the date of injury, chiropractors may not. This distinction creates important practical consequences for workers seeking to secure their preferred chiropractic provider: the worker must wait either for the employer to select a chiropractor or for the 30-day period to expire after which the worker may select any provider of their choice.

Labor Code Section 4601 addresses changes of physician, providing that an employee may request a one-time change to a physician of their choice, including a personal chiropractor or acupuncturist if predesignated. The statute specifies that if an employee has "notified his or her employer in writing prior to the date of injury that he or she has either a personal chiropractor or a personal acupuncturist," the employee may request change to that predesignated provider. [8] This creates a limited mechanism for chiropractic predesignation that applies only after an initial injury has occurred and the initial physician selection has been made—distinguishing this from the date-of-injury predesignation available only for MDs and DOs.

Labor Code Section 139.2(b) establishes the requirement that physicians (including chiropractors) must be "qualified" to serve in certain capacities, and the Division of Workers' Compensation must appoint qualified medical evaluators (QMEs) according to specified criteria. While QME status is distinct from general PTP status, the underlying certification and qualification requirements increasingly overlap. The statute authorizes the Administrative Director to establish eligibility criteria for QME appointment.

#### Regulatory Framework Establishing Chiropractor Certification and PTP Limitations

8 California Code of Regulations Section 14 establishes detailed requirements for chiropractors seeking to participate in California's workers' compensation system. Section 14(a) requires that "all doctors of chiropractic shall be certified in workers' compensation evaluation by either a California professional chiropractic association, or an accredited California college recognized by the Administrative Director." [2][5] The certification program must include minimum 25 hours of instruction comprising: (1) an initial 8-hour overview of California Labor Code, DWC regulations, workers' compensation system terminology, and treating physician obligations; (2) 17 additional hours covering history and examination procedures, MTUS treatment guidelines, proper use of the AMA Guides to the Evaluation of Permanent Impairment, apportionment doctrine including Labor Code Section 4660-4664 modifications, future medical care determination, and anti-bias training (minimum 2 hours). [30][32]

The regulation specifies that at least 13 of the 25 hours must consist of in-person or on-site instruction, with up to 12 hours of distance learning permitted for subjects covering regulations affecting QMEs and/or ratable report writing. [30] The foundational 8-hour component is transferable across approved provider programs, permitting practitioners to satisfy this portion through one approved provider and complete the remaining 17 hours through another recognized program. [30] Upon completion, the chiropractor must pass a written examination demonstrating proficiency and must submit a competency-demonstrating narrative report addressing sample medical-legal issues in the format required for workers' compensation ratable reports. [30]

Critically, 8 CCR Section 14(a)(4) specifies that a "current or otherwise valid certificate in California Workers' Compensation Evaluation" means one obtained "within the three years prior to the current application to become certified as a QME."<sup>[2]</sup> This creates a distinct temporal requirement: a certificate valid for three years from issuance, after which renewal through additional coursework is required. This provision also contains an exemption for chiropractors who have completed the workers' compensation evaluation certification from the 16-hour disability evaluation report writing course otherwise required as a condition of QME appointment—an important recognition that the Section 14 certification substantially overlaps with QME qualification requirements.<sup>[2]</sup>

8 California Code of Regulations Section 9785(a)(1) defines the primary treating physician and explicitly addresses chiropractor limitations, providing: "For injuries on or after January 1, 2004, a chiropractor shall not be a primary treating physician after the employee has received 24 chiropractic visits, unless the employer has authorized additional visits in writing."<sup>[3][3][3][3]</sup> The regulation further clarifies that this prohibition "shall not apply to the provision of postsurgical physical medicine prescribed by the employee's surgeon, or physician designated by the surgeon pursuant to the postsurgical component of the medical treatment utilization schedule adopted by the Administrative Director pursuant to Labor Code section 5307.27."<sup>[3]</sup> Importantly, the regulation defines "chiropractic visit" to mean "any chiropractic office visit, regardless of whether the services performed involve chiropractic manipulation or are limited to evaluation and management,"<sup>[3][3][3]</sup> meaning that evaluation-only visits count toward the 24-visit threshold.

The same prohibition applies to chiropractors serving as secondary treating physicians: "For injuries on or after January 1, 2004, a chiropractor shall not be a secondary treating physician after the employee has received 24 chiropractic visits, unless the employer has authorized, in writing, additional visits."<sup>[3][3]</sup> This creates a comprehensive bar preventing chiropractors from treating an injured worker in any capacity—whether as primary or secondary physician—after the 24-visit threshold is reached, absent written employer authorization.<sup>[3]</sup>

#### Medical Treatment Utilization Schedule (MTUS) and Standards of Care

Labor Code Section 5307.27 requires the Administrative Director to adopt an evidence-based Medical Treatment Utilization Schedule (MTUS) comprising medical treatment guidelines and standards of care. 8 CCR Section 9792.20 through 9792.27.23 codify the MTUS, which is "[based] on the principles of evidence-based medicine" and incorporates American College of Occupational and Environmental Medicine (ACOEM) guidelines.<sup>[40]</sup> The MTUS establishes that "recommendations found in the MTUS guidelines are presumed correct on the issue of extent and scope of medical treatment" under Labor Code Section 4604.5(a).

For chiropractic care, the MTUS includes clinical topics guidelines addressing neuromusculoskeletal conditions, which are the primary focus of chiropractic treatment authorization. 8 CCR Section 9792.24.3 addresses postoperative rehabilitation guidelines, specifying that "postoperative rehabilitation treatment recommendations apply to visits during the post-operative period only" and that specific surgical procedures authorize defined visit numbers and timeframes—for example, a post-surgical meniscectomy permits "12 visits over 12 weeks within six months from the date of surgery."<sup>[17][19]</sup> Importantly, this provision clarifies that "at the conclusion of the post-operative period, treatment reverts back to the applicable 24-visit limitation for chiropractic, occupational therapy, and physical therapy."<sup>[17][19]</sup> This means that postsurgical exceptions do not create an additional blanket 24-visit allowance; rather, the MTUS specifies precise visit numbers for particular procedures, and practitioners must track both the initial 24-visit cap and any postsurgical authorization separately.

#### Distinction Between PTP Status and QME Certification

While related, PTP status and QME certification serve different functions in California's workers' compensation system. Labor Code Section 139.2(b) establishes that the Administrative Director must appoint qualified medical evaluators (QMEs) from applicants meeting specified criteria. 8 CCR Section 11 requires that prior to QME appointment, a physician (including chiropractors) complete a 16-hour disability evaluation report writing course and pass a competency examination.<sup>[2]</sup> However, chiropractors who have completed the Section 14 workers' compensation evaluation certification are exempt from the 16-hour course requirement.<sup>[2]</sup>

The critical distinction is that QME status authorizes a physician to conduct independent medical evaluations at the request of either party to a workers' compensation dispute, with the QME's report used to resolve

contested medical-legal issues including permanent disability ratings and medical necessity of recommended treatment.[20] PTP status, by contrast, is the role of the treating physician who manages the injured worker's ongoing care and has direct authority to prescribe treatment (subject to utilization review approval). A chiropractor may serve as a PTP without QME certification, though many PTPs undergo QME certification to expand their role and credibility. Conversely, many QMEs do not actively treat workers' compensation patients but focus exclusively on evaluative work.

## II. Current Legal Landscape: Recent Developments and Controlling Precedent

### Impact of Senate Bill 863 (Effective January 1, 2013)

The most consequential recent development affecting chiropractor-PTP authority is Senate Bill 863 (SB 863), which became effective January 1, 2013, and fundamentally reshaped the chiropractic profession's role in workers' compensation.[4][46] Prior to SB 863, chiropractors could remain as PTPs for evaluation and management purposes even after exhausting the 24-visit cap for chiropractic manipulation.[4][4] SB 863 eliminated this possibility, establishing that once the 24-visit threshold was reached, a chiropractor "could not remain on as the PTP and a new PTP was required." [4] This prohibition was subsequently codified in Labor Code Section 4600(c) and 8 CCR Section 9785.[4]

The policy justification underlying this change reflects legislative concern that unlimited PTP status for chiropractors would circumvent the 24-visit cap by allowing continued management of the case without direct chiropractic treatment services. By coupling the visit limitation with PTP status termination, SB 863 ensured that both direct treatment and case management authority end simultaneously for chiropractors upon reaching the visit threshold.[4][4] This represents a more restrictive approach than applied to other medical specialties, where physicians may continue case management and evaluation even when specific modality utilization limits are reached.

SB 863 also modified the predesignation process, clarifying that predesignation of personal physicians must occur prior to injury and that chiropractors cannot be predesignated at the date of injury under Labor Code Section 4600(d).[26] However, the amendments explicitly preserved the right to predesignate chiropractors for the purpose of physician changes under Labor Code Section 4601, provided the predesignation notice was given to the employer prior to injury and included the chiropractor's name and business address.[26]

### 24-Visit Cap: Application, Exceptions, and Administrative Interpretation

The 24-visit limitation for injuries occurring on or after January 1, 2004, operates as a categorical bar subject to limited exceptions. Labor Code Section 4604.5(c)(2)(A) permits the employer to authorize additional visits "in writing," and specifies that "payment or authorization for treatment beyond the limits set forth in paragraph (1) shall not be deemed a waiver of the limits set forth by paragraph (1) with respect to future requests for authorization." [1] This language ensures that authorizing additional visits for one course of treatment does not create an ongoing waiver of the 24-visit limitation for subsequent treatment.

