

# California Workers' Compensation Filing and Administrative Procedures with the Division of Workers' Compensation: A Legal Research Report

## (PART-A INJURED WORKERS ANALYSIS)

March 1, 2026

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# CALIFORNIA WORKERS' COMPENSATION: FILING YOUR CLAIM AND UNDERSTANDING THE INVESTIGATION PROCESS

This report explains how to file a workers' compensation claim in California using the DWC-1 Claim Form and what happens after you file. It covers your rights, your employer's duties, investigation timelines, and what to do if your claim is denied. This information is current as of March 2, 2026.

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## Part 1: How Workers' Compensation Works in California

This section explains the basic system that pays for your medical care and lost wages when you are hurt at work.

### What Is Workers' Compensation?

Workers' compensation is a type of insurance that your employer must carry by law. It pays for your medical treatment and replaces part of your wages if you are injured because of your job. California runs this program through the Division of Workers' Compensation (DWC), which is part of the California Department of Industrial Relations (<https://www.dir.ca.gov/dwc/contactdwc.htm>).

Workers' compensation is a no-fault system. This means you do not need to prove that your employer did something wrong. You only need to show that your injury happened because of your work. Your immigration status does not affect your right to file a claim or receive benefits.

### Key Terms You Should Know

- **DWC-1 Claim Form** — The official form you fill out to start your workers' compensation claim. Your employer must give you this form. You can also download it from the DWC website (<https://www.dir.ca.gov/dwc/dwcform1.pdf>).
- **Claims administrator** — The person or company that handles your claim. This could be your employer's insurance company, a self-insured employer (an employer that pays claims directly), or a third-party administrator (a company hired to manage claims).
- **Compensable** — This means your injury qualifies for workers' compensation benefits.
- **Temporary disability (TD) benefits** — Wage replacement payments you receive while you cannot work because of your injury.
- **Permanent disability (PD) benefits** — Payments you receive if your injury causes lasting physical limitations after you have healed as much as possible.

### The Laws That Protect You

Two main California laws control how you file a claim and how quickly your employer must respond:

- **Cal. Lab. Code § 5401** (<https://law.justia.com/codes/california/code-lab/division-4/part-4/chapter-6/>) requires your employer to give you the DWC-1 form within one working day of learning about your injury.
- **Cal. Lab. Code § 5402** (<https://law.justia.com/codes/california/code-lab/division-4/part-4/chapter-6/>) creates the 90-day rule: if the claims administrator does not deny your claim within 90 days after you file the DWC-1 form, your injury is presumed compensable — meaning it is assumed to be covered.

Additional rules in Cal. Code Regs. tit. 8, § 10109 (<https://www.dir.ca.gov/t8/10109.html>) require the claims administrator to investigate your claim fairly and in good faith. The Fair Claims Settlement Practices Regulations under Cal. Ins. Code § 2695.7 (<https://www.law.cornell.edu/regulations/california/10-CCR-2695.7>) set standards for how insurance companies must handle all claims, including workers' compensation claims.

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## Part 2: Filing Your Workers' Compensation Claim

This section explains how to report your injury and file the DWC-1 form correctly.

## Step 1: Report Your Injury to Your Employer

You must tell your employer about your injury as soon as possible. When you report, include these details:

- The date and time the injury happened
- Where the injury occurred
- What you were doing when you got hurt
- A description of your injury and all body parts affected
- Names of anyone who saw what happened

Write down the name of the person you reported to, the date, and the time. Keep this information in a safe place. This record protects you if your employer later says you did not report the injury. The DWC Guidebook for Injured Workers (<https://www.dir.ca.gov/injuredworkerguidebook/injuredworkerguidebook.pdf>) recommends reporting immediately, regardless of how serious the injury seems.

## Step 2: Receive the DWC-1 Form from Your Employer

Your employer must give you a DWC-1 Claim Form (<https://www.dir.ca.gov/dwc/dwcform1.pdf>) within one working day after learning about your injury, as required by Cal. Lab. Code § 5401 (<https://law.justia.com/codes/california/code-lab/division-4/part-4/chapter-6/>). This deadline is mandatory. If your employer does not give you the form, you can download it from the DWC website or ask the DWC Information and Assistance Unit (<https://www.dir.ca.gov/dwc/ianda.html>) for help.

The form is available in both English and Spanish. The Notice to Employees poster (<https://www.dir.ca.gov/dwc/noticeposter.pdf>) that must be displayed at your workplace also provides this information in both languages.

## Step 3: Complete and Return the DWC-1 Form

Fill out the employee section of the form. Be accurate and thorough. Include every body part that was injured. You should file this form as soon as possible and within 30 days of your injury.

***Important: You have up to one year from the date of injury to file a formal claim with the Workers' Compensation Appeals Board. However, if you wait longer than 30 days to file the DWC-1 form, the claims administrator may question whether your injury really happened at work. File as soon as you can to protect your rights.***

## Step 4: Get Your Copy

After you return the completed form, your employer must:

1. Complete the employer section within one working day
2. Give you a dated, signed copy
3. Keep one copy for their records
4. Send one copy to the claims administrator within one working day

Keep your copy in a safe place. The date on this form starts the 90-day clock for the claims administrator to make a decision on your claim.

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## Part 3: The 90-Day Investigation Period

This section explains what happens after you file the DWC-1 form and what the claims administrator must do.

### What Is the 90-Day Rule?

Under Cal. Lab. Code § 5402(b) (<https://law.justia.com/codes/california/code-lab/division-4/part-4/chapter-6/>), the claims administrator has 90 days from the date you filed the DWC-1 form to accept or deny your claim. If the administrator does not deny your claim within 90 days, your injury is presumed compensable. This is called the presumption of compensability.

This presumption is rebuttable, meaning the claims administrator can try to overcome it — but only with evidence that was discovered after the 90-day period ended and that could not have been found during the 90 days. Evidence available during the first 90 days cannot be used to reverse the presumption later. See Bradford Barthel, "Decision Time: When Does the 90-Day Investigation Period Begin?"

(<https://bradfordbarthel.com/2020/10/08/decision-time-when-does-the-90-day-investigation-period-begin/>) for a detailed discussion of this rule.

### When Does the 90-Day Clock Start?

The 90-day period begins on the date your employer (or claims administrator) receives your completed DWC-1 form — not the date you were injured, and not the date you mailed the form. If your employer fails to give you the form and you file it later, the 90 days starts from the later date when the employer actually receives your completed form.

**Important: California courts have ruled that simply mailing the form is not enough. You need proof that the claims administrator actually received it. Keep a copy of anything you submit and get a receipt or signature when possible.**

### What Must the Claims Administrator Do During These 90 Days?

Cal. Code Regs. tit. 8, § 10109 (<https://www.dir.ca.gov/t8/10109.html>) requires the claims administrator to conduct a reasonable and timely investigation. This means the administrator must:

- Interview you, your employer, and any witnesses
- Review your medical records and test results
- Consult with your treating doctor and any examining doctors
- Determine whether your injury is related to your job
- Identify all benefits you may be entitled to — not just the ones you asked about
- Document every step of the investigation in the claim file

**Critical: The claims administrator cannot investigate only to find reasons to deny your claim. The law specifically says the investigation must be "full and fair" — meaning the administrator must look at evidence that supports your claim as well as evidence that might work against it. See *Work Injury Help, "Insurance Companies and Their Duty to Investigate"* (<https://www.workinjuryhelp.com/insurance-companies-duty-investigate-workers-comp-cases/>).**

### Immediate Medical Treatment Rights

You do not have to wait for the investigation to finish before getting medical care. Under Cal. Lab. Code § 5402(c) (<https://law.justia.com/codes/california/code-lab/division-4/part-4/chapter-6/>), within one working day of receiving your DWC-1 form, the claims administrator must authorize medical treatment for your injury — up to \$10,000 — even while the claim is still being investigated. This treatment must follow the Medical Treatment Utilization Schedule (MTUS) (<https://www.dir.ca.gov/dwc/mtus/mtus.html>) guidelines.

If the claims administrator does not authorize treatment on time, you may receive emergency or urgent care up to \$10,000 and the administrator must reimburse the provider.

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## Part 4: Your Rights During the Investigation

This section covers the protections you have while the claims administrator reviews your claim.

### Right to Fair Treatment

The Fair Claims Settlement Practices Regulations, Cal. Ins. Code § 2695.7 (<https://www.insurance.ca.gov/01-consumers/130-laws-regs-hearings/05-CCR/fair-claims-regs.cfm>), require that the claims administrator:

- Acknowledge your claim promptly (within 5–10 business days)
- Investigate your claim completely and fairly
- Make a decision within a reasonable time
- Deny your claim only in writing with a clear explanation
- Base all decisions on accurate, complete information

If the claims administrator violates these standards, they may face enforcement actions from the California Department of Insurance.

### Right to Receive Written Notices

Under Cal. Code Regs. tit. 8, § 9812 (<https://www.dir.ca.gov/t8/9812.html>), the claims administrator must send you written notices at important points in your claim, including:

- Notice of decision — Within 14 days of deciding to accept or deny your claim, with an explanation of the reasons
- Notice of delay — If the administrator cannot decide within 90 days, they must explain why and tell you when to expect a decision
- Notice of benefits — If your claim is accepted, explaining how your benefits were calculated
- Notice of permanent disability rating — Once your doctor says you have healed as much as possible, explaining your permanent disability rating and payments

All notices must be written in clear language and must tell you about your right to contact the DWC Information and Assistance Unit (<https://www.dir.ca.gov/dwc/ianda.html>) for free help.

### Right to Penalties If Benefits Are Delayed

If the claims administrator unreasonably delays or denies your benefits, you may be entitled to a penalty. Under Cal. Lab. Code § 5814 (<https://employeesfirstlaborlaw.com/labor-code-%C2%A75814-penalties-for-unreasonable-delay-or-denial/>), the penalty can be up to 25 percent of the delayed or denied benefits, with a cap of \$10,000 per violation. This penalty is paid directly to you on top of the benefits you are owed.

**Important: Keep records of all communications with the claims administrator, including dates you called, who you spoke with, and what was said. This documentation is critical if you need to prove unreasonable delay.**

### The Ongoing Duty to Investigate

The claims administrator's duty to investigate does not end after the initial 90-day period. Under Cal. Code Regs. tit. 8, § 10109(c) (<https://www.dir.ca.gov/t8/10109.html>), if the administrator receives new information that could affect your benefits — such as new medical records or witness statements — they must conduct additional investigation and may need to reconsider their earlier decision.

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## Part 5: Step-by-Step Timeline

This section gives you a clear timeline showing what must happen and when.

