

California Workers' Compensation Utilization Review System: Legal Analysis for Judicial and Legal Practitioners

(PART-A INJURED WORKERS ANALYSIS)

February 26, 2026

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CALIFORNIA WORKERS' COMPENSATION UTILIZATION REVIEW SYSTEM: LEGAL ANALYSIS

This report explains California's utilization review (UR) system — a process that decides whether your medical treatment in a workers' compensation case is medically necessary. UR determines who has authority over your treatment: the claims administrator's medical reviewer, or a Workers' Compensation Judge (WCJ). Understanding UR procedures, deadlines, and your rights is critical whether you are an injured worker, a treating physician, or an employer.

Key findings of this report:

- A WCJ can decide whether treatment is medically necessary only when UR was never done, or when the UR decision was late or had serious procedural problems.
- Strict deadlines apply to UR decisions: five working days for standard review, seventy-two hours for urgent review, and thirty days for review after treatment has already been provided. Missing these deadlines makes the UR decision invalid.
- New regulations taking effect April 1, 2026, tighten documentation requirements and create higher standards for UR compliance.
- A major court decision, *Illinois Midwest Insurance Agency v. WCAB (Rodriguez)*, eliminated a rule that previously protected ongoing treatment from UR review — though the California Supreme Court is currently reconsidering this decision.

Part 1: The Law That Creates the Utilization Review System

This part explains the main state law that requires employers to have a UR process and sets the rules for how it works.

What Is Utilization Review?

Utilization review (UR) is the process by which an employer or its insurance company reviews a doctor's treatment recommendation and decides whether to approve, change, or deny it based on medical necessity — meaning whether the treatment is needed to cure or relieve your work injury. This definition comes from Cal. Lab. Code § 4610 (<https://law.justia.com/codes/california/2011/lab/division-4/4600-4614.1/4610/>).

UR happens at three points in time:

- Prospective review — before treatment is provided
- Concurrent review — during an inpatient hospital stay
- Retrospective review — after treatment has already been given

Important: Only a licensed physician who is qualified to evaluate your specific medical issue may change, delay, or deny your treatment request for medical necessity reasons. If a non-physician makes that decision, the UR decision may be invalid. This restriction is set out in Cal. Lab. Code § 4610(e) (<https://law.justia.com/codes/california/2011/lab/division-4/4600-4614.1/4610/>).

Medical Guidelines Used in UR

The criteria used in UR must meet four requirements under Cal. Lab. Code § 4610(f) (<https://law.justia.com/codes/california/2011/lab/division-4/4600-4614.1/4610/>):

- They must be developed with input from practicing physicians
- They must be consistent with the Medical Treatment Utilization Schedule (MTUS), which is California's official set of treatment guidelines adopted under Cal. Lab. Code § 5307.27 (<https://www.dir.ca.gov/dwc/mtus/mtus.html>)
- They must be reviewed at least once a year and updated if needed
- They must be shared with the physician and employee when used to change or deny treatment in a specific case

Medical Director Requirement

Every employer or insurer conducting UR must have a medical director — a physician with an unrestricted California medical license — who is responsible for overseeing all UR decisions. This requirement comes from Cal. Lab. Code § 4610(d) (<https://law.justia.com/codes/california/2011/lab/division-4/4600-4614.1/4610/>) and is further described in the DWC UR FAQs for Claims Administrators (https://www.dir.ca.gov/dwc/utilizationreview/ur_faq.htm).

Part 2: Mandatory Deadlines for UR Decisions

This part explains the strict time limits that apply to every UR decision. Missing these deadlines makes the UR decision invalid and may give a judge the power to decide your treatment dispute.

Standard Prospective and Concurrent Review: Five Working Days

For standard (non-urgent) reviews done before or during treatment, the claims administrator must make a decision within five normal business days from the date it first receives a complete written request for authorization. This deadline is set by Cal. Lab. Code § 4610(i) (<https://law.justia.com/codes/california/2011/lab/division-4/4600-4614.1/4610/>) and 8 C.C.R. § 9792.9.1(c)(3) (<https://www.dir.ca.gov/t8/979291.html>).

The five-day count starts the day after the request is received. Saturdays, Sundays, and holidays do not count as business days.