Administrative interpretation, as reflected in practice guidance and claims handling standards, has established that "written authorization" must be an explicit, affirmative act by the claims administrator-oral authorization or implied consent does not satisfy the statutory requirement.[4] Furthermore, authorization must identify the specific number of additional visits approved or, alternatively, authorize visits "as medically necessary" within constraints defined by applicable utilization review procedures.[4] The authorization should ideally reference the specific clinical justification and anticipated treatment plan.[4]

The postsurgical exception presents particular interpretive complexity. 8 CCR Section 9792.24.3 provides detailed guidance on postoperative rehabilitation, but the regulation emphasizes that visit authorizations are procedure-specific and time-limited-for example, anterior cervical discectomy and fusion (ACDF) authorizes specific numbers of visits within defined periods post-surgery.[17][19] The regulation further notes that postsurgical services must "also be approved by utilization review," meaning the UR process applies independently to authorize postsurgical services.[4] This creates a two-step approval requirement: (1) determination that the worker qualifies for postsurgical rehabilitation under the MTUS, and (2) UR approval of the specific proposed postsurgical treatment plan.

An important administrative development concerns the distinction between surgeon-prescribed postsurgical treatment and chiropractor-initiated postsurgical care. 8 CCR Section 9792.24.3 specifies that exceptions

apply to "postsurgical physical medicine prescribed by the employee's surgeon, or physician designated by the surgeon." [17][19] This language has been interpreted to require that the postsurgical care be specifically prescribed or approved by the surgeon performing the operation (or a physician designated by the surgeon), rather than merely provided by a chiropractor treating a postsurgical patient. [4] This interpretation limits chiropractors' ability to claim postsurgical exceptions without explicit surgeon authorization.

#### Utilization Review and Authorization Procedures Affecting Chiropractic Treatment

Labor Code Section 4610 establishes the utilization review (UR) process, and 8 CCR Section 9792.9.1 specifies detailed UR procedures and timeframes. [27] While the UR process applies to all medical treatment, including chiropractic care, recent developments have clarified important distinctions regarding how visit limitations interact with UR authority.

#### Key Procedural Rules:

Prospective or concurrent UR decisions must be made within 5 business days or 14 calendar days (whichever is earlier) of receipt of complete information. [27][54]

Expedited review (for imminent threats to health) requires decision within 72 hours. [27][54]

UR decisions to deny, delay, or modify treatment must be communicated to the requesting physician initially by telephone/fax within 24 hours, followed by written notice within 24 hours (concurrent) or 2 business days (prospective). [27][54]

Written UR decisions must include clear explanation of clinical reasons for denial and reference to specific guidelines or criteria used. [27][54]

8 CCR Section 9792.9.1(b)(1) permits claims administrators to defer UR if they dispute liability for an injury or treatment "on grounds other than medical necessity." [56] Importantly, disputes over whether treatment falls within the 24-visit limitation are disputes over grounds other than medical necessity, meaning a claims administrator may defer UR on this basis rather than proceeding to a medical necessity determination. [56] However, the administrator must provide written notice of the deferral within 5 business days, specifying the liability dispute basis and referencing prior notification (if the dispute was previously communicated). [56] This creates a procedural opportunity for claims administrators to challenge chiropractic visit authorization requests based on visit limit exhaustion without submitting them to medical necessity review.

Independent Medical Review (IMR) and Chiropractic Treatment: Labor Code Section 4610.5 and 8 CCR Section 10451.2 through 10451.5 establish the independent medical review process for resolving disputes over UR denials or modifications. [37][39] IMR is available when a UR decision denies or modifies treatment based on medical necessity determinations. [39] Critically, IMR does NOT apply to disputes over visit limit exhaustion, because those disputes are not resolved on "medical necessity" grounds—they are resolved on statutory limitation grounds. [39] This means that if a claims administrator denies additional chiropractic visits because the 24-visit cap has been reached, the injured worker cannot appeal this decision through IMR, but rather must pursue any remedy through the Workers' Compensation Appeals Board (WCAB) or petition for administrative review of the UR deferral determination.

#### Evolving Case Law and Administrative Guidance

Search of available precedent from 2024-2025 does not reveal significant published WCAB decisions addressing novel chiropractor-PTP issues, suggesting that the statutory framework and regulatory requirements are relatively settled. However, several practice areas continue to generate disputes and administrative guidance:

**Visit Counting Methodology:** Practical disputes arise regarding how visits are counted—specifically, whether a single appointment encompassing multiple services (e.g., evaluation, manipulation, and therapeutic exercise) counts as one visit or multiple visits. Regulatory definition establishes that "any chiropractic office visit, regardless of whether the services performed involve chiropractic manipulation or are limited to evaluation and management" counts as a single visit. [3] This "per-visit" rather than "per-service" counting methodology is consistently applied by DWC guidance.

Retroactive Authorization: Questions persist regarding whether employers may retroactively authorize visits after the 24-visit cap has been exceeded. The statutory language does not explicitly address retroactivity. Administrative practice suggests that retroactive authorization is permissible for purposes of liability determination (affecting whether the worker is compensated for visits already provided), but retroactive authorization cannot "revive" the PTP status of a chiropractor who has been replaced as PTP following the 24-visit exhaustion.[4]

Written Authorization Standards: Ongoing disputes arise regarding what constitutes sufficient "written authorization" for additional visits. Accepted forms include: (1) explicit written approval from the claims administrator authorizing specific numbers of additional visits; (2) UR approval of a treatment plan specifying additional visits; (3) documented agreement between the parties to a specific treatment plan; and (4) WCAB order or settlement agreement authorizing additional treatment.[4] Unilateral claims administrator email, oral conversation without written confirmation, or implied consent from payment of bills historically would not satisfy the statutory requirement, though administrative practice on this point continues to evolve.[4]

### Federal and State Regulatory Landscape (2025 Update)

As of the most current information available (March 2026), no significant federal legislation has modified chiropractor treatment in the Medicare program affecting workers' compensation standards, though practitioners should note that Medicare coverage of chiropractic services remains restricted to manual manipulation of the spine for subluxation, contrary to the broader coverage available in workers' compensation.[29] This distinction is important because some employers and claims administrators mistakenly apply Medicare limitations to workers' compensation coverage.

California state law continues to recognize chiropractors as "physicians" within the workers' compensation definition, and no recent legislative proposals have sought to modify this status, though periodic efforts to restrict chiropractic visit limitations have been proposed by business and insurance industry groups without success.

### III. San Francisco-Specific Context and Northern California Implementation

#### San Francisco Immigration Court Integration (Note on Misfiled Query)

The initial research brief references "The Law Offices of Fernando Hidalgo, Inc." based in San Francisco, which specializes in immigration law. This workers' compensation chiropractor-PTP research report is substantially outside the firm's typical practice area. If this report is being generated for an immigration-law context (e.g., addressing workers' compensation issues affecting an immigrant client's eligibility for certain benefits or visa categories), additional context would be needed. However, we proceed with the assumption that this is a workers' compensation research request and provide general Northern California context applicable statewide, with California-specific details regarding San Francisco and the Bay Area where relevant.

#### San Francisco Workers' Compensation Case Processing

Northern California's workers' compensation system is administered through the Workers' Compensation Appeals Board (WCAB), with the San Francisco office located at specified administrative locations handling cases from the greater Bay Area region.[45] While WCAB proceedings do not typically involve chiropractor-PTP status disputes at the appellate level (most are resolved administratively), disputes over visit limit authorizations, UR denials, and PTP termination occasionally reach the WCAB.

#### Practical Considerations for San Francisco and Bay Area Practitioners:

Claims administrators in the San Francisco Bay Area (including self-insured employers) vary substantially in their written authorization procedures for additional chiropractic visits

Some Bay Area employers and insurers have developed standardized forms for authorizing additional visits, while others rely on ad hoc written communications

The San Francisco Division of Workers' Compensation Medical Unit maintains a registry of approved certification providers for chiropractor workers' compensation evaluation training, with several providers operating in the Bay Area

Access to DWC resources is available through San Francisco office locations for practitioners seeking certification guidance or filing applications

Northern California ICE Enforcement Context (Not Applicable)

The personalization information references ICE (Immigration and Customs Enforcement) field office operations and detention procedures, which are not relevant to workers' compensation practice. This appears to reflect the personalization template's default immigration-law focus, which does not apply to this workers' compensation research topic.

California State Law Interactions

California Labor Code Section 4600-4614.1 are state statutes fully controlling workers' compensation medical treatment regulation, and no federal workers' compensation system creates parallel or conflicting requirements. Practitioners should note that California workers' compensation is a state-level system with no federal OSHA or Medicare equivalents directly governing chiropractic treatment within workers' compensation (though Medicare and OSHA standards may be cited as persuasive authority in certain contexts).

#### IV. Strategic Analysis Framework: Stakeholder Perspectives and Legal Positions

##### Injured Worker Perspective: Protecting Access to Chiropractic Treatment

**Primary Legal Arguments:** An injured worker seeking to maximize access to chiropractic treatment has several strategic considerations. First, the worker should establish that chiropractic care is medically necessary by ensuring the primary treating physician (whether initially a chiropractor or another provider) clearly documents the medical necessity for ongoing chiropractic treatment in submitted reports and RFA forms.<sup>[3]</sup> This creates a strong evidentiary foundation for claims administrator authorization of additional visits, as written authorization for additional visits is discretionary with the employer/claims administrator.<sup>[1][4]</sup>

Second, the worker should proactively request written authorization for additional visits well before the 24-visit threshold approaches, rather than waiting until visit 24 is exhausted and then seeking retroactive authorization.<sup>[4]</sup> By submitting a detailed RFA (Request for Authorization) with clinical documentation supporting the need for visits 25 through X, the worker allows the claims administrator time to conduct UR and issue written authorization.<sup>[50]</sup> If authorization is obtained before visit 24 is reached, the worker secures PTP continuity.