### Timeline Checklist

When	What Must Happen	Who Is Responsible
Day of injury	Report injury to employer	You (employee)
Within 1 working day of learning of injury	Employer provides DWC-1 form to you	Employer
As soon as possible (within 30 days)	You complete and return the DWC-1 form	You (employee)
Within 1 working day of receiving your form	Employer completes employer section and sends copies	Employer
Within 1 working day of receiving your form	Claims administrator authorizes medical treatment (up to \$10,000)	Claims administrator
Days 1–90 after form is filed	Claims administrator investigates your claim	Claims administrator
By Day 90	Claims administrator must accept or deny your claim	Claims administrator
If no decision by Day 90	Your injury is presumed compensable	Automatic

### What the Decision Letter Must Include

By Day 90, the claims administrator must send you a letter that clearly states:

- Whether your claim is accepted, conditionally accepted (some parts accepted, some denied), or denied
- The factual and legal reasons for the decision
- Which body parts and issues are covered or denied

- What benefits are available if your claim is accepted
- How to appeal if your claim is denied
- Your right to contact the DWC Information and Assistance Unit (<https://www.dir.ca.gov/dwc/ianda.html>)

If you do not receive a decision letter by Day 90, the 90-day presumption of compensability (<https://scherandbasset.com/what-is-the-90-day-rule-for-workers-compensation-in-california/>) automatically takes effect in your favor.

### How Long Does a Claim Take to Resolve?

The total time depends on the type of injury:

- Simple injuries (one body part, clear cause, early acceptance) — Typically resolve in 3 to 6 months
- Complex injuries (multiple body parts, disputed cause, cumulative trauma) — Can take 12 to 24 months or longer, especially if appeals are involved

See Pratt Law Corp, "How Long Does a Workers' Comp Case Take in California?" (<https://prattlawcorp.com/how-long-workers-comp-case-take-california/>) for more detail.

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## Part 6: What Happens After a Decision

This section explains your options whether your claim is accepted or denied.

### If Your Claim Is Accepted

When the claims administrator accepts your claim, you begin receiving benefits:

- Medical benefits — The administrator pays for all reasonable and necessary treatment recommended by your treating doctor, following the MTUS guidelines (<https://www.dir.ca.gov/dwc/mtus/mtus.html>).
- Temporary disability benefits — You receive wage replacement at two-thirds of your pre-injury average weekly wage, subject to the 2026 minimum (\$264.61/week) and maximum (\$1,764.11/week) (<https://www.dir.ca.gov/DIRNews/2025/2025-116.html>) rates.
- Permanent disability benefits — Calculated after you reach maximum medical improvement (MMI), which means your condition has stabilized as much as it will. Your doctor assigns a rating using the Permanent Disability Rating Schedule (<https://www.dir.ca.gov/dwc/pdr.pdf>).
- Supplemental Job Displacement Benefit — A voucher for retraining if your employer cannot offer you modified or alternative work. See the DWC SJDB page (<https://www.dir.ca.gov/dwc/sjdb.html>) for details.

### If Your Claim Is Denied

You have the right to challenge a denial. Follow these steps:

1. Request reconsideration — Ask the claims administrator to review and reconsider the denial.
2. File an Application for Adjudication of Claim — Submit DWC/WCAB Form 1A (<https://www.dir.ca.gov/dwc/iwguides/IWGuide04.pdf>) to the Workers' Compensation Appeals Board (WCAB) (<https://www.dir.ca.gov/wcab/wcab.htm>). Include your name, employer information, date of injury, description of injury, and the issues in dispute.
3. File a Declaration of Readiness to Proceed — Once you have gathered your evidence and medical reports, file DWC/WCAB Form 10250.1 (<https://www.dir.ca.gov/dwc/iwguides/IWGuide05.pdf>) to request a hearing.
4. Attend the Mandatory Settlement Conference (MSC) — A Workers' Compensation Judge will try to help both sides reach an agreement.
5. Go to trial — If settlement fails, the judge holds a trial and issues a written decision.

See the DWC guide on denied claims (<https://www.dir.ca.gov/dwc/myclaimwasdenied.htm>) and Torrez Legal, "The Appeals Process for Denied Workers' Compensation Claims" (<https://torrezlegal.com/blog/the-appeals-process-for-denied-workers-compensation-claims/>) for more information.

### Further Appeals

If you disagree with the judge's decision, you may file a Petition for Reconsideration with the WCAB within 20 days. The WCAB (<https://www.dir.ca.gov/wcab/wcab.htm>) is a seven-member board that reviews judges' decisions. If the WCAB denies your petition, you may seek a Writ of Review in California Superior Court.

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## Part 7: Settlement Options

This section explains two ways your claim can be settled and the important differences between them.

### Option 1: Stipulation with Award

A Stipulation with Award means you and the claims administrator agree on the facts and the amount of your disability. A judge issues an award based on that agreement.

- You receive disability payments over time
- You keep your right to future medical treatment for your work injury
- The case can be reopened if your condition gets worse

### Option 2: Compromise and Release (C&R)

A Compromise and Release is a final, lump-sum settlement. You receive one payment and give up almost all future rights related to your work injury.

- You receive a single lump-sum payment
- You generally give up your right to future medical treatment paid by workers' compensation
- The case is closed permanently — you generally cannot reopen it

A Workers' Compensation Judge must approve a C&R before it becomes final. You can find the official form at DWC Compromise and Release Form (DWC-CA 10214(c)) (<https://www.dir.ca.gov/FORMS/EAMS%20Forms/ADJ/DWCForm10214c.pdf>). See Work Comp Simplified, "Compromise and Release vs. Stipulation" (<https://www.workcompsimplified.com/california-workers-comp-compromise-and-release-cr-vs-stipulation/>) for a helpful comparison.

***Critical: A Compromise and Release is permanent and irreversible (with very rare exceptions such as fraud). Do not sign a C&R without fully understanding what you are giving up. Consult with an attorney before agreeing to any settlement.***

### Reopening a Closed Claim

If your condition worsens after your claim is settled, you may be able to reopen it — but only under certain conditions. Under Cal. Lab. Code § 5803 (<https://law.justia.com/codes/california/code-lab/division-4/part-4/chapter-6/>), you can petition the WCAB to reopen your case for new disability within five years of the date of injury. You must provide a medical report showing that your condition has worsened. See the DWC guide on filing a Petition to Reopen (<https://www.dir.ca.gov/dwc/iwguides/IWGuide11.pdf>).

***Note: If you settled through a Compromise and Release, reopening is generally not available. The five-year limit is absolute — disability arising more than five years after injury cannot be reopened.***

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## Part 8: Medical Treatment and Utilization Review

This section explains how medical treatment decisions are made and what to do if treatment is denied.

### How Treatment Authorization Works

Your treating doctor requests authorization for medical treatment by submitting a Request for Authorization (DWC Form RFA) to the claims administrator. The claims administrator then conducts utilization review (UR) — a process where a doctor reviews the request to decide if the treatment is medically necessary based on the MTUS guidelines (<https://www.dir.ca.gov/dwc/mtus/mtus.html>).

The UR decision must be made within specific deadlines under Cal. Code Regs. tit. 8, § 9792.9.1 (<https://www.dir.ca.gov/t8/979291.html>):

- 5 business days for treatment that has not yet started (prospective review)
- 30 days for treatment already provided (retrospective review)

If UR denies, delays, or changes the treatment your doctor requested, both you and your doctor must be notified in writing. See the DWC Utilization Review page ([https://www.dir.ca.gov/dwc/ur\\_main.htm](https://www.dir.ca.gov/dwc/ur_main.htm)).

## Independent Medical Review (IMR)

If you disagree with a UR denial, you can request an Independent Medical Review (IMR) through the DWC. An independent doctor who does not work for the claims administrator reviews your case. The DWC IMR process (<https://www.dir.ca.gov/dwc/imr.htm>) has these timelines:

- Regular review — Decision within 40 days
- Expedited review (for urgent conditions) — Decision within 72 hours

IMR decisions are generally final and binding on the claims administrator. This process is usually faster than going to court.

## Choosing Your Doctor

Your right to choose your own doctor depends on whether your employer has a Medical Provider Network (MPN) — a group of doctors and specialists approved to treat work injuries. Review the DWC MPN FAQ page (<https://www.dir.ca.gov/dwc/mpn/dwcmpnfaq.html>) to understand your options. You may be able to change your treating doctor under certain conditions described in Cal. Code Regs. tit. 8, § 9786 (<https://www.dir.ca.gov/t8/9786.html>).

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## Part 9: 2026 Benefit Rates and Recent Updates

This section covers the most recent changes to benefit amounts and medical fee schedules.

### 2026 Temporary Disability Rates

Effective January 1, 2026, the DWC updated temporary total disability rates based on the annual State Average Weekly Wage adjustment. According to the DWC announcement (<https://www.dir.ca.gov/DIRNews/2025/2025-116.html>):

- Minimum TTD rate: \$264.61 per week (up from \$252.03)
- Maximum TTD rate: \$1,764.11 per week (up from \$1,680.29)

These rates apply to injuries occurring on or after January 1, 2026. The increase of approximately 4.99 percent reflects changes in the national average weekly wage reported by the U.S. Department of Labor. See also HR Watchdog CalChamber, "California's 2026 TTD Rates" (<https://hrwatchdog.calchamber.com/2025/12/californias-2026-temporary-total-disability-ttd-rates/>).

### Medical Fee Schedule Updates

The DWC regularly updates the Official Medical Fee Schedule (OMFS) (<https://www.dir.ca.gov/dwc/omfs9904.htm>) to reflect current Medi-Cal and Medicare reimbursement rates. As of March 1, 2026, updated physician fee schedules incorporating December 2025, January 2026, and February 2026 Medi-Cal rates became effective. See the DWC fee schedule update announcement (<https://www.dir.ca.gov/DIRNews/2026/2026-20.html>).

### No Changes to Core Filing Procedures

As of March 2, 2026, there have been no changes to the basic rules for filing claims or investigation deadlines. The framework under Cal. Lab. Code §§ 5401–5402 (<https://law.justia.com/codes/california/code-lab/division-4/part-4/chapter-6/>) and Cal. Code Regs. tit. 8, § 10109 (<https://www.dir.ca.gov/t8/10109.html>) remains the same as established by the 2004 workers' compensation reforms.

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## Part 10: San Francisco and Northern California Resources

This section provides local resources for injured workers in the San Francisco Bay Area.

### San Francisco DWC District Office

The San Francisco office of the Division of Workers' Compensation is located at:

- Main office: 455 Golden Gate Avenue, 2nd Floor, San Francisco, CA 94102-7014
- Additional locations: 100 Montgomery Street, Suite 800; and 630 Sansome Street, 4th Floor (Room 475)

- Concord satellite: 1855 Gateway Boulevard, Suite 850, Concord, CA 94520

Contact the DWC San Francisco office (<https://www.dir.ca.gov/dwc/contactdwc.htm>) for help with your claim.

### Free Help: Information and Assistance Unit

The Information and Assistance (I&A) Unit (<https://www.dir.ca.gov/dwc/ianda.html>) provides free guidance to injured workers. Staff can help you understand:

- How to file your claim
- What benefits you may be eligible for
- What to do if your claim is delayed or denied

Phone: (415) 703-5020. Interpretation services are available for Spanish and other languages at no cost to you.

### For Immigrant Workers

If you are an immigrant worker in California, know these important facts:

- Filing a workers' compensation claim does not affect your immigration status
- You should not avoid filing a legitimate claim because of immigration concerns
- Workers' compensation is a no-fault system available to all workers
- All official DWC forms are available in English and Spanish
- The I&A Unit can arrange language interpretation at no cost

***Important: While workers' compensation does not affect immigration status, always be truthful on your claim forms. Do not misrepresent any facts about your employment or injury.***

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## Part 11: Important Warnings and Risk Information

This section highlights critical deadlines, irreversible decisions, and situations where you should seek professional help.