Extensions: Up to Fourteen Days

The deadline may be extended if the reviewer needs additional medical records, test results, or a specialist consultation. Under Cal. Lab. Code § 4610(i)(1) (<https://law.justia.com/codes/california/2011/lab/division-4/4600-4614.1/4610/>), the claims administrator must:

- Notify the treating physician, the injured worker, and any attorney in writing within five business days
- Explain what information, testing, or consultation is needed
- Provide an expected date for the decision

If the missing information is not received within fourteen days, the reviewer must deny the request, but must state that the request will be reconsidered when the information is provided.

Expedited (Urgent) Review: Seventy-Two Hours

When an injured worker faces an imminent and serious threat to health — such as severe pain or potential loss of life or limb — the treating physician may request expedited review. Under Cal. Lab. Code § 4610(i)(3) (<https://law.justia.com/codes/california/2011/lab/division-4/4600-4614.1/4610/>) and 8 C.C.R. § 9792.9.1(c)(4) (<https://www.dir.ca.gov/t8/979291.html>), the UR decision must be made within seventy-two hours of receiving the necessary information.

The requesting physician must certify in writing why urgent review is needed. If the request does not reasonably show an imminent threat, the standard five-day timeline applies instead. For more detail on expedited review requirements, see Sullivan Attorneys — Expedited Review of Requests for Treatment (<https://www.sullivanattorneys.com/blog/expedited-review-of-requests-for-treatment-revisited>).

Retrospective Review: Thirty Days

For treatment that has already been provided, the UR decision must be made within thirty days of receiving the authorization request and reasonably necessary medical information, per 8 C.C.R. § 9792.9.1(c)(5) (<https://www.dir.ca.gov/t8/979291.html>).

Communication Deadlines

After a UR decision is made, it must be communicated to the requesting physician according to 8 C.C.R. § 9792.9.1(e) (<https://www.law.cornell.edu/regulations/california/8-CCR-9792.9.1>):

- Concurrent review: Within twenty-four hours of the decision
- Prospective review: Within two business days of the decision

Communication may happen first by phone, fax, or email, but must be followed by a written notice.

Critical: Failure to communicate the decision within these timeframes makes the UR decision invalid, as the WCAB held in *Bodam v. San Bernardino County (2014)* and *Shanley v. Henry Mayo Newhall Memorial Hospital (2014)*. See *daisyBill — Shanley v. Henry Mayo (https://kb.daisybill.com/articles/shanley-v-henry-mayo-newhall-memorial-hospital-2014)*.

Part 3: When a Judge Can Decide Medical Necessity

This part explains the circumstances under which a Workers' Compensation Judge regains authority to decide whether treatment is medically necessary.

The General Rule: Valid UR Removes Judge Authority

The core principle is this: a UR determination that is timely and procedurally correct takes away the judge's power to decide medical necessity. Instead, any dispute goes through Independent Medical Review (IMR), a separate review process described in Part 5 of this report.

This principle was established in the landmark en banc decision *Dubon v. World Restoration, Inc.*, 79 Cal. Comp. Cases 313 (WCAB en banc 2014) (https://www.dir.ca.gov/wcab/EnBancdecisions2014/Dubon_Jose.pdf). The Appeals Board held that a UR determination is invalid — and the judge's authority is restored — only when the UR decision is untimely or has material procedural defects that undermine its integrity. Minor or technical errors are not enough. For the full decision text, see *Dubon II* on Justia (<https://law.justia.com/cases/california/workers-compensation-appeals-board/2014/adj4274323-ana-0387677.html>).

What Makes a UR Decision Invalid

The following problems can make a UR decision invalid and restore a judge's authority, as explained in *RJY Law — Utilization Review and WCJ Authority* (<https://www.rjylaw.com/utilization-review-in-california-workers-compensation-when-can-a-judge-address-medical-necessity/>):

- Late decision: The claims administrator missed the five-day, seventy-two-hour, or thirty-day deadline
- Non-physician decision-maker: Someone other than a licensed physician denied or modified treatment for medical necessity reasons, violating Cal. Lab. Code § 4610(e) (<https://law.justia.com/codes/california/2011/lab/division-4/4600-4614.1/4610/>)
- No physician actually reviewed the case: The record does not show that a qualified physician reviewed the request and made the decision
- Improper notice about missing information: The claims administrator denied a request for missing records but did not tell the physician exactly what information was needed
- Failure to apply MTUS guidelines: The written decision does not explain how it applied the MTUS (<https://www.dir.ca.gov/dwc/mtus/mtus.html>) or other evidence-based guidelines

Important: When UR is found invalid or was never conducted, the judge decides medical necessity. However, the burden of proof shifts to the injured worker to show through medical evidence that the treatment is reasonably required.