Third, if the claims administrator denies authorization based on medical necessity (rather than visit limit exhaustion), the worker may pursue independent medical review (IMR) under Labor Code Section 4610.5, arguing that the UR decision was not supported by adequate clinical evidence.<sup>[37][39]</sup> IMR decisions uphold only approximately 16% of UR denials, but the process provides a non-judicial forum for challenging UR denials.<sup>[37]</sup>

Fourth, the worker should carefully track whether any postsurgical exception applies, because postsurgical care is exempt from the 24-visit limitation if properly prescribed by the surgeon.<sup>[17][19]</sup> If the worker has undergone relevant surgery and the surgeon has approved ongoing chiropractic care, the worker should ensure this authorization is clearly documented and communicated to the claims administrator.

**DHS/Claims Administrator Strongest Counter-Arguments:** The claims administrator's strongest arguments emphasize the clear statutory language limiting chiropractic visits and the policy rationale for visit limitations. The administrator can argue that: (1) the statute unambiguously limits chiropractic visits to 24 unless the employer writes authorization; (2) no express delegation to UR procedures permits overriding this statutory cap; (3) authorization is a discretionary employer decision, not a right; and (4) the legislature deliberately imposed stricter limits on chiropractic than on other specialties, reflecting cost-containment policy preferences that must be respected.<sup>[1][4][4]</sup> If the worker argues that further chiropractic care is medically necessary, the administrator can respond that medical necessity does not override statutory visit limitations—statutory limitations are independent of medical necessity determinations.<sup>[1][56]</sup>

**Risk Assessment for Worker:** Likelihood of obtaining additional chiropractic visits beyond 24 is MODERATE to MEDIUM-HIGH if the claims administrator is responsive to UR procedures and the clinical documentation supports necessity. However, if the claims administrator takes a strict statutory interpretation

stance, likelihood drops to LOW to MEDIUM. The primary risk is that after visit 24, the chiropractor loses PTP status regardless of authorization timing, forcing transition to a new PTP (potentially non-chiropractic), creating continuity disruptions and treatment delays.

#### Employer and Claims Administrator Perspective: Cost Management and Statutory Compliance

Primary Legal Arguments: Employers and claims administrators have clear statutory authority and practical incentives to deny authorization for chiropractic visits beyond 24 per injury. The primary arguments are: (1) the statute imposes a 24-visit cap absent written authorization, reflecting legislative cost-control policy; (2) authorization is discretionary, not mandatory, and employers have legitimate cost-control objectives; (3) alternative medical providers (MDs, physical therapists) are available to continue treatment; and (4) the worker's claim to additional necessity does not override statutory limits.[1][4] This creates a strong legal posture for denying additional visits or conditioning authorization on specific clinical justifications or evidence-based protocols.

However, claims administrators must be procedurally careful when denying additional chiropractic visits. If the denial is based on medical necessity (not visit limit exhaustion), the UR procedures of Labor Code Section 4610 and 8 CCR Section 9792.9.1 apply, and failure to follow proper UR procedures may result in WCAB jurisdiction over the medical necessity issue.[56] The safer approach is to issue a written UR deferral under 8 CCR Section 9792.9.1(b), explicitly stating that the request for treatment beyond the 24-visit cap is being deferred as a "statutory limitation" dispute rather than submitted to medical necessity review.[56]

For claims administrators implementing authorization procedures, best practices include: (1) maintaining clear visit-counting documentation; (2) issuing written authorization (or denial) for additional visits before visit 24 is exhausted; (3) if authorizing additional visits, specifying the number of authorized additional visits and any clinical conditions; and (4) ensuring chiropractors are notified in writing when the 24-visit threshold is reached and PTP status terminates, along with information about transitioning to alternative providers.[4]

Risk Assessment for Employer: Risk of adverse determination on visit limit enforcement is LOW if procedures are followed correctly. The statutory language is clear, and discretionary authorization is an express employer right. Primary risks arise from procedural non-compliance (failing to follow UR deferral procedures, resulting in WCAB jurisdiction) or failure to document visit counts accurately (creating factual disputes about whether the 24-visit cap has been reached).

#### Chiropractor Perspective: Maximizing Scope and Income Within Statutory Constraints

Primary Legal Arguments: Chiropractors seek to maintain PTP status and treatment authorization by: (1) ensuring careful documentation that each chiropractic service (evaluation, manipulation, therapeutic exercise) is medically necessary and consistent with MTUS guidelines; (2) proactively requesting visit authorization before exhausting the 24-visit cap, supported by detailed clinical narratives; (3) seeking to establish that postsurgical exceptions apply when treating post-operative patients; and (4) maintaining QME certification (if applicable) to enhance credibility and authority in disputes over medical necessity.[4][25][20] Chiropractors should also ensure they have completed required 25-hour workers' compensation certification and maintain current documentation of this certification.[2][5][30]

Strategically, chiropractors can argue that the 24-visit limitation is a "hard cap" on direct treatment but does not prevent continuing as PTP for evaluation and medical management once the cap is reached-however, this argument was rejected by SB 863's amendments, and current law prohibits continued PTP status after visit 24 regardless of the nature of services provided.[4][4] A chiropractor cannot rebut this position and must accept that PTP status terminates upon visit-24 exhaustion absent written authorization for additional visits.

DHS/Claims Administrator Counter-Arguments: Employers can argue that chiropractors, unlike other providers, have built-in statutory limitation on their authority and scope, reflecting legislative policy prioritizing cost containment over expanded chiropractic treatment access. This is not a legal flaw in the chiropractor's authorization but rather a deliberate statutory design.

Risk Assessment for Chiropractor: Likelihood of maintaining indefinite PTP status (absent written authorization) is ZERO-the statute does not permit this. Likelihood of obtaining written authorization for additional visits depends on the strength of clinical documentation and the employer's authorization policies, ranging from LOW to MEDIUM-HIGH. Primary risk is loss of patient relationship and income stream when

PTP status terminates, forcing transition to another provider or requiring that the worker specifically request the chiropractor as a secondary provider (subject to the same 24-visit limitation).

### Competing Stakeholder Interests: Synthesis

The legal framework explicitly embodies a policy balance favoring employer cost control (through statutory visit limitations) while preserving worker access to chiropractic care (through authorization discretion) and provider participation (through statutory recognition and MTUS incorporation). Disputes arise when this balance is contested—most commonly when workers and chiropractors argue that medical necessity justifies exceeding statutory limits, while employers and claims administrators maintain that statutory limits override medical necessity determinations for chiropractic services (distinguishing chiropractic from other specialties where visit limitations are modality-specific but do not terminate provider authority).[1][4][4]

## V. Practical Implementation: Procedural Roadmap for Stakeholders

### Procedures for Chiropractor Seeking Initial PTP Designation

**Step 1: Obtain Workers' Compensation Certification (Prerequisite) Before serving as a PTP, a chiropractor must complete a DWC-approved 25-hour workers' compensation evaluation certification program offered by recognized California professional chiropractic associations or accredited California colleges.[2][5][30] The curriculum must cover the foundational 8-hour overview and 17 additional hours specified in 8 CCR Section 14(b)(2).[30] Upon completion, the chiropractor receives a certificate of completion, which is valid for three years.[2] The chiropractor should maintain documentation of this certification, as it may be required to demonstrate eligibility for PTP designation.**

**Step 2: Obtain Employment/Network Affiliation A chiropractor typically becomes designated as a PTP through one of three mechanisms: (1) employer direct selection during the first 30 days after injury; (2) employee selection from employer-affiliated network or provider list after initial treatment; or (3) employee predesignation under Labor Code Section 4601 (change of physician provision) after injury has been established.**

For employers with established Medical Provider Networks (MPNs), chiropractors seeking PTP designation must first be listed in the MPN provider directory and meet MPN access standards, credentialing requirements, and contracting obligations.[33][58][60]

**Step 3: Submit Initial Report Upon First Examination Upon first evaluation, the chiropractor-PTP must submit form DLSR 5021 ("Doctor's First Report of Occupational Injury or Illness") to the claims administrator within 5 working days of initial examination.[3][3] This report should include clear documentation of: (1) the injury diagnosis and causation; (2) planned treatment frequency, duration, and type (including chiropractic manipulation, evaluation and management, or other services); (3) anticipated number of visits needed; and (4) estimated timeframe for treatment.**

**Step 4: Monitor Visit Count and Plan Authorization Requests The chiropractor should carefully track visit count internally and monitor approach to the 24-visit threshold. Well before reaching 24 visits (ideally around visit 18-20), if additional treatment appears medically necessary, the chiropractor should submit an RFA (Request for Authorization) form with supporting clinical documentation explaining the ongoing medical necessity for continued treatment.[50][3] This allows the claims administrator time to conduct UR and issue written authorization before the threshold is reached.**

### Request for Authorization (RFA) Procedures for Additional Chiropractic Visits

The DWC Form RFA is the standardized request mechanism.[50] The chiropractor should complete the form by: (1) identifying the employee, diagnosis, and current treatment status; (2) specifying the requested services, diagnosis codes, CPT codes (if known), frequency, duration, and quantity; (3) attaching supporting documentation (progress report, DLSR 5021, or equivalent narrative); (4) explaining the clinical necessity for the requested treatment with reference to specific MTUS guidelines or other evidence-based standards if applicable; and (5) signing and dating the form.[50] The RFA must be submitted to the claims administrator by mail, fax, or email to the address designated by the administrator for treatment requests.[50]

Upon receipt, the claims administrator has defined timeframes to respond: (1) prospective or concurrent review decisions must be made within 5 business days of complete request receipt, or 14 calendar days

(whichever is earlier); (2) expedited decisions (for imminent threat to health) must be made within 72 hours; (3) approval must be communicated to the requesting physician within 24 hours (concurrent) or 2 business days (prospective), followed by written confirmation.[27][54] If the administrator denies or modifies the request, the written decision must explain clinical reasons and reference specific guidelines used.[27][54]

#### Written Authorization: Optimal Documentation and Procedures

Employers and claims administrators seeking to authorize additional chiropractic visits beyond 24 should issue written authorization that explicitly states: (1) the number of additional visits approved (e.g., "10 additional chiropractic visits" or "chiropractic visits as medically necessary to [specify clinical goal]"); (2) the timeframe for the authorized visits; (3) clinical conditions or milestones at which authorization terminates (e.g., "until patient reaches pain level of X or demonstrates functional improvement Y"); (4) date of authorization; and (5) statement that authorization is limited to the identified patient and injury, and does not establish a waiver of the 24-visit limitation for subsequent claims.[1]

Optional but recommended provisions include: (1) requirement that chiropractor provide periodic progress reports; (2) specification that authorization is subject to UR approval for services as provided; (3) notation that authorization is contingent on treatment remaining medically necessary and consistent with MTUS guidelines; and (4) clear communication that upon conclusion of authorized treatment, PTP status of the chiropractor will terminate (if no further authorization is issued).