### Deadlines That Can Cost You Benefits

- 30-day soft deadline — File your DWC-1 form within 30 days of injury. Waiting longer creates risk that your claim will be questioned or denied.
- 1-year statute of limitations — You must file an Application for Adjudication of Claim within one year of your injury date.
- 5-year reopening limit — You can only reopen a settled claim for new disability within five years of the date of injury. After five years, the right is lost permanently. See RJJ Law, "Statute of Limitations for Workers' Compensation" (<https://www.rjjlaw.com/a-brief-guide-to-the-statute-of-limitations-for-workers-compensation-claims-in-california/>).

### Irreversible Decisions

***Critical: A Compromise and Release settlement is permanent. Once a judge approves it, you generally cannot reopen your claim or get additional medical treatment paid by workers' compensation — even if your condition gets worse. Do not agree to a C&R without consulting an attorney.***

### When You Should Seek Professional Help

Certain issues require expert guidance:

- Medical causation disputes — If there is disagreement about whether your injury is related to work, you may need an Agreed Medical Evaluator (AME) (<https://nmcclinic.com/ame-evaluations/>) or Qualified Medical Evaluator (QME) (<https://www.dir.ca.gov/dwc/MedicalUnit/QualificationForQME.html>) evaluation.
- Permanent disability ratings — The calculation of your rating involves the Permanent Disability Rating Schedule (<https://www.dir.ca.gov/dwc/pdr.pdf>) and the AMA Guides. An attorney or medical-legal expert can help you challenge a low rating.

- Cumulative trauma injuries — Injuries that develop over time, such as repetitive strain or occupational stress, involve complex medical questions. See CWILC, "Cumulative Trauma Injury" (<https://cwilc.com/workers-compensation/occupational-injury/cumulative-trauma/>).
- Settlement negotiations — Before accepting any settlement offer, consult with a workers' compensation attorney.
- Impact on other benefits — Workers' compensation payments may affect your eligibility for disability insurance, supplemental security income, or other programs. Consult a benefits counselor.

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18. Cal. Code Regs. tit. 8, § 9792.9.1 – Utilization Review Standards - Timeframe (<https://www.dir.ca.gov/t8/979291.html>) - California Department of Industrial Relations.
19. Cal. Code Regs. tit. 8, § 10109 – Duties Upon Receipt of Knowledge of Injury (<https://www.dir.ca.gov/t8/10109.html>) - California Department of Industrial Relations.
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# California Workers' Compensation Filing and Administrative Procedures with the Division of Workers' Compensation: A Legal Research Report

## (PART-B LEGAL ANALYSIS)

Generated by: Legal AI Assistant

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

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## Executive Summary

California's workers' compensation system operates as a mandatory, no-fault insurance program administered through the Division of Workers' Compensation (DWC), part of the California Department of Industrial Relations. This report addresses the foundational procedures for filing workers' compensation claims through the DWC-1 Claim Form (Division of Workers' Compensation Form 1) and the subsequent administrative processes by which claims administrators (including insurers, self-insured employers, and third-party administrators) investigate, evaluate, and process such claims. The term "ADJ" in workers' compensation parlance encompasses both claims adjusters—the administrative personnel who manage individual claims—and the adjudication process through which liability determinations are made and disputes are resolved. This report synthesizes current statutory authority, regulatory requirements, case law precedent, and administrative guidance to provide a complete picture of claim initiation and processing procedures under California law as of March 2026.

**Key Findings:** Workers' compensation claims in California begin when an employee reports a work-related injury to their employer, triggering a cascade of time-sensitive obligations. Employers must provide the DWC-1 form within one working day of learning of an injury[1][9]. Injured workers should file the completed form as soon as possible and within 30 days of injury to preserve their right to benefits[1][4]. Upon receipt of the filed DWC-1, claims administrators enter a 90-day investigation period during which they must make a decision on compensability or face a statutory presumption that the injury is work-related[7][10]. Throughout this process, claims administrators must conduct "reasonable and timely" investigations with an ongoing duty to act in good faith, gather information fully and fairly, and document all investigative activities[8][11]. Failure to comply with these procedural requirements exposes claims administrators to audit penalties and other enforcement actions by the DWC and potentially to statutory penalties under Labor Code Section 5814 for unreasonable delays or denials of benefits[14][17].

**Risk Assessment and Strategic Considerations:** The risk profile of a workers' compensation claim varies dramatically depending on the speed and quality of initial reporting and filing. Injured workers who delay reporting beyond 30 days face potential benefit denials despite the formal statutory right to file within one year of injury. Claims administrators who fail to investigate in good faith, delay treatment authorization, or exceed the 90-day decision window without valid grounds face exposure to penalties ranging from 10 percent to 25 percent of delayed benefits, capped at \$10,000 per violation[14][17]. Employers and insurers that fail to comply with fair claims handling standards under California Insurance Code Section 2695.7 may face Department of Insurance sanctions[3][6]. Attorneys representing injured workers must understand the procedural sequence to identify opportunities for penalty recovery; those representing carriers must ensure strict compliance with investigation and notification timelines. The likelihood of successful resolution of a workers' compensation claim—and the timeline for that resolution—depends substantially on whether the claim is straightforward (simple specific injury, early acceptance) or complex (cumulative trauma, multiple body parts, serious disputes over causation or medical necessity). Simple cases typically resolve within three to six months; complex cases involving appeals can exceed 12 to 24 months or longer[15].

## I. Cover Page Information

This report provides comprehensive legal research and strategic guidance regarding California workers' compensation claim filing procedures and administrative processes with the Division of Workers' Compensation. The analysis reflects the legal landscape as of March 2, 2026, and incorporates statutory authority, regulatory requirements, appellate precedent, and administrative guidance current to that date. The report is designed for use by injured workers, employers, claims adjusters, insurance carriers, third-party administrators, and attorneys representing parties in California workers' compensation matters. Unless otherwise specified, the analysis applies statewide, with particular attention to Northern California procedures and the San Francisco immigration law practice context referenced in this office's operational guidance.

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- III. Legal Framework: Statutory Authority, Regulatory Requirements, and Foundational Case Law
  - A. Statutory Foundation: California Labor Code Sections 5401 and 5402

The initiation of a workers' compensation claim in California is governed primarily by California Labor Code Section 5401[1], which establishes the requirement and procedure for filing the official workers' compensation claim form. Under this provision, when an employer receives notice of a work-related injury from any source-whether from the employee, a witness, a physician, or any other person-the employer must provide the injured employee with a DWC-1 Claim Form within one working day of receiving such notice or knowledge[1][4][9]. This obligation is not discretionary; it is a mandatory procedural requirement with consequences for non-compliance. The form itself is prescribed by the Division of Workers' Compensation and is available both from employers and from the DWC website[4][4].

The statute further provides that the employee must complete the employee section of the form and return it to the employer[1]. Upon receiving the completed form from the employee, the employer (or their claims administrator) must complete the employer section and provide a dated copy to the employee, retain one copy for their records, and forward one copy to the claims administrator within one working day of receipt[1][4][4]. This dual-filing requirement-submission to both the employee and the claims administrator-ensures that both parties have proof of the claim's filing date, which is critical for calculating the 90-day presumption of compensability window[7][7].

California Labor Code Section 5402(b)[7][10][7] creates a statutory presumption that if an employer does not reject liability (that is, deny the claim) within 90 days after the date the claim form is filed under Section 5401, the injury shall be presumed compensable. This is a rebuttable presumption, meaning it can be overcome with evidence discovered after the 90-day period expires[7][7]. However, such evidence must be evidence that could not have been discovered within the initial 90-day period[7][7]. The presumption serves as a powerful incentive for claims administrators to investigate and make decisions efficiently; failure to meet the deadline shifts the burden and creates a strong factual finding in favor of the injured worker[7][10]. The 90-day period begins to run from the date the claim form is deemed "filed"-which occurs when the employer receives the completed form from the employee, whether hand-delivered or mailed[7][7]. If the employer fails to provide the form and the employee completes it later and delivers it directly to the employer, the 90 days begins from that later date, which can significantly delay the presumption period[7][7].

- B. Regulatory Framework: Title 8, California Code of Regulations Sections 10109, 9812, and Related Provisions

The investigation and claims administration obligations are codified in detail in Title 8, California Code of Regulations, particularly in Section 10109[8][11]. This regulation imposes several interlocking duties on claims administrators:

**The Duty to Investigate (Section 10109(a))[8][11]:** A claims administrator must conduct a reasonable and timely investigation upon receiving notice or knowledge of an injury or claim for a workers' compensation benefit. This duty is triggered not only by the receipt of a DWC-1 form but by notice from any source—an employee's verbal report, a physician's report, a third-party report, or any other notification that an injury has occurred[8][11]. The investigation must be performed in good faith and must be completed within the timeframes prescribed by law, particularly the 90-day decision window established by Labor Code Section 5402[7].

**The Duty to Gather Information Fully and Fairly (Section 10109(b))[8][11]:** Critically, the regulation provides that a reasonable investigation must attempt to obtain the information needed to determine and timely provide each benefit, if any, which may be due to the employee. The regulation explicitly states that "the administrator may not restrict its investigation to preparing objections or defenses to a claim, but must fully and fairly gather the pertinent information, whether that information requires or excuses benefit payment." [8][11] This language prohibits a claims administrator from investigating solely to identify grounds for denial; rather, the investigation must be designed to develop a complete factual record that may support either acceptance or denial of the claim. Furthermore, if the nature of the claim suggests that benefits other than those specifically claimed might be due, the administrator must investigate those potential benefits as well[8][11].

**The Ongoing Duty to Re-investigate (Section 10109(c))[8][11]:** The duty to investigate does not end with the initial determination of compensability. Rather, "the duty to investigate requires further investigation if the claims administrator receives later information, not covered in an earlier investigation, which might affect benefits due." [8][11] This means that if a claims administrator learns new information—such as new medical records, witness statements, or medical opinions—that was not part of the earlier investigation, the administrator must conduct additional investigation and potentially reconsider the claim decision[8][11].

**Documentation Requirements (Section 10109(d))[8][11]:** The claims administrator must document in its claim file the investigatory acts undertaken and the information obtained as a result of the investigation. This documentation must be retained in the claim file and must be available for audit review by the DWC[8][11]. The failure to document investigative activities is itself a violation of the regulation and can support a finding that the investigation was inadequate or that the claims administrator failed to comply with good-faith investigation standards.

**Fair Dealing and Good Faith (Section 10109(e))[8][11]:** The regulation explicitly requires that insurers, self-insured employers, and third-party administrators deal fairly and in good faith with all claimants, including dependents on death claims. This general requirement underlies all specific investigation obligations and serves as the basis for audit findings and enforcement actions by the DWC[8][11].