What a Valid UR Denial Must Include

A written decision that denies or modifies treatment must contain specific information under 8 C.C.R. § 9792.9.1(e) (<https://www.dir.ca.gov/t8/979291.html>):

- The date the decision was made
- A description of the treatment requested
- A description of any treatment approved
- A clear explanation of the medical reasons for the denial, including the guidelines used
- The name, specialty, and U.S. phone number of the reviewing physician
- The physician's availability (at least four hours per week) to discuss the decision
- Information about the injured worker's right to disagree and how to contact the DWC Information and Assistance unit

Part 4: The Rodriguez Decision and Ongoing Treatment

This part explains a major court ruling that changed how UR applies to treatment that was previously approved.

Background: The Patterson Doctrine

Before November 2025, a rule known as the Patterson doctrine (from *Patterson v. The Oaks Farm*) said that if an employer had previously authorized a course of treatment, it could not stop that treatment without proving the worker's condition had changed. This meant ongoing or "maintenance" treatment was largely protected from UR review.

The Rodriguez Court of Appeal Decision

In November 2025, the Second District Court of Appeal issued a published decision in *Illinois Midwest Insurance Agency, LLC v. WCAB (Rodriguez)* (<https://law.justia.com/cases/california/court-of-appeal/2025/b344044.html>) that eliminated the Patterson doctrine.

In that case, Orlando Rodriguez suffered severe head and brain injuries. His treating physician requested continued home health care services. The claims administrator sent the request to UR, and the UR physician denied it. Instead of going through IMR, Rodriguez's attorney argued under Patterson that the employer could not stop the care without showing a change in condition.

The Court of Appeal disagreed and held that:

- For injuries on or after January 1, 2013, the exclusive remedy for medical necessity disputes is IMR
- There is no exception for ongoing or maintenance treatment
- Whether a request is for new treatment, continuing treatment, or re-authorization of previously approved treatment, the dispute belongs in the UR/IMR system — not before a judge

For a detailed analysis, see *P. Badillo & Welch Law — The Death of the Patterson Doctrine* (<https://www.pbw-law.com/the-death-of-the-patterson-doctrine-how-the-rodriguez-decision-returns-control-to-utilization-review/>).

Critical: On January 21, 2026, the California Supreme Court granted a Petition for Review in Rodriguez (Case No. S294463). This means the Court of Appeal decision is not final, and the Supreme Court will reconsider the issue. You should monitor this case closely because the outcome could change the rules again.

Part 5: Independent Medical Review — The Final Step for Treatment Disputes

This part explains the IMR process, which is the main way to challenge a UR denial for injuries occurring on or after January 1, 2013.

What Is Independent Medical Review?

Independent Medical Review (IMR) is a process where an independent physician — not connected to the employer or the injured worker — reviews the UR decision and decides whether the denied treatment is medically necessary. IMR became effective July 1, 2013, under Cal. Lab. Code §§ 4610.5 and 4610.6 (https://www.dir.ca.gov/dwc/IMR/IMR_FAQs.htm), and applies to all injured workers regardless of injury date.

How to Request IMR

You must file a request within thirty days of receiving the written UR decision (or ten days if the dispute involves only medication covered by the MTUS Drug List). The request must be:

- Made on DWC Form IMR
- Submitted with a copy of the UR decision
- Sent to Maximus Federal Services, Inc., which administers IMR for the California Division of Workers' Compensation

For full instructions, see *DWC — Independent Medical Review FAQs* (<https://www.dir.ca.gov/dwc/IMR/IMRFAQs.htm>) and *8 C.C.R. § 9792.10.1* (https://www.dir.ca.gov/t8/979210_1.html).

IMR Timeline

- Regular review: Documentation must be provided within fifteen calendar days; decision issued within thirty days of receiving complete documentation
- Expedited review (imminent threat to health): Documentation due within twenty-four hours; decision within three days if treatment has not yet been provided, or within thirty days if it has

IMR Reviewer Qualifications

The IMR reviewer must hold an M.D. or D.O. degree and have current board certification in the medical specialty relevant to the treatment being reviewed. The reviewer must apply the MTUS (<https://www.dir.ca.gov/dwc/mtus/mtus.html>) or, if the MTUS does not address the treatment, other evidence-based medical guidelines.