#### Transition Procedures Upon 24-Visit Exhaustion (No Authorization)

If no additional authorization is obtained and visit 24 is completed, the following procedures should be implemented:

##### By Chiropractor:

Notify patient in writing that PTP status is terminating upon completion of visit 24, with effective date specified

Recommend that patient select alternative PTP (MD, DO, or PT) and assist with transition planning

Provide copies of all treatment records to claims administrator and (if patient consents) to new PTP

Document in final progress report date of visit 24 and any clinical recommendations for ongoing care

##### By Claims Administrator:

Issue written notice to injured worker explaining that chiropractor's PTP status is terminating per statutory limit

Provide list of alternative PTPs available within MPN (if applicable) or in geographic area

Allow worker one-time physician change right under Labor Code Section 4601 to select alternative PTP

Establish new PTP relationship with alternative provider and provide necessary medical records

#### Utilization Review Deferral Procedure for Visit Limit Disputes

If a claims administrator wishes to deny additional chiropractic visits based on statutory visit limitation (not medical necessity), the administrator should issue a written "UR Deferral" under 8 CCR Section 9792.9.1(b) rather than submitting the request to medical necessity UR. The deferral notice should: (1) be issued within 5 business days of receiving the RFA; (2) clearly state that utilization review is being deferred because the requested treatment implicates the statutory 24-visit limitation for chiropractic services (Labor Code Section 4604.5), which is a liability/scope question, not a medical necessity question; (3) reference prior notification of this deferral if the worker/chiropractor was previously notified; (4) include plain-language statement advising the injured worker that any dispute over the statutory limitation must be resolved through WCAB or by agreement of the parties; and (5) specify the effective date of the deferral decision.[56]

This procedure ensures WCAB has jurisdiction over the limitations dispute if the worker contests it, rather than leaving medical professionals to resolve a statutory question through UR.

#### Procedures for Identifying and Claiming Postsurgical Exceptions

When a worker has undergone surgery and may be eligible for postsurgical chiropractic rehabilitation, the following procedures apply: (1) obtain explicit written approval from the surgeon (or surgeon-designated physician) authorizing postsurgical chiropractic care; (2) identify the specific surgical procedure from the MTUS postsurgical guidelines (found in 8 CCR Section 9792.24.3 and clinical topics of the MTUS); (3) note the applicable visit authorization for the procedure (e.g., "12 visits over 12 weeks within 6 months from date of surgery"); (4) submit RFA with documentation of surgical approval and reference to specific MTUS postsurgical guideline; and (5) proceed through normal UR approval process for the postsurgical visits, which are separate from and do not count against the 24-visit limit for non-postsurgical care.[17][19][40]

It is critical to document that visits are "postsurgical physical medicine" rather than routine chiropractic care, because at conclusion of the postsurgical period (as defined in the specific MTUS guideline for the procedure), treatment "reverts back to the applicable 24-visit limitation." [17][19] This means postsurgical authorization is time-limited, and any chiropractic treatment continuing beyond the postsurgical window must be counted against the 24-visit cap.

## VI. Medical-Legal and Reporting Obligations for Chiropractor-PTPs

### Disability Evaluation Report Requirements Under 8 CCR Section 11.5

Chiropractors serving as PTPs who must provide disability evaluation reports (typically at permanent and stationary status) must comply with 8 CCR Section 11.5 standards, which require reports to address: (1) the role of the QME in the disability evaluation process; (2) elements of medical-legal reports including Labor Code and regulatory requirements; (3) language and communication clarity; (4) evaluation of disability (impairment and disability distinction); (5) occupational history; (6) physician examination and testing; (7) MTUS guidelines application; (8) causation determination; (9) permanent and stationary status determination; (10) apportionment doctrine; (11) future medical care assessment; (12) activity of daily living evaluation; (13) work restrictions; (14) AMA Guides application; (15) report mechanics and submission procedures.[38]

For chiropractor-PTPs, the most challenging aspects often include: (1) properly applying the AMA Guides despite chiropractic training emphasizing structural correction over impairment/disability frameworks; (2) clearly distinguishing impairment (anatomic/physiologic loss of function) from disability (inability to engage in usual occupation or any occupation); (3) addressing causation with rigor, explaining why the work injury (not pre-existing conditions) is responsible for current impairment; and (4) making credible apportionment determinations when the worker has pre-existing conditions.

### Primary Treating Physician Reporting Duties Under 8 CCR Section 9785

8 CCR Section 9785(e) requires the PTP to submit the Doctor's First Report within 5 working days of initial examination, specifying on line 24 of the form: (A) methods, frequency, and duration of planned treatment(s); (B) planned consultations, referrals, surgeries, or hospitalization; and (C) type, frequency, and duration of planned physical medicine services (e.g., chiropractic manipulation, acupuncture).[3][3][3] This initial specification of planned treatment is important because it signals the anticipated number of chiropractic visits, allowing the claims administrator to anticipate whether authorization requests for additional visits will be needed.

8 CCR Section 9785(f) requires the PTP to report to the claims administrator within 20 days of occurrence when: (1) the employee's condition undergoes unexpected significant change; (2) significant changes in the treatment plan occur (including extension of duration or frequency, new need for surgery/hospitalization, new referrals, changes in treatment methods, or need for durable medical equipment); (3) the employee's condition permits return to modified or regular work; (4) changes in work restrictions become necessary; (5) the employee is released from care; or (6) permanent disability precludes engaging in usual occupation.[3][3][3] For chiropractor-PTPs, this reporting duty requires prompt notice to the claims administrator when the number of needed visits increases, triggering RFA and authorization procedures well before visit 24 is reached.

8 CCR Section 9785(h) requires the PTP to report at permanent and stationary status regarding: (1) existence and extent of permanent impairment and limitations; and (2) need for continuing or future medical care.[3][3][3] The timing requirement is within 20 days of examination at which permanent and stationary status is determined. This report may be submitted on form PR-3 or PR-4 (Permanent and Stationary forms), and for disability evaluation performed after January 1, 2005, impairment descriptions must use AMA Guides methodology.[3]

## Implications of PTP Status Termination on Reporting Obligations

Upon termination of chiropractor PTP status (at visit 24 absent further authorization), the chiropractor's reporting duties under Section 9785 conclude. The new PTP assumes all reporting responsibilities, including obligations to obtain and comment on reports from secondary providers (which may include the prior chiropractor).[3] The transitioning chiropractor should provide a clear final summary report documenting: (1) total number of visits provided; (2) clinical status at final visit; (3) recommended ongoing care or specialist referrals; and (4) permanent impairment assessment (if applicable). This final report becomes part of the medical record and informs the new PTP's treatment planning.

## VII. Dispute Resolution: Appeal Strategy for Visit Limit Conflicts

### Immigration Court Proceedings and WCAB (Note on Jurisdiction)

This research brief is addressed to immigration law practitioners at The Law Offices of Fernando Hidalgo, Inc. Workers' compensation disputes are resolved through the California workers' compensation system (WCAB), not immigration courts. If an immigration case involves workers' compensation issues (e.g., work authorization effects on eligibility for compensation, or deportation consequences of a workers' compensation claim affecting visa status), specialized coordination between immigration counsel and workers' compensation counsel is required. For purposes of this report, we address WCAB procedures and appeals.

### Challenging Denials of Additional Chiropractic Visit Authorization

**Administrative Level (Independent Medical Review):** If a claims administrator denies additional chiropractic visits based on a medical necessity UR decision (not statutory visit limitation), the injured worker may request independent medical review (IMR) under Labor Code Section 4610.5.[37][39] The worker must file an Application for Independent Medical Review (DWC Form IMR-1) within 30 days of service of the written UR denial, attaching a copy of the UR determination.[39] The IMR request is submitted to the DWC Administrative Director, who determines eligibility and assigns the case to an independent review organization (currently MAXIMUS).[37][39] The independent reviewer (a physician) conducts a paper review of medical records and issues a written determination regarding whether the denied/modified treatment is medically necessary.[39]

**Critical Limitation:** IMR does not apply if the UR denial is based on visit limit exhaustion (statutory limitation) rather than medical necessity.[39] In this case, the worker's remedy is WCAB petition (below) or negotiated settlement.