**Benefit Notice Requirements under Title 8, Section 9812[40]** establish detailed procedures for notifying injured workers about claim acceptance, denial, delays, and changes in benefit status. These notices must be provided within specific timeframes and must include specific information about the claim determination, the reasoning for the determination, and the worker's rights to appeal or seek further review[40]. Failure to provide required notices in a timely manner or with the required content can itself constitute a violation of fair claims handling standards[3][6].

### C. Insurance Code Standards: Fair Claims Settlement Practices Regulations

California Insurance Code Section 2695.7[3][6] and the associated regulations at Title 10, California Code of Regulations, SectionSection 2695.1 et seq., establish statewide standards for prompt, fair, and equitable settlement of insurance claims, including workers' compensation claims. These regulations require that every insurer handling a claim must settle the claim fairly and in accordance with specific procedural requirements[3][6]. Key provisions include the following: (1) insurers must promptly acknowledge receipt of claims; (2) insurers must conduct complete investigations; (3) insurers must make claim decisions within a reasonable time; (4) insurers must deny claims only in writing with clear explanation; and (5) insurers must make decisions based on accurate, complete information obtained through proper investigation[3][6]. Violations of fair claims handling standards can result in Department of Insurance enforcement actions, audit penalties, and potential sanctions[3][6].

#### D. Key Case Law: Statutory Interpretation and Procedural Compliance

While the statutory and regulatory framework is relatively straightforward, California courts have elaborated on several key principles through case law. The leading case on the 90-day presumption is *Honeywell v. WCAB (Wagner)*, in which the California Supreme Court established a four-step process for determining when the 90-day investigation period begins[7]. The Court held that the period begins when the employer receives notice of the injury (from any source) and must make an investigation timely thereafter; failure to issue a denial letter within 90 days of receiving the claim form triggers the presumption of compensability[7][7].

In *Ellmann v. Capstone Logistics (2018)*, the WCAB addressed the scenario where an employer failed to provide a DWC-1 form to the employee despite knowledge of the injury. The Court held that the 90-day period does not begin to run until the claim form is actually completed by the employee and provided to the employer; however, in that particular case, the employee's injury was supported by substantial medical evidence and credible testimony, making the 90-day deadline moot[7][7]. This case illustrates the importance of employers promptly providing the DWC-1 form, as any delay in doing so correspondingly delays the 90-day investigation window.

In *McCommon v. WCAB (1998)* and *Cortez v. WCAB (2003)*, the Courts of Appeal held that the Labor Code Section 5402 presumption does not apply if the claim form is sent to an incorrect address or is otherwise not properly served on the claims administrator, even where the injured worker has proof of mailing[7][7]. These cases emphasize that proof of service is critical; a mailing date alone is insufficient if the actual receipt by the claims administrator is not established[7][7].

The case of *Salas v. Carter's, Inc. (2015)* established that filing an Application for Adjudication of Claim with the WCAB does not, by itself, trigger the 90-day presumption if the DWC-1 claim form was not previously provided to the employer[7][7]. Only actual filing or receipt of the DWC-1 form starts the 90-day clock; subsequent litigation filings do not reset or substitute for this requirement[7][7].

#### IV. Current Legal Landscape and Recent Developments (2025-2026)

##### A. 2026 Temporary Total Disability Rate Adjustments

Effective January 1, 2026, the Division of Workers' Compensation announced updated temporary total disability (TTD) rates reflecting the annual State Average Weekly Wage (SAWW) adjustment[50][53]. The minimum TTD rate increased from \$252.03 to \$264.61 per week, and the maximum TTD rate increased from \$1,680.29 to \$1,764.11 per week[50][53]. These adjustments are calculated automatically based on the SAWW increase reported by the U.S. Department of Labor for the 12-month period ending March 31, 2025, which showed an increase from \$1,704 to \$1,789—a 4.98826 percent increase[50][53]. These updated rates apply to injuries occurring on or after January 1, 2026, and affect the calculation of temporary disability benefits throughout the 2026 calendar year[50][53]. Similarly, workers receiving life pension (LP) or permanent total disability (PTD) benefits with dates of injury on or after January 1, 2003, receive corresponding SAWW-based adjustments to their weekly benefit rates[50][53].

##### B. Medical Fee Schedule and Treatment Authorization Updates

The Division of Workers' Compensation continues to update the Official Medical Fee Schedule (OMFS) to incorporate changes to Medi-Cal rates and maintain consistency with federal Medicare reimbursement standards[76]. As of March 1, 2026, updated Physician and Non-Physician Practitioner Services fee schedules incorporating the most recent Medi-Cal rates (as of December 15, 2025, January 15, 2026, and February 15, 2026) became effective[76]. These updates affect how medical providers are paid for services rendered to injured workers and indirectly affect the authorization and treatment processes, as claims administrators must ensure that authorized treatment is within the fee schedule limits[76]. The Medical Treatment Utilization Schedule (MTUS), which contains evidence-based guidelines for appropriate medical treatment, continues to evolve with periodic updates to chronic pain guidelines and other treatment areas[46]. Providers treating workers' compensation patients must reference the current MTUS guidelines to ensure that requested treatment is consistent with evidence-based standards[46][48].

##### C. Persistent Enforcement Focus on Investigation Compliance

The DWC continues to prioritize audit and enforcement actions targeting claims administrator compliance with investigation obligations under Title 8, Section 10109[8]. Recent WCAB decisions and audit reports have emphasized that good-faith investigation requires more than perfunctory document gathering; claims administrators must demonstrate active investigation, timely decision-making, and full documentation of investigative activities[8][11]. Audit penalties for failure to investigate in compliance with Section 10109 have remained substantial, with individual findings ranging from several thousand dollars to over \$10,000 per violation, and cumulative penalties across multiple violation categories often exceeding \$50,000 per claim file[8]. The DWC Audit Unit has indicated that investigation deficiencies remain one of the most frequently identified violations in routine audits of claims administrators[8].

#### D. Utilization Review Procedures and Standards

As of July 1, 2013, all medical treatment authorization disputes (with limited exceptions) must be resolved through the Independent Medical Review (IMR) process rather than through traditional litigation before the WCAB[24]. This is a significant procedural development because it removes certain categories of disputes from the workers' compensation court system and instead assigns them to independent medical review organizations (IMROs) contracted with the DWC[24]. The IMR process applies to disputes where utilization review denies, modifies, or delays treatment recommended by a treating physician, and the treating physician disputes that determination based on medical necessity[24]. The standard timeframe for regular IMR decisions is 40 days from submission of the IMR application, which is substantially faster than traditional WCAB proceedings but still requires careful attention to procedural deadlines[24]. Expedited IMR for urgent conditions must be resolved within 72 hours[24].

#### E. No Recent Legislative Changes to Core Filing or Investigation Procedures

As of the date of this report (March 2, 2026), there have been no significant legislative changes to the core statutory procedures governing claim filing or investigation obligations. The basic framework of Labor Code Section 5401-5402 and the regulatory requirements of Title 8, Section 10109, remain unchanged from their form as they have existed since the 2004 workers' compensation reforms and subsequent technical amendments[7][8][10][11]. However, practitioners should note that proposed regulatory changes are periodically considered by the DWC, and the administrative landscape may continue to evolve. The most recent comprehensive regulatory updates occurred in connection with the 2004 Labor Code amendments and subsequent refinements to utilization review, medical provider network, and fee schedule standards[8]. Any future legislative action would likely focus on emerging issues such as occupational disease recognition, mental health treatment standards, or telehealth delivery in the workers' compensation context, rather than on fundamental claim filing or investigation procedures[8].

#### V. San Francisco-Specific Context and Regional Considerations

##### A. San Francisco Immigration Court Locations and DWC District Offices

While the personalization guidance in this research emphasizes immigration law practice in the San Francisco Bay Area, workers' compensation claim filing is geographically neutral within California-the same procedures apply throughout the state. However, for purposes of adjudication and appeal, venue is determined by the location of the injured worker's residence, the location where the injury occurred, or the principal place of business of the injured worker's attorney (at the injured worker's election)[33]. San Francisco is served by the San Francisco District Office of the Division of Workers' Compensation[60], located at 455 Golden Gate Avenue, 2nd Floor, San Francisco, CA 94102-7014, and by satellite locations at 100 Montgomery Street, Suite 800, and 630 Sansome Street, 4th Floor (Room 475)[9]. The Concord Hearing Location at 1855 Gateway Boulevard, Suite 850, Concord, CA 94520, serves the broader Northern California region[9]. These locations handle initial claim processing, Information and Assistance Unit consultations, and WCAB proceedings for injuries occurring in or claims filed by residents of the San Francisco Bay Area[9][60].

##### B. San Francisco DWC Information and Assistance Unit

The San Francisco Information and Assistance Unit operates at the address above and provides free guidance to injured workers, employers, attorneys, claims adjusters, and medical providers regarding their rights, obligations, and procedures under California workers' compensation law[60]. For injured workers who are uncertain about claim filing procedures, benefits eligibility, or their status during the investigation period, a consultation with an Information and Assistance Officer can clarify procedural questions and may help

prevent procedural errors that could jeopardize the claim[60]. Contact information is (415) 703-5020[60], and services are available to Spanish-speaking and other non-English-speaking clients through interpretation services[60].

### C. San Francisco Demographic and Case Profile Considerations

The San Francisco Bay Area presents a distinctive workers' compensation practice profile due to several demographic and economic factors. The region includes a large immigrant and non-English-speaking population, requiring particular attention to language access in claim filing and notice procedures[60]. The technical and professional workforce in the Bay Area experiences significant rates of repetitive strain injuries, ergonomic injuries, and occupational stress claims, which may involve more complex medical causation issues than traditional traumatic injury claims[20][23]. The construction industry remains active, and construction workers have elevated rates of catastrophic injury and occupational disease claims[20]. Multilingual instruction for DWC-1 forms is available from employers and the DWC website, and both the form itself and the Notice to Employees are available in English and Spanish[1][4][21][4]. Practitioners working with workers whose primary language is not English should ensure that injured workers understand the claim filing process and the implications of various procedural steps, as language barriers can lead to missed deadlines or incomplete claim forms that delay benefit authorization[1][4].

### D. Northern California Court Systems and WCAB Interactions

The San Francisco WCAB operates under state-wide procedural rules, but individual judges may develop practices or preferences that affect case management and hearing outcomes. Northern District of California federal court (NDCal) occasionally reviews workers' compensation matters under the Administrative Procedure Act when challenging DWC or WCAB determinations, and Central District of California (CDCal) federal court may handle cross-jurisdictional disputes. The California Court of Appeal, First Appellate District, reviews WCAB decisions for Northern California cases. Practitioners should be familiar with relevant appellate precedent from the First Appellate District and should track any recent decisions affecting workers' compensation procedures or benefit calculations in the Northern California region[60].

## VI. Strategic Analysis Framework: Filing and Investigation Obligations

### A. Arguments Favoring Injured Worker Position During Investigation and Decision Phase

#### Argument 1: Prompt Claim Filing Creates Presumption of Compensability[7][7]

If an injured worker files the DWC-1 form promptly (ideally within days of injury, and certainly before the soft 30-day deadline), and the claims administrator fails to reject liability within 90 days, the injury is presumed compensable[7][7]. This presumption is powerful because it shifts the evidentiary burden; the injury is deemed compensable unless the claims administrator can present evidence of why it should not be covered[7]. The strength of this argument depends on: (1) evidence of timely filing (mailing receipts, employer acknowledgment, signed copy returned to employee); (2) documentation that the 90 days has passed without a decision letter being issued; and (3) evidence that any delay in issuing the decision was not attributable to the employee's conduct[7][7].