Challenging an IMR Decision

IMR decisions are presumed correct and can only be overturned by clear and convincing evidence of one of five narrow grounds, as described in Bradford & Barthel — *Appealing IMR Determinations* (<https://bradfordbarthel.com/2020/05/04/how-appealing-is-your-appeal/>):

1. The decision was based on a conflict of interest
2. The decision was obviously wrong on its face based on the medical evidence
3. The decision was fraudulent
4. The decision resulted from gross negligence
5. The decision was based on a plainly erroneous finding of fact that is a matter of common knowledge (not expert opinion)

Important: Even if the WCAB reverses an IMR decision, the case goes back to a different IMR reviewer — the WCAB itself cannot decide medical necessity.

Part 6: The Medical Treatment Utilization Schedule

This part explains the MTUS, which is the official standard for deciding what medical treatment is reasonable and necessary in California workers' compensation cases.

What Is the MTUS?

The Medical Treatment Utilization Schedule (MTUS) is a set of regulations in 8 C.C.R. §§ 9792.20–9792.27.23 (<https://www.dir.ca.gov/dwc/mtus/mtus.html>) that contain medical treatment guidelines based on evidence-based medicine — meaning treatment recommendations supported by the best available scientific research.

The MTUS adopts guidelines developed by the American College of Occupational and Environmental Medicine (ACOEM), which California medical providers can access free of charge through the MDGuidelines platform (<https://acoem.org/Practice-Resources/Practice-Guidelines-Center/MDGuidelines%C2%AE>).

Why the MTUS Matters

Treatment consistent with the MTUS is presumed to be reasonable and necessary. This means:

- If your doctor recommends treatment that follows the MTUS, you generally should not need to prove medical necessity
- UR reviewers must use the MTUS as their starting point when reviewing treatment requests
- If a UR reviewer denies treatment that follows the MTUS, they must explain why

Treatment Not Covered by the MTUS

When recommended treatment is not addressed by the MTUS, it may still be authorized if supported by other nationally recognized, evidence-based medical guidelines. However, the treating physician bears the burden of submitting substantial medical evidence — such as peer-reviewed articles or clinical studies — showing the treatment is medically necessary. This is required under 8 C.C.R. § 9792.8 (https://www.dir.ca.gov/t8/9792_8.html).

Note: Treatment may not be denied solely because it is not covered by the ACOEM guidelines or the MTUS.

The MTUS Drug Formulary

California adopted a drug formulary as part of the MTUS under Assembly Bill 1124 (https://calmatters.digitaldemocracy.org/bills/ca_201520160ab1124). The MTUS Drug Formulary (<https://www.dir.ca.gov/dwc/mtus/MTUS-Formulary.html>) categorizes medications as:

- Exempt — Does not require UR before prescribing
- Non-exempt — Requires UR before prescribing
- Special fill — Requires specific authorization
- Peri-operative fill — For pain management around surgery

Disputes about formulary medications use a shorter IMR filing deadline of ten days rather than thirty.

Part 7: Deferring UR When Liability Is Disputed

This part explains what happens when the employer disputes whether it is responsible for the injury or treatment at all.

When UR Can Be Deferred

Under Cal. Lab. Code § 4610(l) (<https://law.justia.com/codes/california/2011/lab/division-4/4600-4614.1/4610/>), UR is not required while the employer is disputing liability for the injury or the treatment condition. This makes sense because there is no point reviewing whether treatment is medically necessary if the employer might not be responsible for the injury at all.

The implementing regulation, 8 C.C.R. § 9792.9.1(b) (<https://www.dir.ca.gov/t8/979291.html>), sets the rules for deferral. The claims administrator must issue a written deferral decision within five business days of receiving the treatment request.

What the Deferral Notice Must Say

The written deferral must include, per 8 C.C.R. § 9792.9.1(b) (<https://www.dir.ca.gov/t8/979291.html>) and Sullivan on Comp — Deferring Utilization Review (<https://www.sullivanoncomp.com/blog/deferring-utilization-review>):

- The date the authorization request was received
- A description of the specific treatment requested
- A clear explanation of why liability is being disputed (not just a form letter — the reason must be specific)
- A plain-language statement telling you that disputes can be resolved by agreement or through the WCAB

What Happens After Liability Is Determined

Once liability is established — either by WCAB decision or by agreement — the clock starts for UR:

- For retrospective review of treatment already provided during the deferral period, the thirty-day UR timeline begins on the date liability becomes final
- For prospective review of new treatment requests, the timeline begins when the claims administrator receives a new authorization request after the final liability determination

Consequences of Failing to Properly Defer

In *Hough v. CooperVision, Employers Insurance* (2018) (<https://compfox.io/caselaw/sherry-hough-vs-coopervision-employers-insurance>), the Appeals Board held that if the claims administrator fails to properly issue a deferral notice, the WCAB may exercise jurisdiction to decide medical necessity directly. This means the employer loses the ability to use UR later. Strict compliance with deferral notice requirements is essential.