**WCAB Level:** If the worker disputes a claims administrator's decision denying additional chiropractic visits (whether framed as UR denial, deferral, or statutory limitation bar), the worker may petition the WCAB for determination. The petition should: (1) clearly identify the factual and legal basis for the dispute (e.g., "Chiropractor-PTP provided 24 visits; requests authorization for 6 additional visits; claims administrator denied based on statutory visit limitation; worker contends additional visits are medically necessary and justify exception"); (2) attach copies of all RFA submissions, UR decisions, visit records, and clinical reports; (3) cite applicable statutes and regulations (Labor Code Section 4604.5(c), 8 CCR Section 9785, MTUS guidelines); and (4) articulate the legal theory (e.g., ambiguity in statute permitting additional authorization for documented medical necessity; failure to follow proper UR procedures; or postsurgical exception application).

**Standard of Review:** The WCAB applies a substantial evidence standard, meaning that a WCAB judge will overturn a claims administrator's denial if the medical record does not support the basis for denial or if statutory/regulatory requirements were not followed. If the claims administrator properly deferred UR based on visit limit dispute (not medical necessity), the WCAB judge reviews whether the statutory limit applies to the factual circumstances, not whether the treatment was medically necessary.

### Strongest Arguments for Worker at WCAB Level:

Proper UR procedures were not followed (e.g., failure to provide timely written notice, failure to reference specific guidelines)

Postsurgical exception applies but was not recognized by claims administrator

Ambiguity in "written authorization" requirement was not satisfied, but de facto authorization occurred through payment/prior acknowledgment

Chiropractor's certification and clinical documentation establish medical necessity meeting MTUS standards, warranting authorization

Worker's injury is of such severity that 24 visits is manifestly insufficient and unreasonable, raising due process concerns (weaker argument, but occasionally raised)

#### Challenging Termination of Chiropractor PTP Status

If a worker challenges the removal of their preferred chiropractor as PTP upon visit-24 exhaustion (absent authorization), the legal position is significantly weaker. The statute is unambiguous: chiropractors cannot continue as PTP after 24 visits unless employer authorizes additional visits.[1][3] A worker cannot successfully petition the WCAB arguing that PTP status should be preserved despite visit exhaustion, because the statute does not permit this except through written authorization.

However, a worker may argue: (1) that implicit or prior written authorization for additional visits exists (requiring factual development); (2) that the chiropractor's visit count was miscounted; or (3) that certain visits should not count toward the limitation (e.g., administrative/evaluation-only visits distinct from manipulation). These factual arguments may warrant WCAB hearing if genuinely disputed.

#### Preserved Arguments for Appeal to Appellate Level

Even if a WCAB judge rules against the worker on visit limit authorization, the worker may file a Petition for Reconsideration or Petition for Removal to the full WCAB panel, or in limited circumstances, file a Writ of Review to the Court of Appeal. Preserved arguments for appellate-level consideration include:

**Constitutional Arguments (rarely successful):** Whether strict statutory visit limitations violate due process or equal protection by denying workers adequate medical care

**Statutory Interpretation Arguments:** Whether ambiguity in "written authorization" language should be resolved in favor of broader authorization standards

**Regulatory Compliance Arguments:** Whether specific UR procedures violated statutory requirements, rendering denials procedurally defective

**Equitable Arguments:** Whether unjust enrichment or estoppel principles apply if employer benefited from chiropractic treatment while failing to authorize additional visits

**Precedential Arguments:** Whether specific WCAB panel decisions or California Supreme Court precedent supports a different interpretation

#### VIII. Alternatives, Contingencies, and Supplementary Strategies

##### Plan B Options: Alternative Treatment Modalities Upon Chiropractor PTP Termination

Upon termination of chiropractor PTP status at the 24-visit threshold (absent authorization), several alternative treatment pathways are available:

**Physical Therapy Continuation:** If the worker's injury is amenable to physical therapy, the worker may transition to a physical therapist as PTP, subject to the same 24-visit limitation applicable to physical therapy.[1] Physical therapy often complements or substitutes for chiropractic care, and many injuries respond favorably to either modality.

**Occupational Therapy:** Similarly, occupational therapy is limited to 24 visits per injury but may provide alternative modalities for functional restoration, work simulation, and ADL (activities of daily living) training.

**Physician-Directed Care (MD/DO):** A medical doctor or osteopathic doctor may continue managing the case without visit limitations on physician services generally (though specific modality limitations apply to services provided by those physicians-e.g., if a physician prescribes physical therapy as part of their treatment plan, the 24-visit PT limit still applies to those PT services).

Acupuncture: Licensed acupuncturists are available as treating providers or consultants, subject to 24-visit limitations on acupuncture services specifically (not combined with chiropractic cap).

#### Negotiation Strategies for Obtaining Written Authorization

For chiropractors and injured workers seeking written authorization for additional chiropractic visits, several negotiation strategies may prove effective:

##### Robust Clinical Documentation:

Submit detailed progress reports with objective clinical findings (range of motion measurements, imaging results, functional capacity assessments) supporting ongoing medical necessity. Claims administrators are more likely to authorize additional visits when clinical documentation is compelling and unambiguous.

##### Reference to MTUS and Evidence-Based Guidelines:

Explicitly reference applicable MTUS clinical topics guidelines showing that the recommended treatment for the worker's condition extends beyond 24 visits. This shifts the burden to the claims administrator to explain why MTUS-compliant treatment should be denied.

##### Graduated Authorization Requests:

Rather than requesting authorization for all remaining anticipated visits (e.g., 25-50), request authorization in tranches (e.g., visits 25-30 now, with reassessment at visit 30). This allows claims administrators to control costs while maintaining care continuity.

##### Offer Interim Treatment Plan Adjustments:

Propose reducing visit frequency (e.g., from 2x/week to 1x/week) to extend the duration of treatment within available visits, or propose specific clinical milestones at which additional authorization would be sought (e.g., "10 additional visits contingent on worker achieving 50% pain reduction and return to modified work activities").

##### Settlement Coordination:

If the claim is approaching permanent and stationary status and a potential settlement exists, negotiate inclusion of treatment authorization as part of settlement discussions, potentially resolving the visit limit dispute within broader claim resolution.

##### Contingency Planning: Scenarios and Responses

Scenario 1: Visit Limit Reached, No Authorization Obtained Response: Immediately transition to alternative PTP (if possible of the worker's choosing); obtain all medical records for transition; provide final summary report documenting clinical status and recommended ongoing care.

Scenario 2: Written Authorization Obtained, But Is Ambiguous or Disputed Response: Request clarification in writing from claims administrator specifying exact number of authorized visits, dates, and any clinical conditions; if clarification is not provided, document the ambiguity in case records for potential dispute resolution.

Scenario 3: Claims Administrator Retroactively Denies Authorization (Retroactive Deferral) Response: Challenge retroactive application through WCAB petition, arguing that patient relied on apparent authorization (visits were already provided and paid), and retroactive denial creates injustice; alternatively, seek compromise through modification of bills/payment structures.

Scenario 4: Postsurgical Exception Applied, But Period/Visits Unclear Response: Obtain detailed clarification from treating surgeon regarding postsurgical care plan duration and anticipated visits; reference specific MTUS guideline and its visit/timeframe specifications; provide written communication documenting postsurgical authorization to claims administrator.

#### IX. Ethical and Professional Conduct Considerations

##### California Rules of Professional Conduct Applicability (For Practitioners)

For attorneys and other licensed professionals involved in workers' compensation disputes: California Rules of Professional Conduct require candor to tribunals, disclosure of material facts, conflict of interest management, and competent representation. Specifically:

**Candor to Tribunal:** If representing a worker or chiropractor before the WCAB, counsel must disclose material facts affecting the visit limit dispute—including honest visit counts, prior authorization decisions, and whether statutory requirements were satisfied. Counsel cannot misstate the statutory visit limitation or mischaracterize written authorization status.

**Competence Requirement:** Counsel representing clients in workers' compensation disputes must understand applicable statutes, regulations, and WCAB procedures. This requires familiarity with Labor Code Section 4604.5, 8 CCR Section 9785, UR procedures, and IMR availability.

**Conflict of Interest:** Counsel should not represent both the chiropractor and the injured worker in a dispute over PTP status or visit authorization if their interests diverge (e.g., chiropractor wants to preserve PTP status while worker wants to transition to alternative provider). Simultaneous representation may not be feasible.

#### Professional Standards for Chiropractors in Workers' Compensation Practice

California Board of Chiropractic Examiners regulations establish professional standards for chiropractic practice, including in the workers' compensation context. Chiropractors must: (1) maintain current licensure and certification; (2) provide treatment within scope of chiropractic practice; (3) maintain confidentiality of patient information; (4) avoid fraud in billing and authorization; (5) comply with workers' compensation reporting requirements; and (6) not misrepresent their qualifications or authorization status.

Specific risks include: (1) billing for services beyond authorized visits (subject to fraudulent billing allegations); (2) misrepresenting visit count or status to workers or claims administrators; (3) continuing to treat after PTP status terminates without appropriate authorization or provider status transition; (4) submitting false certification documentation or misrepresenting workers' compensation training completion.

#### Self-Referral and Conflict of Interest Prohibitions (Labor Code Section 139.3)

Labor Code Section 139.3 prohibits physicians (including chiropractors) from referring patients for specified medical services (including diagnostic imaging, clinical laboratory, physical therapy, psychometric testing, and others) if the physician has a financial interest in the entity receiving the referral.<sup>[55]</sup> Violations constitute misdemeanors and may result in civil penalties up to \$5,000 per offense, plus disciplinary action by licensing boards.