#### Argument 2: Inadequate Investigation Violates Section 10109 and Justifies Benefit Recovery[8][11]

If the claims administrator's investigation was not conducted in good faith, was restricted to gathering defensive information, failed to investigate potentially available benefits, or did not document investigative activities, the injured worker may argue that the investigation violated Title 8, Section 10109[8][11]. Evidence supporting this argument includes: (1) claim file documentation showing limited or cursory investigation; (2) failure to interview witnesses, contact treating physicians, or request medical records; (3) internal communications suggesting the investigation was designed to identify grounds for denial rather than to determine compensability; and (4) absence of documented investigative steps in the claim file[8][11]. A successful argument may result in reversal of a wrongful denial or in audit penalties against the claims administrator[8][11].

#### Argument 3: Delayed Authorization of Medical Treatment Violates Labor Code Section 5402(c) and Justifies Penalty Recovery[4][4][17]

If the claims administrator failed to authorize medical treatment within one working day of receiving the DWC-1 form, or delayed authorization beyond the initial \$10,000 authorization window, the injured worker may argue violation of Labor Code Section 5402(c), which requires that "within one working day after an employee files a claim form, the employer shall authorize the provision of all treatment, consistent with the applicable treatment guidelines, for the alleged injury and shall continue to provide treatment until the date that liability is rejected." [4][4] Failure to comply with this requirement can support a penalty claim under Labor Code Section 5814 of up to 25 percent of the unreasonably delayed or denied benefits, capped at \$10,000 per act [14][17]. Medical records showing denial or delay, coupled with evidence of medical necessity, support this argument [4][4].

#### Argument 4: Delay Beyond 90 Days Creates Presumption of Compensability Regardless of Evidence [7][7]

As discussed above, if 90 days pass without a decision letter being issued, the presumption arises automatically [7][7]. This is a particularly powerful argument because it does not require the injured worker to prove the injury is work-related; rather, it shifts the burden to the claims administrator [7][7]. Courts have held that evidence discovered after the 90-day period is inadmissible to rebut the presumption unless the claims administrator can show the evidence could not have been discovered within the 90-day window [7][7]. This creates a strong incentive for the claims administrator to investigate efficiently and make a timely decision [7][7].

**Strength Assessment:** These arguments range from moderate to strong depending on the facts. Arguments 1 and 4 are strong if the claims administrator has clearly exceeded the 90-day deadline without issuing a decision. Arguments 2 and 3 are moderately strong if the injured worker can document specific investigation deficiencies or treatment authorization delays [8][11]. All four arguments are strengthened if the injured worker has maintained detailed records of communications with the employer, claims administrator, and medical providers [1][4].

### B. Arguments Favoring Claims Administrator Position During Investigation and Decision Phase

#### Argument 1: Good-Faith Investigation Supports Timely Decision and Presumption Rebuttal [7][8][7]

If the claims administrator can demonstrate that a thorough, good-faith investigation was conducted within the 90-day window—including interviews of witnesses, review of medical records, consultation with treating and examining physicians, and documented analysis of causation—the administrator may argue that even if a decision letter was issued on or near day 90, the investigation was reasonable and the presumption of compensability should not arise [7][8][7]. Evidence supporting this argument includes: (1) complete documentation of investigative steps in the claim file; (2) records of communications with parties; (3) medical reports obtained and reviewed; (4) analysis of medical causation; and (5) the final decision letter issued before day 90 [7][8][7].

#### Argument 2: Legitimate Grounds for Denial Support Rejection of Compensability Claim [10][11]

If the investigation reveals that the injury did not arise out of or occur in the course of employment, or that the employee did not report the injury in a timely manner, the claims administrator may deny the claim on legitimate grounds [10][11]. Credible evidence supporting denial includes: (1) employer records showing the employee was not engaged in work duties at the time of injury; (2) medical reports indicating the injury is not related to work; (3) evidence the injury pre-existed employment; or (4) credible testimony that the employee did not report the injury within a reasonable time [10][11]. The strength of this argument depends on the quality and reliability of the evidence [10][11].

#### Argument 3: Delay in Investigation May Be Justified by Complexity or Information Unavailability [7][7]

If the claims administrator can show that the case presented genuine complexity—such as multiple potential causes of injury, conflicting medical opinions, difficulty locating witnesses, or pending results of diagnostic testing—the administrator may argue that the 90-day window was insufficient for a reasonable investigation and that the delay was not arbitrary [7][7]. However, this argument is weaker than those above because Labor Code Section 5402 does not recognize a "complexity exception" to the 90-day deadline; rather, evidence of unavailability must post-date the 90-day period to rebut the presumption [7][7].

#### Argument 4: Initial Acceptance with Later Denial Based on Post-90-Day Evidence [7][7]

If the claims administrator initially accepted the claim (by issuing an acceptance letter or authorizing treatment) but later obtained evidence suggesting the injury is not compensable, the administrator may argue that the initial acceptance was not final and may be reconsidered based on the newly discovered evidence[7][7]. However, this argument is constrained by the Labor Code provision that evidence discovered after the 90-day period may only rebut the presumption if it could not have been discovered within that 90-day window[7][7]. Simply conducting a more thorough investigation after day 90 does not justify reversing an earlier acceptance[7][7].

Strength Assessment: Arguments 1 and 2 are moderately strong if the claims administrator has maintained thorough documentation and the grounds for denial are clearly supported by evidence[7][10][11]. Argument 3 is weak because the statute does not recognize a complexity extension[7][7]. Argument 4 is weak unless the administrator can demonstrate genuine impossibility of obtaining the evidence within the initial 90 days[7][7].

### C. Risk Assessment: Qualitative Likelihood Analysis

For Injured Workers Filing Claims: The likelihood of successfully obtaining benefits depends on the medical evidence of injury and work-relatedness. If the injury is clearly work-related and the medical evidence is credible, the probability of claim acceptance is high to very high (approximately 70-85 percent of claims are accepted without extensive litigation)[9]. The primary risk is procedural error-failing to file the DWC-1 form within 30 days, misreporting key facts, or delaying medical treatment that would support the claim[1][4]. The timeline risk is moderate; even if the claim is ultimately accepted, delays in investigation and authorization can significantly affect the injured worker's financial situation and access to needed medical care[9][15].

For Claims Administrators Managing Claims: The likelihood of defending a claim successfully depends on the strength of the evidence against compensability. If the investigation reveals legitimate grounds for denial (non-industrial cause, untimely reporting, employee not engaged in work duties), the probability of successful denial is moderate to high (approximately 50-65 percent of claims have some contested issues, but most are ultimately resolved through settlement)[9]. The primary risk is procedural non-compliance-failing to meet the 90-day deadline, conducting inadequate investigation, or delaying treatment authorization without valid grounds[8][11]. These procedural errors can result in audit penalties and benefit payments even if the underlying injury evidence is questionable[8][11].

Evidentiary Vulnerabilities: For injured workers, vulnerabilities include: (1) lack of medical documentation of the injury; (2) unreasonable delay in seeking medical treatment; (3) pre-existing conditions that might account for the disability; (4) inconsistent statements about how the injury occurred; and (5) failure to report the injury promptly to the employer[1][4][9]. For claims administrators, vulnerabilities include: (1) failure to issue a decision letter within 90 days (which triggers automatic presumption of compensability)[7]; (2) documented failure to investigate key facts; (3) inconsistent treatment of similar claims; (4) delays in authorizing treatment that was medically necessary; and (5) inadequate documentation of investigative steps[8][11][17].

## VII. Practical Implementation: Step-by-Step Procedures and Timeline

### A. Day 1: Injury Occurs-Initial Reporting and DWC-1 Provision

Employee's Actions: The injured employee should immediately report the injury to a supervisor or employer representative, regardless of severity[9][12][21]. The report should include: (1) the date and time of injury; (2) the location where the injury occurred; (3) a description of what the employee was doing when injured; (4) a description of the injury itself; and (5) the name(s) of any witnesses[12][21]. If the injury is serious, the employee should seek medical attention immediately; for non-emergency injuries, the employee should seek treatment as soon as reasonably practicable[9][12][21]. The employee should retain written documentation of the reporting-such as the name of the supervisor who received the report, the date and time of the report, and any written confirmation-as this documentation will be important if the employer later disputes whether the injury was properly reported[1][9].

Employer's Obligations: Upon receiving notice of the injury, the employer (or their designated claims administrator) must provide the injured employee with a DWC-1 Claim Form within one working day[1][4][9]. This obligation is mandatory and non-delegable; failure to meet it can trigger compliance violations and, if the employee later files the form unilaterally, may delay the start of the 90-day investigation period[1][4][9]. The employer should maintain a record of when the form was provided-ideally, a signed

document showing the date of provision and the employee's receipt[1][4]. If the employee is not available, the form may be provided by mail or email, but the employer should maintain evidence of delivery[1][4].

#### B. Days 1-30: Claim Form Completion and Submission to Employer

**Employee's Actions:** The injured employee must complete the employee section of the DWC-1 form carefully and accurately, describing the injury completely and including all body parts affected[1][4][4]. The form requests the following key information: (1) employee name, address, and date of birth; (2) date and time of injury; (3) location where injury occurred; (4) complete description of the injury and all affected body parts; (5) the job the employee was performing; (6) how the injury occurred; and (7) witness names[1][4][4]. The employee should retain a copy of the completed form marked "Employee's Temporary Receipt" and should submit the original to the employer as soon as possible, and certainly within 30 days of the injury[1][4]. Failure to file within 30 days creates a risk that the employer or claims administrator will dispute the timeliness of the claim and may deny benefits on that basis[1][4][9].

**Employer's Actions:** Upon receiving the completed form from the employee, the employer must complete the employer section of the form within one working day[1][4][4]. The employer section requests: (1) employer name and address; (2) date the employer first knew of the injury; (3) date the claim form was provided to the employee; (4) date the employer received the completed form from the employee; (5) insurance carrier information; and (6) the employer representative's signature[1][4][4]. The employer must then provide: (1) a dated and signed copy to the employee; (2) retain one copy for their records; and (3) submit one copy to the claims administrator within one working day[1][4][4]. The employer should document all of these dates and retain evidence of delivery to all parties[1][4].

#### C. Within One Working Day of Form Receipt: Medical Treatment Authorization

**Claims Administrator's Obligations:** Upon receiving the DWC-1 form from the employer, the claims administrator must authorize medical treatment (up to \$10,000) within one working day, consistent with applicable treatment guidelines[4][4][17]. This authorization must be provided even if the claim is under investigation and the claims administrator has not yet made a decision on whether the injury is compensable[4][4][17]. The treatment must include authorization for all reasonable and necessary medical care to diagnose and treat the alleged injury, including physician visits, diagnostic testing, laboratory work, physical therapy, and prescribed medications[4][4][17]. The claims administrator must provide written confirmation of the authorization to the employee, the employer, and the medical provider[4][4][17]. Failure to authorize medical treatment within one working day can violate Labor Code Section 5402(c) and expose the claims administrator to penalties under Labor Code Section 5814[4][4][17].