Part 8: New Regulations Effective April 1, 2026

This part explains important changes to UR rules that take effect on April 1, 2026.

Overview

On December 30, 2025, the California Office of Administrative Law approved major amendments to the UR regulations. These changes were announced in DIR News Release 2025-125 (<https://www.dir.ca.gov/DIRNews/2025/2025-125.html>) and are summarized in detail by Enlyte — California UR Regulation Updates (<https://www.enlyte.com/insights/news-release/utilization-management/california-utilization-review-regulation-updates-effective-2026>).

Key Changes

"Delay" is no longer a separate UR outcome. UR outcomes are now limited to three categories: approval, modification, or denial. What was previously called a "delay" is now treated as either a temporary denial pending information or a deferral pending liability resolution.

Tighter UR plan approval process. The Administrative Director must now respond within thirty days about whether a UR plan filing is complete. For plans that deny or modify treatment, a decision must be issued within sixty days of complete submission. After ninety days without action, provisional approval is granted.

"Material modification" definition expanded. Changes in medical director, company address, name, or corporate structure now count as material modifications that must be filed within thirty days.

Twelve-month effectiveness rule clarified. A UR denial remains effective for twelve months for the same treatment from the same physician or practice group — unless the physician documents a material change in the patient's condition.

First thirty-day treatment exemption (SB 1160). Treatment within the first thirty days of injury is generally exempt from prospective UR, provided the treating physician submits the Doctor's First Report (DIR Form 5021) and a request for authorization listing all anticipated treatment. Exceptions include surgery, psychological treatment, advanced imaging, home health care, expensive equipment, electrodiagnostic medicine, and spinal injections.

Administrative Penalties

The 2026 amendments establish or clarify penalties under 8 C.C.R. § 9792.12 (https://www.dir.ca.gov/t8/9792_12.html) for UR violations, including:

- Operating without an approved UR plan: \$50,000
- Failure to obtain or maintain URAC accreditation: \$5,000–\$10,000
- Allowing a non-physician to deny treatment on medical necessity grounds: \$10,000–\$50,000
- Failure to meet the five-working-day decision deadline: \$2,000–\$5,000
- Failure to meet the seventy-two-hour expedited review deadline: \$5,000–\$10,000

Part 9: Practical Steps and Procedures

This part provides a step-by-step overview of how UR works in practice and what you need to do at each stage.

Step 1: Submitting a Request for Authorization

The treating physician submits a written Request for Authorization (RFA) using DWC Form RFA or a narrative letter, as required by 8 C.C.R. § 9785.5 (https://www.dir.ca.gov/t8/9785_5.html). The request must:

- Identify the employee and the provider
- Describe the recommended treatment with specificity
- Include documentation supporting medical necessity

Per 8 C.C.R. § 9792.6.1 (<https://www.dir.ca.gov/t8/979261.html>), a request is "completed" only when all three elements are present. Incomplete requests may be returned.

Step 2: UR Decision-Making

Once a completed RFA is received:

1. Standard review: Decision within five working days (extendable to fourteen days with proper notice)

2. Expedited review: Decision within seventy-two hours
3. Retrospective review: Decision within thirty days

Step 3: Communication of the Decision

The decision must be communicated to the requesting physician:

- Within twenty-four hours for concurrent review
- Within two business days for prospective review

Written follow-up notice is required.

Step 4: If Treatment Is Denied or Modified

If UR denies or modifies treatment:

1. File a request for Independent Medical Review within thirty days (ten days for medication-only disputes)
2. Use DWC Form IMR and include a copy of the UR decision
3. Send to Maximus Federal Services, Inc.
4. Await the IMR decision (generally within thirty days of complete documentation)

Step 5: Challenging a UR Decision on Procedural Grounds

If you believe the UR decision was untimely or had material procedural defects, you may raise this issue before the WCAB — these are legal questions for a judge, not for IMR. If the judge agrees the UR was invalid, you must then prove through medical evidence that the treatment is reasonably required.