For chiropractors operating clinics or owning interests in diagnostic facilities, diagnostic imaging centers, or physical therapy practices, this means that self-referrals are prohibited unless an exception applies. Labor Code Section 139.31(e) provides an exception for services "performed within, or goods that are supplied by, a physician's office, or the office of a group practice," meaning that chiropractors in integrated group practices may refer to other practitioners within the same office without violating Section 139.3.<sup>[53]</sup> However, referring to a separate legal entity in which the chiropractor has a financial interest (even if located in the same building) may violate Section 139.3.

## X. Risk Warnings and Compliance Disclaimers

### Limitations of This Research

This report provides general legal analysis of California workers' compensation law governing chiropractor-PTP status as of March 1, 2026. The report does not constitute legal advice applicable to specific factual circumstances. Readers should consult with qualified workers' compensation attorneys regarding application to particular cases or situations. Laws and regulations cited are subject to amendment, and this report does not provide notice of potential future legislative changes.

### Irreversible Consequences of Strategic Decisions

For Injured Workers:

Once a chiropractor reaches the 24-visit threshold without authorization, PTP status is terminated immediately and cannot be revived by subsequent authorization (authorization can only apply to additional visits, not restore terminated PTP status)

Transition to alternative PTP creates treatment disruptions and may require worker to undergo re-evaluation by new provider, delaying care

Failure to request authorization before visit 24 may result in forfeiture of opportunity to obtain authorization at that stage

For Employers and Claims Administrators:

If written authorization for additional visits is issued, the authorization may create estoppel preventing later claims that statutory limitations apply (if authorization language is sufficiently broad)

Failure to follow proper UR procedures may result in WCAB jurisdiction over medical necessity determinations that would otherwise be discretionary

Retroactive authorization of previously-denied visits may trigger payment obligations for previously-withheld compensation

For Chiropractors:

Continuing to treat a patient after PTP status terminates (post-24 visits, absent authorization) without proper provider status transition may result in claims that treatment was unauthorized and payment for such treatment may be denied

Misrepresentation of certification status, visit count, or authorization status may result in licensing board investigation and professional discipline

Irreversible Procedural Deadlines

30-day period to request physician change: Workers have limited time after injury to exercise one-time change of physician right; after 30 days, alternative rights apply

IMR request deadline: Independent Medical Review applications must be filed within 30 days of service of UR decision; late applications are ineligible

WCAB petition filing deadlines: Specific deadlines apply to Petitions for Reconsideration and Petitions for Removal; failure to meet deadlines results in loss of appellate rights

Statute of limitations for bringing workers' compensation claims: Injury claims generally must be filed within certain periods or benefits are forfeited

Information Requiring Expert Consultation

This report addresses workers' compensation medical treatment regulations. The following specialized topics require consultation with experts in adjacent fields:

Tax consequences of workers' compensation settlements: IRS and California Franchise Tax Board treatment of structured settlements and lump-sum awards

Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI) interactions: How workers' compensation payments affect federal disability benefits eligibility

Immigration law consequences: Whether workers' compensation case participation or settlement status affects visa sponsorship or deportation risk (relevant to The Law Offices of Fernando Hidalgo, Inc.'s immigration law practice)

Personal injury/third-party liability interactions: Whether workers' compensation bars or coordinates with third-party claims against responsible parties

XI. Preservation Requirements and Appeal Strategy Framework

Arguments Suitable for Immigration Court (Not Applicable)

This research is for workers' compensation law, not immigration proceedings. Immigration courts do not adjudicate workers' compensation disputes. However, immigration attorneys representing clients should be aware of potential intersections:

Workers' compensation benefits may affect a client's ability to demonstrate financial support for visa sponsorship

Workers' compensation litigation or employment-related disputes may affect the factual record in immigration proceedings

Deportation consequences of workers' compensation participation should be evaluated separately

Coordination between workers' compensation and immigration counsel is advisable if these intersections arise.

Arguments Suitable for Preservation at WCAB Level

Even if a WCAB judge rules against a worker on the merits of a visit limit dispute, the worker should ensure that the factual record fully develops arguments that may support appellate review:

**Statutory Ambiguity Arguments:** Clearly state positions on meaning of "written authorization" requirement; document claims administrator's actual authorization procedures and any inconsistencies

**Equitable Arguments:** Document any worker reliance on apparent authorization; identify instances where claims administrator appeared to authorize treatment through actions or payment history

**Procedural Defect Arguments:** Fully develop any failures by claims administrator to follow 8 CCR Section 9792.9.1 UR procedures (e.g., failure to provide timely notice, failure to reference guidelines, failure to communicate decision)

**Postsurgical Exception Arguments:** If applicable, fully develop surgical evidence and MTUS guideline application; establish that postsurgical authorization requirements were satisfied

**Constitutional Arguments:** If plausible, raise due process and equal protection concerns regarding disproportionate visit limitations on chiropractic vs. other modalities (likely to fail but should be preserved)

Certification Strategy vs. Appeal Decisions

If a WCAB judge denies authorization for additional chiropractic visits based on statutory visit limitation, the worker faces strategic choice: (1) appeal to full WCAB panel through Petition for Reconsideration; (2) certify the case to the full panel under Labor Code Section 5300 et seq.; or (3) pursue Writ of Review to Court of Appeal.

Certification may be appropriate if the case presents unresolved questions of law or fact affecting multiple claims or requiring full panel deliberation. However, for visit limit disputes, the statute is generally unambiguous, making certification less strategic.

Appeal to full WCAB panel is more typical, allowing the worker to argue that the judge misapplied statutory or regulatory provisions, misweighed evidence, or failed to follow proper procedures.

## XII. Current Administrative Enforcement and Policy Developments

### DWC Medical Unit Policies and Enforcement

As of 2026, the Division of Workers' Compensation Medical Unit maintains oversight of: (1) chiropractor certification programs compliance; (2) QME appointment and continued eligibility; (3) utilization review plan filing and compliance; (4) medical provider network credentialing and access standards; and (5) professional discipline for violations of workers' compensation requirements.

Recent administrative priorities have focused on ensuring robust utilization review compliance and preventing abuse of telehealth and remote authorization procedures. For chiropractic treatment specifically, DWC attention has increased regarding accurate visit counting and clear authorization documentation practices.

### Pending Regulatory Changes and Proposed Reforms

As of the most current information available (March 2026), no proposed regulatory changes specifically targeting chiropractor visit limitations or PTP authority are under active DWC consideration or rulemaking. However, ongoing legislative debate exists regarding whether visit limitations are adequately balanced with worker access to necessary care. Practitioners should monitor the California Legislature's workers' compensation reform proposals, which periodically surface discussions about visit limits.

#### Insurance Industry and Employer Association Guidance

Major workers' compensation insurers and employer groups have collectively issued guidance documents and best-practice standards for handling chiropractic treatment authorization. Key themes include: (1) early visit counting and authorization request management; (2) standardized written authorization forms; (3) clear communication to workers about visit limits; and (4) smooth transition procedures to alternative PTPs.

These industry standards, while not legally binding, influence claims administrator practices statewide and often establish de facto minimum procedural expectations.

#### XIII. Complete Source Citations and Bibliography

[1] California Labor Code Section 4604.5(c)(1) - 24-visit limitation for chiropractic, physical therapy, and occupational therapy services for injuries on or after January 1, 2004

[2] California Code of Regulations Title 8, Section 11, Eligibility Requirements for Initial Appointment as a QME - QME qualification requirements including chiropractor certification in workers' compensation evaluation

[3] California Code of Regulations Title 8, Section 9785, Reporting Duties of the Primary Treating Physician - PTP definition, reporting duties, and prohibition on chiropractors continuing as PTP after 24 visits

[4] Friedman Law Offices, "The 24-Visit Cap: A Sixty-Second Seminar in Workers' Compensation Claims Handling" (2023) - Practice guidance on 24-visit limitation, exceptions, and SB 863 impact

[5] California Code of Regulations Title 8, Section 14, Doctors of Chiropractic: Certification in Workers' Compensation Evaluation - Detailed certification requirements for chiropractors

[6] Dani C. Lipton & Associates, "Can a Chiropractor be Predesignated as a Personal Physician?" (2013) - Analysis of distinction between date-of-injury predesignation (unavailable for chiropractors) and change-of-physician predesignation (available)

[7] Employees First Labor Law, "Labor Code Section 4600 - Right to Medical Treatment" - Overview of Labor Code Section 4600 medical treatment authorization

[8] California Code of Regulations Title 8, Section 9781, Employee's Request for Change of Physician - Procedures for employee-initiated physician changes including chiropractor selection

[9] Alameda County Health Care Services Agency, "Facts About Workers' Compensation" - Plain-language guide to workers' compensation benefits including chiropractic treatment

[3] California Code of Regulations Title 8, Section 9785 (reprint) - PTP reporting duties and chiropractic limitations

[10] California Workers' Compensation Institute, "Predesignation of Personal Physicians and Reporting Duties of the Primary Treating Physician" - Comprehensive guide to PTP predesignation and reporting requirements

[11] Cornell Law School Legal Information Institute, Title 8 CCR Section 11 - QME appointment requirements

[12] Department of Industrial Relations, "Appointment of Qualified Medical Evaluators" - QME appointment procedures and eligibility

[13] California Code of Regulations Title 8, Section 9779.3, Obligations of Employers Covered by Health Care Organizations - HCO provider network requirements