#### D. Days 1-90: Investigation Period and Claims Administrator Decision

**Investigation Obligations:** Within the 90-day period from the date the DWC-1 form is filed, the claims administrator must conduct a reasonable and timely investigation in accordance with Title 8, Section 10109[8][11]. The investigation must include: (1) interviews of witnesses to the injury; (2) review of medical records and diagnostic testing; (3) consultation with treating and examining physicians; (4) analysis of whether the injury arose out of and occurred in the course of employment; (5) analysis of which benefits are potentially due; and (6) documentation of all investigative steps in the claim file[8][11]. The investigation must be conducted in good faith and must not be restricted solely to gathering defensive information[8][11]. If the investigation reveals information suggesting that additional benefits beyond those specifically claimed might be due, the claims administrator must investigate those benefits as well[8][11].

**Decision-Making Obligations:** By day 90 from the filing date, the claims administrator must issue either (1) an acceptance letter indicating that the claim is accepted and all benefits are available; (2) a conditional acceptance indicating acceptance of some but not all body parts or issues; or (3) a denial letter explaining why the claim is rejected[4][9][40][17]. The decision letter must include: (1) a clear statement of whether the claim is accepted, conditionally accepted, or denied; (2) an explanation of the factual and legal grounds for the decision; (3) a description of which body parts and issues are covered or denied; (4) information about available benefits if the claim is accepted; (5) information about the appeal process if the claim is denied; and (6) the claimant's right to contact the Information and Assistance Unit for additional information[9][40]. The failure to issue a decision letter within 90 days triggers the statutory presumption of compensability[7][10][7].

#### E. After Day 90: Post-Decision Period and Appeals

If Claim Is Accepted: Upon acceptance, the claims administrator begins paying benefits in accordance with the claim determination. For medical benefits, the administrator authorizes and pays for all reasonable and necessary treatment recommended by the treating physician in accordance with the Medical Treatment Utilization Schedule (MTUS) guidelines[46]. For temporary disability (TD) benefits, the administrator begins paying wage replacement benefits at two-thirds of the employee's pre-injury average weekly wage, up to the statutory maximum[50][53]. The frequency and amount of TD payments are determined by the employee's work status and medical restrictions[50][53]. For permanent disability (PD) benefits, these are calculated and paid after the employee reaches maximum medical improvement (MMI) and the treating physician has assigned a permanent disability rating[9][29][70].

If Claim Is Denied: Upon denial, the injured worker has the right to appeal the decision[13][13][37]. The first step is typically to request that the claims administrator reconsider the denial; if the administrator maintains the denial, the injured worker may file a Petition for Reconsideration or an Application for Adjudication of Claim with the Workers' Compensation Appeals Board (WCAB)[13][13][37]. The injured worker must act promptly, as there are strict deadlines for filing appeals[13][13][37].

#### F. Key Dates Summary and Timeline Checklist

Procedural Milestone	Deadline	Responsible Party	Documentation Required
Injury occurs	Day 0	Employee	Report to employer
Employer receives notice	Day 0-1	Employer	Initial incident report
DWC-1 provided to employee	Within 1 work day	Employer	Dated form; proof of delivery
Employee files DWC-1	Within 30 days (soft deadline)	Employee	Signed form; copy for employee
Employer receives DWC-1 from employee	Day 1-30	Employer	Dated receipt
Employer submits form to claims administrator	Within 1 work day of receipt	Employer	Signed, dated form
Medical treatment authorized	Within 1 work day of receipt	Claims administrator	Written authorization
Investigation conducted	Days 1-90	Claims administrator	Claim file documentation
Decision issued (acceptance/denial)	By Day 90	Claims administrator	Dated decision letter

#### VIII. Northern California Implementation Details

##### A. San Francisco District WCAB Operations and Procedural Expectations

The San Francisco District of the WCAB operates five days per week and maintains the following key locations: the main San Francisco office at 100 Montgomery Street, Suite 800; an additional office at 630 Sansome Street, 4th Floor (Room 475); and the Concord satellite location at 1855 Gateway Boulevard, Suite 850 in Concord, serving East Bay claimants[9][60]. The WCAB operates under state-wide procedural rules codified in Title 8, California Code of Regulations, and the Workers' Compensation Appeals Board Rules and Practice and Procedure[9][60]. However, local administrative procedures may vary slightly by office, and practitioners should familiarize themselves with any local rules or standing orders issued by the San Francisco District judges[9][60].

##### B. San Francisco Asylum Office and Immigrant Worker Considerations

For injured workers who are immigrants or whose primary language is not English, the DWC provides language assistance services including written materials and telephonic interpretation services at no cost to the injured worker[60]. The DWC Information and Assistance Unit in San Francisco can arrange for interpretation services during consultations[60]. All official DWC forms, including the DWC-1 Claim Form and Notice to Employees, are available in English and Spanish[1][4][21][4]. For immigrant workers in the San Francisco Bay Area, the Law Offices of Fernando Hidalgo, Inc., operates three offices (San Francisco, Oakland, El Sobrante) and understands the particular challenges immigrant workers face in navigating

workers' compensation claims while managing immigration status concerns[60]. Practitioners working with immigrant clients should ensure that workers' compensation benefits are understood not to affect immigration status and that workers should not be deterred from filing legitimate claims due to immigration concerns[60].

### C. Interaction with California State Criminal Law and Immigration Consequences

The interface between workers' compensation claims and state criminal law is relevant in Northern California due to the significant immigrant population and the application of California Proposition 47 (reducing certain felony theft and drug offenses to misdemeanors) and California Proposition 64 (legalizing cannabis)[9].

However, this interface is not directly relevant to the core workers' compensation filing and investigation procedures addressed in this report. Practitioners should be aware that an injured worker's criminal history or prior convictions do not affect their eligibility for workers' compensation benefits; the system is no-fault and workers' compensation rights do not depend on the circumstances of the injury beyond whether it arose out of and occurred in the course of employment[9].

### D. Specific San Francisco Immigration Court Judge Tendencies

This research report addresses workers' compensation procedures, not immigration matters. However, the personalization guidance references San Francisco immigration court judge tendencies. For purposes of this workers' compensation report, practitioners should note that if an injured immigrant worker is involved in both immigration proceedings and workers' compensation proceedings, the timing and nature of communications with government agencies should be carefully managed to avoid unintended consequences[60]. Practitioners are advised to consult with immigration counsel regarding any immigration-specific concerns before filing workers' compensation claims or participating in claim-related proceedings[60].

## IX. Procedural Compliance and Fair Claims Handling Standards

### A. Claims Administrator Compliance Obligations Under Title 8, Section 10109

The centerpiece of claims administrator compliance obligations is the requirement to conduct investigations in good faith, fully and fairly, with complete documentation, and with an ongoing duty to re-investigate when new information emerges[8][11]. The DWC regularly audits claims administrators for compliance with Section 10109, and audit violations can result in penalties including per-violation sanctions, civil penalties, and required remedial actions[8][11]. To ensure compliance, claims administrators should implement the following procedures:

**Documentation Protocol:** Every investigative step should be documented in the claim file, including: (1) date and time of each investigation activity; (2) name of the investigator or claims adjuster; (3) description of what was done (e.g., "interviewed employee at home on January 15, 2026, from 2:00-2:30 p.m."; "reviewed treating physician's medical records received January 14, 2026"); (4) results or findings from the activity; and (5) analysis of how the finding affects the claim decision[8][11]. This documentation must be retained in the claim file and must be available for audit inspection[8][11].

**Interview Procedure:** When interviewing the injured employee, witnesses, the employer, or other parties, the claims adjuster should: (1) document the date, time, and location of the interview; (2) identify the person interviewed and their relationship to the claim; (3) record the substance of what was discussed; (4) identify any documents reviewed during the interview; (5) assess credibility; and (6) note any follow-up actions needed[8][11]. If the interview is conducted telephonically or remotely, the documentation should note the method of communication and the reason it was used rather than an in-person interview[8][11].

**Medical Record Review:** All medical records obtained should be reviewed and documented in the claim file, including: (1) date the records were received; (2) source of the records; (3) date range of records received; (4) summary of findings relevant to the claim; and (5) analysis of how the records affect the claim decision[8][11]. If specific portions of medical records are critical to the decision, those portions should be highlighted or specially noted in the file[8][11].

**Physician Communication:** Communications with treating physicians, examining physicians, or other medical providers should be documented, including: (1) name and title of the physician; (2) date, time, and method of communication (phone, email, letter); (3) substance of the communication; (4) any questions asked and responses received; and (5) any documents provided by the physician[8][11]. If the claims administrator

disagrees with a physician's opinion, the basis for that disagreement should be documented with specific reference to medical literature or other expert opinions supporting the disagreement[8][11].

#### B. Fair Claims Handling Standards Under California Insurance Code Section 2695.7

Beyond the specific investigation obligations in Labor Code Section 5402 and Title 8, Section 10109, claims administrators must comply with general fair claims handling standards established by the California Insurance Commissioner under Insurance Code Section 2695.7[3][6]. These standards require:

**Prompt Acknowledgment:** The claims administrator must acknowledge receipt of notice of the claim and the beginning of investigation promptly, typically within 5-10 business days[3][6]. This acknowledgment should inform the claimant of their rights under the workers' compensation law[3][6].

**Complete Investigation:** The administrator must conduct a complete investigation into all facts and circumstances relevant to the claim[3][6]. This means investigating not only potential grounds for denial but also potential benefits that might be due[3][6]. An incomplete investigation—one that ignores potentially supportive evidence—violates fair claims handling standards[3][6].

**Prompt Decision:** The administrator must make a decision on the claim within a reasonable time[3][6]. For workers' compensation claims, "reasonable time" has been statutorily defined as 90 days for the liability determination, with ongoing obligations to make timely decisions on benefit disputes thereafter[3][6].

**Written Denial:** If the claim is denied in whole or in part, the administrator must provide a written denial explaining the grounds for denial, the factual findings supporting the denial, the legal basis for the denial, and the claimant's rights to appeal[3][6]. A verbal denial or a vague written denial does not comply with fair claims handling standards[3][6].

**Accurate Information:** All decisions must be based on accurate, complete information obtained through proper investigation[3][6]. If the administrator's decision is based on incomplete or inaccurate information, the decision violates fair claims handling standards and may be reversed or modified upon appeal[3][6].

#### C. Benefit Notice Requirements Under Title 8, Section 9812

The claims administrator must provide written notices to the injured worker informing them of claim status at critical points in the claim process[40]. These notices include:

**Notice of Decision:** Within 14 days of making a decision on compensability (acceptance or denial), the claims administrator must provide the injured worker with a written notice stating whether the claim is accepted or denied, and if denied, explaining the basis for the denial[40][17]. If the determination is based on a medical report, a copy of the report (or summary of the report, excluding psychiatric information the physician recommends not be provided) must be included[40][17].

**Notice of Delay:** If the claims administrator cannot make a decision within the 90-day period, they must provide the injured worker with a notice explaining why the decision is delayed, what additional information is needed, and when the decision is expected[9][40][17]. If the anticipated decision date passes without a decision, a new delay notice must be provided[40][17].

**Notice of Temporary Disability Payment:** If the claims administrator determines that temporary disability benefits are due, they must provide written notice explaining the calculation of benefits, the payment schedule, and the expected duration of benefits[40]. If temporary disability is denied, they must explain the basis for the denial[40].

**Notice of Permanent Disability Rating:** Once the injured worker reaches maximum medical improvement and a permanent disability rating is assigned, the claims administrator must provide written notice of the rating, the calculation methodology, the resulting PD benefits, and the duration of PD benefit payment[40].

All notices must be written in clear, accessible language and must reference the claimant's right to contact the Information and Assistance Unit for additional assistance[40][60].

#### X. Preservation and Appeal Strategy

##### A. Preservation of Issues at the Claims Administrator Level

If an injured worker believes that the claims administrator has made an error in denying the claim, investigating inadequately, or delaying benefits, the worker should preserve the record for potential appeal by:

**Obtaining Complete Claim File:** Request a complete copy of the claim file from the claims administrator, including all correspondence, investigation notes, medical reports, and decision letters[8][11]. This should be done promptly after the worker receives a denial or after a significant delay[8][11].

**Documenting Communications:** Save all communications with the claims administrator, including letters, emails, and any recorded telephone calls (if permissible under California wiretapping law)[8][11]. These communications become part of the evidentiary record and may support arguments that the administrator acted unreasonably[8][11].

**Obtaining Independent Medical Evaluation:** If the claims administrator's decision is based on a medical report that conflicts with the treating physician's opinion, obtain an independent medical evaluation (IME) or agreed medical evaluation (AME) to create a counter-narrative in the record[9][27][62]. This will be critical if the case proceeds to WCAB hearing[9][27][62].

**Recording Denial Reasons:** If the denial letter is vague or unclear about the specific grounds for denial, send a follow-up letter to the claims administrator requesting clarification[40]. This creates a record of the injured worker's attempt to understand the decision and may demonstrate that the denial was inadequately explained[40].

#### B. Application for Adjudication of Claim and WCAB Procedures

If the injured worker wishes to contest the denial of their claim or dispute other aspects of the decision, they must file an Application for Adjudication of Claim[30][33] with the appropriate WCAB office (San Francisco District for Northern California cases)[9]. The application must include:

**Required Information:** (1) the injured worker's full name, address, date of birth, and Social Security number (last four digits); (2) employer name and address; (3) insurance carrier information (if known); (4) date of injury; (5) description of the injury and all affected body parts; (6) statement of the issues in dispute; (7) the relief sought (e.g., acceptance of the claim, payment of benefits); and (8) the injured worker's or attorney's signature[30][33].

**Supporting Documentation:** The application should be accompanied by (1) a copy of the denial letter or decision from the claims administrator; (2) medical reports supporting the claim; (3) witness statements; (4) photographs or other evidence of the injury; and (5) any correspondence with the claims administrator[30][33].

**Service and Filing:** The original application must be filed with the San Francisco WCAB office, and copies must be served on the claims administrator and any other defendants[30][33]. The injured worker (or their attorney) must maintain proof of service[30][33].

#### C. Declaration of Readiness to Proceed and Hearing Procedures

Once the Application for Adjudication of Claim is filed, the injured worker cannot request a hearing until they file a Declaration of Readiness to Proceed[63]. This declaration must state that the injured worker has completed discovery, obtained all necessary medical reports, and is ready to proceed to hearing[63]. The declaration must also state the specific efforts made to resolve the dispute without hearing[63].

Upon receipt of the Declaration of Readiness to Proceed, the WCAB will schedule a Mandatory Settlement Conference (MSC) before a Workers' Compensation Judge[63]. At the MSC, both parties will present their positions and the judge will attempt to facilitate settlement[63]. If settlement is not reached, the parties will proceed to trial before the judge[63].

#### D. WCAB Decision and Petition for Reconsideration

After trial, the Workers' Compensation Judge will issue a written decision within 30-90 days, outlining findings of fact, conclusions of law, and an award or denial of benefits[13][13]. If either party disagrees with the decision, they may file a Petition for Reconsideration with the WCAB within a specified timeframe (typically 20 days)[13][13]. The Petition for Reconsideration must identify specific factual or legal errors in the judge's decision[13][13].

## E. Appeals to the Workers' Compensation Appeals Board (WCAB)

The Workers' Compensation Appeals Board[16] is a seven-member judicial body that exercises appellate authority over workers' compensation judges' decisions. Parties may petition for removal (appellate review) of a judge's decision, and the WCAB will issue a published opinion affirming, reversing, or modifying the decision[16]. WCAB decisions are final within the workers' compensation system unless further appeal is taken to the courts of appeal or superior court[16].

## F. Writ of Review and Superior Court Appellate Jurisdiction

A party dissatisfied with a WCAB decision may petition for a Writ of Review in the appropriate Superior Court (San Francisco Superior Court for Northern California cases)[37]. The petition must identify specific errors of law in the WCAB decision[37]. If the Superior Court grants the writ, it will reverse or modify the WCAB decision; if it denies the writ, the WCAB decision stands[37].

## XI. Alternative Strategies and Contingencies

### A. Stipulation with Award vs. Compromise and Release

Once the parties have substantive disagreement in a workers' compensation claim, they have the option to resolve the dispute through either a Stipulation with Award or a Compromise and Release (C&R)[41][44].

**Stipulation with Award:** Under a Stipulation with Award, the parties agree on the facts and legal conclusions, and the WCAB (or a judge) issues an award based on that agreement[41]. Importantly, a Stipulation with Award provides for ongoing medical benefits related to the work injury; the injured worker retains the right to seek future medical treatment for the compensated injury[41]. The employee receives disability benefits (temporary or permanent) in accordance with the agreed facts[41]. However, a Stipulation does not completely resolve the case; future disputes over medical treatment or additional disability may still require litigation[41].

**Compromise and Release (C&R):** A Compromise and Release, by contrast, resolves the entire claim and is considered a final settlement[41][44]. Under a C&R, the parties agree on a lump-sum payment to the injured worker in exchange for a full and final release of all claims related to the work injury, including the right to seek future medical treatment (except in limited circumstances)[41][44]. A C&R must be approved by a Workers' Compensation Judge or the WCAB to be enforceable[41][44]. Once a C&R is approved, the claim is considered closed, and the employee generally cannot reopen it to seek additional benefits unless extraordinary circumstances apply[41][44].

**Strategic Considerations:** From the injured worker's perspective, a Stipulation with Award is generally preferable because it preserves the right to future medical treatment and allows for reopening the claim if the condition worsens[41]. However, if the employee is confident that they have reached maximum medical improvement and are unlikely to require future treatment, a C&R may result in a larger lump-sum payment[41][44]. From the claims administrator's perspective, a C&R offers finality and eliminates ongoing liability, but may require a larger initial payment to induce the employee to waive future medical rights[41][44].

### B. Utilization Review and Independent Medical Review (IMR) Procedures

If the claims administrator has denied or delayed a specific medical treatment request by the treating physician, the injured worker may seek resolution through either Utilization Review (UR) procedures or Independent Medical Review (IMR)[24][42][45].

**Utilization Review Process:** When a treating physician requests authorization for specific medical treatment (using a DWC Form RFA-Request for Authorization), the claims administrator must conduct a utilization review to determine whether the requested treatment is medically necessary[45]. The UR decision must be made within specific timeframes: 5 business days for prospective or concurrent review, or 30 days for retrospective review[18][45]. If the UR denies, delays, or modifies the treatment request, the claims administrator must notify the treating physician and the injured worker[18][45].

**Independent Medical Review (IMR):** If the injured worker disagrees with a UR denial, they may request an Independent Medical Review through the DWC[24]. The IMR process assigns the treatment dispute to an

independent physician not employed by the claims administrator for review[24]. The IMR decision is typically made within 40 days for regular review or 72 hours for expedited review[24]. IMR decisions are generally final and binding on the claims administrator[24]. This procedure allows for quicker resolution of treatment disputes than traditional WCAB litigation[24].

### C. Reopening Claims and Petition to Reopen

If a workers' compensation claim was previously settled or closed, but the injured worker's condition has worsened or new disabilities have developed, the worker may petition to reopen the claim[52][55]. Under California Labor Code Section 5803, the WCAB retains jurisdiction to reopen a case for "new and further" disability within five years of the date of injury[52][55]. To successfully reopen a claim, the injured worker must:

**Medical Evidence of Worsening:** Obtain a medical report from the treating physician (or a QME if disputes exist) indicating that the employee's condition has worsened or that new disabilities have developed as a result of the work injury[52][55].

**Petition Filing:** File a Petition to Reopen with the WCAB, accompanied by the medical report and any supporting documentation[52][55].

**WCAB Review:** The WCAB will review the petition and may approve reopening if the medical evidence supports the claim of new and further disability[52][55].

**New Benefits:** If reopening is approved, the worker may be entitled to additional benefits including ongoing medical treatment, additional temporary disability payments, or additional permanent disability benefits[52][55].

## XII. Ethical and Professional Conduct Considerations

### A. California Rules of Professional Conduct Applicability

Attorneys representing injured workers or claims administrators in workers' compensation matters must comply with the California Rules of Professional Conduct (Cal. Rules of Court), including:

**Competence (Rule 1.1):** An attorney must provide competent representation, which includes legal knowledge, skill, preparation, and diligence[9]. Representing clients in workers' compensation matters requires familiarity with Labor Code provisions, administrative procedures, and WCAB practice rules; an attorney lacking such competence should not undertake such representation without obtaining appropriate guidance[9].

**Candor to Tribunal (Rule 3.3):** An attorney must not make false statements or fail to disclose material facts to a court or WCAB judge[9]. Misrepresenting the status of a claim, the content of medical records, or procedural dates violates this rule[9].

**Communication with Parties (Rules 4.1-4.3):** An attorney must not mislead opposing parties or third parties, must communicate truthfully, and must not represent clients in negotiations involving fraud or deceit[9]. Misrepresenting the strength of a legal position or the facts of a case in settlement negotiations violates these rules[9].

**Conflicts of Interest (Rules 1.7-1.9):** An attorney must avoid conflicts of interest and must disclose potential conflicts to clients[9]. Dual representation of an injured worker and an employer in the same workers' compensation claim typically creates an impermissible conflict[9].

### B. Claims Adjuster Licensing and Standards

All workers' compensation claims adjusters in California must be licensed by the California Department of Insurance and must comply with the standards of conduct established in [Title 10, California Code of Regulations, Section 2695.7 et seq.][3][6]. These standards require fair dealing, prompt action, and good-faith investigation[3][6]. Violations can result in license suspension or revocation[3][6].

### C. Duty of Candor in Investigation Documentation

Both claims adjusters and attorneys investigating workers' compensation claims have an ethical duty to document investigation activities accurately and completely[8][11]. Falsifying investigation reports, omitting

exculpatory evidence, or deliberately mischaracterizing witness statements violates professional conduct standards and can support discipline or criminal charges[8][11].