- [14] California State University San Marcos, "Instructions for Predesignation of Personal Physician" - Employee guidance on physician predesignation procedures
- [15] California Code of Regulations Title 8, Section 15, Appointment of Retired or Teaching Physicians - Special QME appointment categories
- [3] California Code of Regulations Title 8, Section 9785 (alternative source) - PTP duties and chiropractic limitations (repeat citation for emphasis)
- [16] Department of Industrial Relations, DWC Form 9783, Predesignation of Personal Physician - Official predesignation form
- [3] California Code of Regulations Title 8, Section 9785 (secondary physician provisions) - Secondary physician status and chiropractic limitations
- [17] California Code of Regulations Title 8, Section 9792.24.3, Postoperative Rehabilitation Guidelines - Post-surgical treatment authorization and visit specifications
- [2] Cornell Law School Legal Information Institute, Title 8 CCR Section 11 (alternative link) - QME eligibility requirements
- [18] Cornell Law School Legal Information Institute, Title 8 CCR Section 9783.1, DWC Form 9783.1 Notice of Personal Chiropractor or Personal Acupuncturist - Personal chiropractor/acupuncturist predesignation form
- [19] Cornell Law School Legal Information Institute, Title 8 CCR Section 9792.24.3 (alternative link) - Postoperative rehabilitation guidelines
- [20] Department of Industrial Relations, "DWC Qualified Medical Evaluator (QME) Process" - QME process overview and requirements
- [4] Friedman Law Offices, "The 24-Visit Cap" (repeat citation) - Comprehensive analysis of visit limitation jurisprudence and practice
- [21] California Code of Regulations Title 8, Section 9780.1, Employee's Predesignation of Personal Physician - Predesignation requirements and procedures
- [22] Department of Industrial Relations, "Physician's Guide to Medical Practice in the California Workers' Compensation System" - Comprehensive physician guidance manual including chiropractic treatment standards
- [3] California Code of Regulations Title 8, Section 9785 (PTP reporting) - Detailed reporting duties of PTPs
- [23] Dani C. Lipton, "Can a Chiropractor be Predesignated as a Personal Physician?" (repeat) - Statutory interpretation of chiropractor predesignation limitations
- [24] Alameda County Government, "Facts About Workers' Compensation" (repeat) - Plain-language workers' compensation information
- [25] California Chiropractic Association, "QME Certification + Recertification" - Chiropractic QME training program information
- [26] California Workers' Compensation Institute, "Proposed Amendments to Regulations" (containing analysis of SB 863 impact) - Legislative history and administrative interpretation of SB 863
- [27] Justia Law, California Labor Code Section 4610, Utilization Review - UR statutory framework
- [20] Department of Industrial Relations, "DWC Qualified Medical Evaluator Process" (repeat) - QME process information
- [7] Employees First Labor Law, "Labor Code Section 4600" (repeat) - Medical treatment rights overview
- [28] Department of Industrial Relations, "Utilization Review" - UR program overview and resources
- [23] Dani C. Lipton, "Can a Chiropractor be Predesignated as a Personal Physician?" (repeat for emphasis) - Statutory analysis

- [29] Department of Industrial Relations, "DWC Answers to Frequently Asked Questions About the Workers' Compensation Physician and Non-Physician Practitioner Fee Schedule" - Chiropractic fee schedule and coverage guidelines
- [30] California Code of Regulations Title 8, Section 14 (detailed provisions) - Chiropractic certification curriculum requirements
- [22] Department of Industrial Relations, "Physician's Guide to Medical Practice" (repeat) - Comprehensive physician guidance
- [31] Justia Law, California Labor Code Section 3209.6 - Statutory prohibition against chiropractors representing themselves as physicians
- [32] Justia Law, California Code of Regulations Article 2, Section 14 - Chiropractic certification requirements
- [33] California Code of Regulations Title 8, Section 9767.6, Treatment and Change of Physicians Within MPN - MPN physician selection and chiropractic treatment within networks
- [4] Friedman Law Offices, "The 24-Visit Cap" (third citation) - Practice seminar on visit limitations
- [34] California Code of Regulations Title 8, Section 9773.1, Referrals to Chiropractors - HCO guidelines for chiropractic referrals
- [35] Department of Industrial Relations, "Medical Provider Network, Physician Reporting, Utilization Review" - Comprehensive MPN and UR regulations
- [3] California Code of Regulations Title 8, Section 9785 (fourth citation) - PTP status and duties
- [36] Justia Law, California Labor Code Section 4600.5 - HCO obligations for chiropractic care
- [4] Redula Law Office, "Independent Medical Review Process" - Detailed IMR procedure guidance
- [37] Department of Industrial Relations, "DWC Independent Medical Review (IMR)" - IMR FAQs and procedures
- [38] Cornell Law School Legal Information Institute, Title 8 CCR Section 11.5, Disability Evaluation Report Writing Course - Disability evaluation report standards
- [3] California Code of Regulations Title 8, Section 9785 (fifth citation) - PTP reporting requirements
- [39] Department of Industrial Relations, "DWC Independent Medical Review (IMR)" (repeat) - IMR process
- [20] Department of Industrial Relations, "DWC Qualified Medical Evaluator Process" (third citation) - QME information
- [40] Department of Industrial Relations, "DWC Medical Treatment Utilization Schedule" - MTUS overview and guidelines
- [41] California Workers' Compensation Institute, "MTUS Update Notice" - MTUS evidence-based updates
- [29] Department of Industrial Relations, "DWC Answers to Frequently Asked Questions about the Workers' Compensation Physician and Non-Physician Practitioner Fee Schedule" (repeat) - Chiropractic fee schedule FAQ
- [42] Department of Industrial Relations, "DWC Medical Treatment Utilization Schedule - Disclosure of Conflicts of Interest" - MEEAC member disclosures and MTUS development
- [43] Law Insider, "Medical Treatment Utilization Schedule Definition" - MTUS definition and usage
- [44] Department of Industrial Relations, "DWC Official Medical Fee Schedule (OMFS)" - Medical fee schedule information
- [26] California Workers' Compensation Institute, "Regulatory Analysis" (containing predesignation framework) - Detailed predesignation regulations analysis

- [45] Department of Industrial Relations, "Workers' Compensation Appeals Board (WCAB)" - WCAB overview and filing procedures
- [46] Charles J. Attorneys, "How Senate Bill 863 Will Affect Your Practice" - SB 863 impact analysis
- [8] California Code of Regulations Title 8, Section 9781 (repeat) - Physician change procedures
- [47] Myers Law Group, "Resolving Disputes and Appeals in California Workers' Compensation Cases" - Dispute resolution procedures
- [48] Sullivan & Associates, "SB 863 Five Years Later" - Long-term analysis of SB 863 implementation
- [49] California Board of Chiropractic Examiners, "Rules and Regulations" - Chiropractic practice regulations
- [3] California Code of Regulations Title 8, Section 9785 (sixth citation) - PTP authority and limitations
- [50] Department of Industrial Relations, "DWC Form RFA - Request for Authorization for Medical Treatment" - Official RFA form and instructions
- [51] Justia Law, California Business and Professions Code Section 1000, Chiropractic Practice Definition - Chiropractic licensure statute
- [20] Department of Industrial Relations, "DWC Qualified Medical Evaluator Process" (fourth citation) - QME function and role
- [52] California Workers' Compensation Institute, "RFA Form Guidance" - RFA procedure documentation
- [53] Work Comp Academy, "Self-Referral Prohibition Does Not Apply to Same Office Facilities" - Labor Code Section 139.3 self-referral exemptions
- [54] California Code of Regulations Title 8, Section 9792.9.1, Utilization Review Standards - Detailed UR procedures and timeframes
- [4] Friedman Law Offices, "The 24-Visit Cap" (fourth citation) - Visit limit exception analysis
- [55] Justia Law, California Labor Code Section 139.3, Physician Self-Referral Prohibition - Self-referral prohibition statute
- [56] Sullivan & Associates, "Deferring Utilization Review" - UR deferral procedures for statutory limitation disputes
- [3] California Code of Regulations Title 8, Section 9785 (seventh citation) - PTP authority
- [57] Department of Industrial Relations, "Final Text of Regulations" (2024 updates) - Current regulatory text with amendments
- [58] California Code of Regulations Title 8, Section 9767.3, Application for a Medical Provider Network Plan - MPN credentialing requirements
- [21] California Code of Regulations Title 8, Section 9780.1 (repeat) - Predesignation procedures
- [59] Department of Industrial Relations, "DWC Approved Regulations 2025" - Current regulatory updates
- [60] Department of Industrial Relations, "DWC Answers to Frequently Asked Questions About Medical Provider Networks" - MPN FAQs including chiropractor network inclusion requirements
- [61] California Code of Regulations Title 8, Section 9783, DWC Form 9783 Predesignation of Personal Physician - Official predesignation form regulations

Conclusion: Synthesis of Key Findings and Recommendations

California workers' compensation law creates a framework that recognizes chiropractors as statutory "physicians" with authority to serve as primary treating physicians, while imposing categorical limitations—specifically, the 24-visit cap per industrial injury—that distinguish chiropractic treatment from other medical specialties. This framework reflects a deliberate policy balance established through the 2004 and 2013

workers' compensation reforms, prioritizing cost containment while maintaining injured worker access to chiropractic care when medically necessary and authorized by employers.

The legal landscape is well-settled: the 24-visit limitation is unambiguous, exceptions are narrow and specifically defined, and chiropractors' authority terminates upon visit-24 exhaustion absent written employer authorization for additional visits. While interpretive questions persist regarding visit counting methodology, written authorization sufficiency, and postsurgical exception application, these are fact-specific and resolved through administrative procedures (UR, IMR) rather than creating systemic legal uncertainty.

For practitioners across all stakeholder positions-injured workers, employers, chiropractors, and attorneys-the key strategic imperative is proactive documentation, clear communication, and early authorization request submission well before the 24-visit threshold approaches. Claims administrators should implement clear authorization procedures and communicate visit-limit status to workers and providers transparently. Chiropractors should ensure compliance with certification requirements, maintain meticulous visit documentation, and coordinate authorization requests with clinical documentation supporting medical necessity. Injured workers should understand that PTP status termination is not waivable after visit 24 absent prior authorization, necessitating advance planning for provider transition if authorization is denied.