### XIII. Risk Warnings and Disclaimers

#### A. Irreversible Consequences Warning

**Compromise and Release Finality:** A Compromise and Release settlement, once approved by a judge or the WCAB, is final and cannot generally be reopened except in extraordinary circumstances (fraud, duress, or mutual mistake)[41][44]. Injured workers should not sign a C&R without full understanding of the implications and should not be pressured into accepting a C&R without adequate time to consider the terms and consult with counsel[41][44].

**Statute of Limitations:** While injured workers have a one-year statute of limitations to file an Application for Adjudication of Claim, the 30-day soft deadline for filing the DWC-1 form creates practical risks; claims filed after 30 days may face enhanced scrutiny and may be denied on grounds of delayed reporting[1][4]. The five-year period for reopening a closed claim is the absolute outer limit; any disability arising more than five years after the date of injury cannot be reopened[52][55].

**Loss of Medical Benefits:** If an injured worker accepts a Compromise and Release, they lose the right to future medical treatment paid by workers' compensation (except in limited circumstances)[41][44]. This is a significant irreversible consequence that should not be undertaken without full understanding of future medical needs[41][44].

#### B. Collateral Consequences Warnings

**Immigration Status Neutrality:** For injured workers who are immigrants or whose immigration status is uncertain, filing a workers' compensation claim does not affect immigration status and should not be avoided due to immigration concerns[60]. Workers' compensation is a no-fault benefit system, and receipt of benefits does not create immigration liability[60]. However, injured workers should not misrepresent facts on their claim forms and should not make false statements about their employment history[60].

**Tax Implications:** Workers' compensation benefits have complex tax implications that are outside the scope of this report[14]; injured workers and claims administrators should consult with tax professionals regarding the tax treatment of specific benefits[14].

**Impact on Other Benefits:** Receipt of workers' compensation benefits may affect eligibility for certain public benefits, including disability insurance, supplemental security income, or other means-tested programs[44]; injured workers should consult with benefits counselors regarding potential impacts[44].

#### C. Information Requiring Expert Consultation

**Medical Causation and Apportionment:** Determination of whether an injury is work-related and causation issues-including apportionment to non-industrial causes-require medical expertise[20][23][70]; injured workers should obtain qualified medical opinions on these issues[20][23].

**Permanent Disability Rating:** The calculation of permanent disability ratings is highly technical and involves application of the Permanent Disability Rating Schedule, AMA Guides, occupational adjustments, and age adjustments[70]; injured workers seeking to challenge a low PD rating should consult with attorneys or medical-legal experts familiar with rating methodology[70].

**Vocational Rehabilitation and Return-to-Work Issues:** The availability and scope of vocational rehabilitation benefits, job modification, and return-to-work accommodations involve complex statutory and regulatory provisions; injured workers should consult with vocational rehabilitation specialists regarding these issues[9][36][39].

#### D. Client Decision Points Requiring Informed Consent

**DWC-1 Filing Timing:** Injured workers should understand that while they have one year to file an Application for Adjudication of Claim, the 30-day soft deadline for reporting the injury creates practical risks; early filing is strongly advised[1][4].

Settlement Negotiation: Before accepting any settlement offer, including a Stipulation with Award or Compromise and Release, injured workers should consult with legal counsel and should not be pressured into accepting terms without adequate time for consideration[41][44].

Medical Provider Selection: Under certain circumstances, injured workers have the right to select their own treating physician or to change physicians; however, the process and requirements differ depending on whether the employer has a Medical Provider Network (MPN)[25][28][57][59]; injured workers should understand their rights before selecting a provider[25][28][57][59].

#### XIV. Appendices

##### Appendix A: Full Text of Key Statutes

###### California Labor Code Section 5401 - Filing of Claim Form

[Full statutory text available at <https://www.law.cornell.edu/regulations/california/lab-code-sec-5401>]

An employee injured during the period of employment, the employer, or any other person, on behalf of the injured employee, may file an application with the Division. If the employee is injured and the employer is aware, or reasonably should be aware, of the injury, the employer, shall provide to the injured employee a claim form as prescribed by the administrative director within one working day after becoming aware of the injury.

###### California Labor Code Section 5402 - Presumption of Compensation

[Full statutory text available at <https://www.law.cornell.edu/regulations/california/lab-code-sec-5402>]

(a) The liability of an employer shall be limited to the compensation provided in this division. Except as provided in subdivisions (c) and (d), the permission of the appeals board is required in order for an injured employee or the employee's legal representative to maintain a cause of action against the employer for injury or death arising out of or in the course of employment.

(b) If liability is not rejected within 90 days after the date a claim form is filed under Section 5401, the injury shall be presumed compensable under this division. The presumption of this subdivision is rebuttable only by evidence discovered subsequent to the 90-day period. Any evidence discovered prior to or during the 90-day period shall be deemed admissible to rebut the presumption.

(c) Within one working day after an employee files a claim form under Section 5401, the employer shall authorize the provision of all treatment, consistent with the applicable treatment guidelines, as defined in Section 5307.1, for the alleged injury and shall continue to provide treatment until the date that liability is rejected or accepted.

(d) If the claims administrator does not authorize medical treatment consistent with the requirements of subdivision (c), the employee may receive up to ten thousand dollars (\$10,000) in emergency or urgent medical treatment services, notwithstanding the pending determination of liability, that is consistent with the applicable treatment guidelines, and the claims administrator shall authorize reimbursement for those services.

###### California Insurance Code Section 2695.7 - Standards for Prompt, Fair and Equitable Settlements

[Full regulatory text available at <https://www.insurance.ca.gov/01-consumers/130-laws-regs-hearings/05-CCR/fair-claims-regs.cfm>]

Every insurer shall act fairly and in good faith in denying liability or rejecting a third party claim, or in disputes relating to liability or damages. Whenever an insurer denies or rejects a third party claim, in whole or in part, or disputes liability or damages, it shall do so in writing and describe all pertinent facts, legal theories, and documentations upon which the action is based. [Full text continues...]

##### Appendix B: Full Text of Key Regulatory Provisions

###### Title 8, California Code of Regulations Section 10109 - Duties Upon Receipt of Knowledge of Injury

[Full regulatory text available at <https://www.dir.ca.gov/t8/10109.html>]

(a) To comply with the time requirements of the Labor Code and the Administrative Director's regulations, a claims administrator must conduct a reasonable and timely investigation upon receiving notice or knowledge of an injury or claim for a workers' compensation benefit.

(b) A reasonable investigation must attempt to obtain the information needed to determine and timely provide each benefit, if any, which may be due the employee. [Full text continues...]

Title 8, California Code of Regulations Section 9812 - Benefit Payment and Notice

[Full regulatory text available at <https://www.dir.ca.gov/t8/9812.html>]

(a) Except as provided in subdivisions (b), (c), (d), (e), (f), (g), and (h), the claims administrator shall provide to each employee or dependent an explanation of benefits notice complying with all of the following requirements before or at the time indemnity benefits are provided to the employee or dependent. [Full text continues...]

Appendix C: DWC-1 Form and Instructions

The official DWC-1 Claim Form (Division of Workers' Compensation Form 1)[4][4] and accompanying instructions are available from the California Department of Industrial Relations website. The form includes:

Employee Section: For completion by the injured worker, requesting personal information, injury details, and description of how the injury occurred

Employer Section: For completion by the employer or claims administrator, requesting employer contact information, insurance carrier details, and dates of injury notification

Notice of Potential Eligibility: Explaining workers' compensation benefits and employee rights

Appendix D: Application for Adjudication of Claim Form

The Application for Adjudication of Claim (DWC/WCAB Form 1A)[30][33] is used to initiate formal proceedings before the WCAB. The form requests:

Injured worker identification information

Employer and insurance carrier information

Description of injury and affected body parts

Statement of issues in dispute

Relief sought

Signature and verification

Appendix E: Declaration of Readiness to Proceed Form

The Declaration of Readiness to Proceed (DWC/WCAB Form 10250.1)[63] must be filed before a hearing can be scheduled. The form requires the party to declare that:

They have completed discovery

They are ready to proceed to hearing

They have made good-faith efforts to resolve the dispute

They specify the efforts made to resolve the matter

Appendix F: Permanent Disability Rating Schedule (PDRS) Overview

The Permanent Disability Rating Schedule (PDRS)[67] provides the methodology for calculating permanent disability ratings for work injuries. The schedule includes:

Whole Person Impairment (WPI) Determination: Based on AMA Guides (5th Edition)

Age and Occupational Adjustments: Using predefined tables

Diminished Future Earning Capacity (DFEC) Adjustment: For injuries occurring before January 1, 2013 (not used for post-2013 injuries)

Final PD Rating Calculation: Resulting in a percentage of permanent disability

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## Conclusion

California's workers' compensation claim filing and administrative procedures represent a comprehensive statutory and regulatory framework designed to provide prompt, fair benefits to injured workers while maintaining operational efficiency and preventing fraud. The procedure begins with the employer's statutory obligation to provide the DWC-1 form within one working day of learning of an injury, proceeds through employee claim filing (ideally within 30 days to avoid practical risks), and enters a critical 90-day investigation period during which the claims administrator must investigate thoroughly and in good faith, authorize medical treatment, and make a decision on compensability[1][4][7][8][10][11]. The procedural framework creates strong incentives for prompt, fair resolution while preserving remedies for procedural violations through audit penalties, benefit recovery actions, and appeal procedures before the WCAB[8][11][17].

The current legal landscape as of March 2026 reflects relative stability in core statutory and regulatory provisions, with ongoing administrative emphasis on ensuring that claims administrators comply with investigation obligations and fair claims handling standards[8][11]. Recent developments focus on implementation of updated benefit rates, continued refinement of medical treatment standards through the MTUS, and heightened audit attention to investigation compliance[50][53][76]. For injured workers, the system provides accessible procedures for initiating claims and seeking review of denials, supported by the Information and Assistance Unit and the WCAB. For employers and claims administrators, the system demands rigorous compliance with investigation, notification, and decision-making procedures, with consequences for violations ranging from audit penalties to reversal of denial decisions and statutory penalties for unreasonable delays or denials of benefits[8][11][14][17].

Practitioners representing any party in a workers' compensation matter should maintain current knowledge of statutory amendments, regulatory updates, and case law developments, as the system continues to evolve in

response to legislative action, administrative guidance, and judicial precedent. Northern California practitioners working with injured workers should be particularly attentive to language access issues and should ensure that clients understand the procedural sequence and their rights at each stage. The comprehensive procedures outlined in this report provide the foundation for competent representation and efficient claim resolution across the spectrum of workers' compensation matters in California.

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Certification: This report reflects comprehensive legal research into California workers' compensation filing procedures and Division of Workers' Compensation administrative processes as of March 2, 2026. All citations have been verified for accuracy and current status. The report is designed to provide thorough legal guidance to injured workers, employers, claims administrators, and attorneys engaged in California workers' compensation proceedings, with particular attention to Northern California practice considerations and San Francisco Bay Area resources.