This report provides the comprehensive legal and procedural framework necessary for informed decision-making by all stakeholders navigating the chiropractor-PTP role within California's workers' compensation system.

## References

- California Labor Code Section 4604.5(c)(1) - 24-Visit Limitation (<https://backtochiropractic.net/PDF/Work%20Comp%20Visit%20Limits.pdf>)
- California Code of Regulations Title 8, Section 11 - QME Eligibility Requirements (<https://www.dir.ca.gov/t8/11.html>)
- California Code of Regulations Title 8, Section 9785 - Reporting Duties of Primary Treating Physician (<https://www.dir.ca.gov/t8/9785.html>)
- Friedman Law Offices - The 24-Visit Cap Seminar (<https://www.friedmanlawoffices.com/2023/01/the-24-visit-cap-a-sixty-second-seminar-in-workers-compensation-claims-handling/>)
- California Code of Regulations Title 8, Section 14 - Chiropractic Certification (<https://www.dir.ca.gov/t8/14.html>)
- Dani C. Lipton - Chiropractor Predesignation Analysis (<https://dclbv.com/newsletters/2013/q1/can-a-chiropractor-be-predesignated-as-a-personal-physician/>)
- Labor Code Section 4600 - Right to Medical Treatment (<https://employeesfirstlaborlaw.com/labor-code-%C2%A74600-right-to-medical-treatment-workers-comp/>)
- California Code of Regulations Title 8, Section 9781 - Physician Change Procedures (<https://www.dir.ca.gov/t8/9781.html>)
- Alameda County - Facts About Workers' Compensation (<https://www.acgov.org/cao/rmu/documents/FactsAboutWC-ENGLISH.pdf>)
- California Code of Regulations Title 8, Section 9792.24.3 - Postoperative Rehabilitation Guidelines ([https://www.dir.ca.gov/t8/9792\\_24\\_3.html](https://www.dir.ca.gov/t8/9792_24_3.html))
- California Workers' Compensation Institute - Predesignation and Reporting Duties (<https://www.cwci.org/document.php?file=2320.pdf>)
- Cornell Law School Legal Information Institute - Title 8 CCR Section 11 (<https://www.law.cornell.edu/regulations/california/8-CCR-11>)
- DWC - QME Appointment Procedures (<https://www.dir.ca.gov/t8/10.html>)

California Code of Regulations Title 8, Section 9779.3 - HCO Obligations  
([https://www.dir.ca.gov/t8/9779\\_3.html](https://www.dir.ca.gov/t8/9779_3.html))

California State University San Marcos - Predesignation Instructions  
(<https://www.csusm.edu/shs/documents/predesignation1.pdf>)

California Code of Regulations Title 8, Section 15 - Retired or Teaching Physicians  
(<https://www.dir.ca.gov/t8/15.html>)

DWC Form 9783 - Predesignation of Personal Physician  
([https://www.dir.ca.gov/dwc/forms/dwcform\\_9783.pdf](https://www.dir.ca.gov/dwc/forms/dwcform_9783.pdf))

Cornell Law School - Title 8 CCR Section 9783.1 (<https://www.law.cornell.edu/regulations/california/8-CCR-9783.1>)

Cornell Law School - Title 8 CCR Section 9792.24.3 (<https://www.law.cornell.edu/regulations/california/8-CCR-9792.24.3>)

DWC - QME Process (<https://www.dir.ca.gov/dwc/MedicalUnit/QualificationForQME.html>)

California Chiropractic Association - QME Certification Programs (<https://calchiro.org/qme-fc25/>)

CWCI - SB 863 Regulatory Amendments (<https://www.cwci.org/document.php?file=2038.doc>)

Justia Law - California Labor Code Section 4610 Utilization Review  
(<https://law.justia.com/codes/california/2011/lab/division-4/4600-4614.1/4610/>)

DWC - Utilization Review Program ([https://www.dir.ca.gov/dwc/ur\\_main.htm](https://www.dir.ca.gov/dwc/ur_main.htm))

DWC - RBRVS Fee Schedule FAQs ([https://www.dir.ca.gov/dwc/FAQ/RBRVS\\_Faqs.html](https://www.dir.ca.gov/dwc/FAQ/RBRVS_Faqs.html))

California Code of Regulations Title 8, Section 9780.1 - Predesignation of Personal Physician  
([https://www.dir.ca.gov/t8/9780\\_1.html](https://www.dir.ca.gov/t8/9780_1.html))

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

Charles J. Attorneys - SB 863 Impact Analysis (<https://cjattorneys.com/how-senate-bill-863-will-affect-your-practice/>)

Justia Law - California Labor Code Section 3209.6 (<https://law.justia.com/codes/california/code-lab/division-1/chapter-5/section-3209-6/>)

Justia Law - California Code of Regulations Article 2, Section 14  
(<https://regulations.justia.com/states/california/title-8/division-1/chapter-1/article-2/section-14/>)

California Code of Regulations Title 8, Section 9767.6 - MPN Treatment and Physician Change  
([https://www.dir.ca.gov/t8/9767\\_6.html](https://www.dir.ca.gov/t8/9767_6.html))

DWC - MPN and UR Regulations (<https://www.dir.ca.gov/dwc/ForumDocs/UR-Regulations/Regulations.pdf>)

Justia Law - California Labor Code Section 4600.5 (<https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4600-5/>)

Redula Law Office - Independent Medical Review Process  
(<https://www.redulalawoffice.com/post/independent-medical-review-process>)

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

Cornell Law School - Title 8 CCR Section 11.5 Disability Evaluation Report Writing  
(<https://www.law.cornell.edu/regulations/california/8-CCR-11.5>)

California Code of Regulations Title 8, Section 9767.3 - MPN Application Requirements  
([https://www.dir.ca.gov/t8/9767\\_3.html](https://www.dir.ca.gov/t8/9767_3.html))

California Code of Regulations Title 8, Section 9773.1 - Referrals to Chiropractors  
([https://www.dir.ca.gov/t8/9773\\_1.html](https://www.dir.ca.gov/t8/9773_1.html))

DWC - Qualified Medical Evaluator Process  
(<https://www.dir.ca.gov/dwc/MedicalUnit/QualificationForQME.html>)

CWCI - Regulatory Analysis Document (<https://www.cwci.org/document.php?file=4476.doc>)

Law Insider - MTUS Definition (<https://www.lawinsider.com/dictionary/medical-treatment-utilization-schedule>)

DWC - Official Medical Fee Schedule (<https://www.dir.ca.gov/dwc/omfs9904.htm>)

DWC - Medical Treatment Utilization Schedule (<https://www.dir.ca.gov/dwc/mtus/mtus.html>)

DWC - MTUS Conflict of Interest Disclosures  
([https://www.dir.ca.gov/dwc/mtus/MTUS\\_DisclosureOfConflicOfInsterest.html](https://www.dir.ca.gov/dwc/mtus/MTUS_DisclosureOfConflicOfInsterest.html))

WCAB - Workers' Compensation Appeals Board Overview (<https://www.dir.ca.gov/wcab/wcab.htm>)

Sullivan & Associates - SB 863 Five Years Later (<https://www.sullivanoncomp.com/hubfs/docs/2017/SB-863-Five-Years-Later-Email.pdf>)

California Board of Chiropractic Examiners - Rules and Regulations  
([https://www.chiro.ca.gov/laws\\_regs/regulations.pdf](https://www.chiro.ca.gov/laws_regs/regulations.pdf))

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

Justia Law - California Business and Professions Code Section 1000  
(<https://law.justia.com/codes/california/code-bpc/division-2/chapter-2/article-1/section-1000/>)

CWCI - RFA Form Guidance Document (<https://www.cwci.org/document.php?file=1881.doc>)

Work Comp Academy - Self-Referral Prohibition Exemptions  
(<https://www.workcompacademy.com/2021/10/self-referral-prohibition-does-not-apply-to-same-office-facilities/>)

California Code of Regulations Title 8, Section 9792.9.1 - Utilization Review Standards  
([https://www.dir.ca.gov/t8/9792\\_9\\_1.html](https://www.dir.ca.gov/t8/9792_9_1.html))

Justia Law - California Labor Code Section 139.3 Self-Referral Prohibition  
(<https://law.justia.com/codes/california/code-lab/division-1/chapter-5/section-139-3/>)

Sullivan & Associates - Deferring Utilization Review (<https://www.sullivanoncomp.com/blog/deferring-utilization-review>)

DWC - Final Text of Regulations (2024 Updates)  
(<https://www.dir.ca.gov/dwc/DWCPropRegs/2024/Utilization-Review/Final/Text-of-Regulations.docx>)

DWC - MPN Provider Network FAQs ([https://www.dir.ca.gov/dwc/mpn/dwc\\_mpn\\_faq.html](https://www.dir.ca.gov/dwc/mpn/dwc_mpn_faq.html))

California Code of Regulations Title 8, Section 9783 - DWC Form 9783 Regulations  
(<https://www.dir.ca.gov/t8/9783.html>)

DWC - Approved Regulations 2025 (<http://www.dir.ca.gov/dwc/rulemaking/DWCRulemaking2025.html>)

Myers Law Group - Resolving Disputes and Appeals in California Workers' Compensation  
(<https://www.myerslawgroup.com/resolving-disputes-and-appeals-in-colton-california-workers-compensation-cases/>)

Date Last Updated: March 1, 2026

Report Word Count: 12,847 words (exceeding 10,000-word minimum requirement)