Part 10: Important Considerations Going Forward

This part highlights emerging issues that may affect your case.

The Rodriguez Decision Is Under Supreme Court Review

The California Supreme Court accepted review of Rodriguez (Case No. S294463) on January 21, 2026. Until the Supreme Court rules, there is uncertainty about whether the Patterson doctrine protecting ongoing treatment will be revived. Monitor updates from P. Badillo & Welch Law (<https://www.pbw-law.com/the-death-of-the-patterson-doctrine-how-the-rodriguez-decision-returns-control-to-utilization-review/>).

Regulatory Compliance Is More Important Than Ever

The April 1, 2026 amendments raise the technical standards for UR. Claims administrators face larger penalties for procedural violations. Injured workers and their representatives should carefully review UR decisions for any deadline, documentation, or procedural failures.

UR Data Transparency Remains Limited

Despite laws like SB 1160 and SB 537 (<https://legiscan.com/CA/text/SB537/id/2056534>) requiring UR data reporting, the DWC has not provided transparent UR statistics to the public. This is documented by daisyBill — CA DWC UR Audit Failures (<https://blog.daisybill.com/ca-dwc-ur-audit-workers-comp>). This lack of transparency makes it harder for injured workers and the public to evaluate whether UR denials are appropriate.

Legislative Efforts on UR Physician Licensing

SB 636 (2023–2024) (https://calmatters.digitaldemocracy.org/bills/ca_202320240sb636), which would have required UR physicians reviewing cases for private employers to hold a California medical license, was vetoed by the Governor. See daisyBill — SB 636 (<https://blog.daisybill.com/ca-sb-636-demands-ca-licensed-ur-physicians>). Future legislative efforts in this area should be monitored.

Procedural Defects as Negotiation Tools

If you are an injured worker, carefully check every UR denial for timing violations, missing information, failure to identify the reviewing physician, or failure to cite medical guidelines. Even minor problems can be used as leverage in settlement discussions or to restore a judge's authority over your treatment dispute.

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California Workers' Compensation Utilization Review System: Legal Analysis for Judicial and Legal Practitioners

(PART-B LEGAL ANALYSIS)

Generated by: Legal AI Assistant

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California Workers' Compensation Utilization Review System: Comprehensive Legal Analysis for Judicial and Legal Practitioners

Executive Summary

The California workers' compensation utilization review (UR) system represents one of the most complex and procedurally intricate aspects of modern employment law, fundamentally determining the allocation of authority between claims administrators, treating physicians, medical reviewers, and the judiciary.^{[1][3]} This report examines the statutory framework governing UR determinations, the procedural requirements that strip or restore Workers' Compensation Judge (WCJ) jurisdiction over medical necessity disputes, and the regulatory landscape following the December 30, 2025 approval and April 1, 2026 effective date of comprehensive UR regulation amendments. The analysis reveals that UR has evolved into a highly technical administrative process where procedural compliance directly determines judicial authority, and where even minor documentation failures can invalidate UR determinations and restore WCAB jurisdiction over medical necessity questions.

Key findings: First, WCJ jurisdiction to determine medical necessity exists only when UR is either never conducted, or when a UR determination is timely and procedurally valid.^{[8][11][44]} Second, the statutory timelines for UR decision-making are mandatory: five working days for prospective review (extendable to fourteen days upon proper notice), seventy-two hours for expedited review, and thirty days for retrospective review, with failures to meet these deadlines rendering UR determinations invalid and restoring judicial authority.^{[4][36]} Third, the recent regulatory amendments effective April 1, 2026 substantially tighten documentation, materiality, and physician reviewer requirements in ways that directly impact claims administration practices.^{[13][13]} Fourth, the landmark *Illinois Midwest Insurance Agency v. WCAB (Rodriguez)* decision from the Court of Appeal eliminates the "Patterson doctrine" exception to UR, meaning that ongoing or maintenance treatment is no longer exempt from prospective UR review.^{[24][39][42]}

Client risk assessment: For employers and claims administrators, non-compliance with UR procedural requirements creates significant litigation risk. For injured workers and treating physicians, understanding the procedural defects that invalidate UR is essential to restoring judicial authority. For practitioners, precision in UR documentation, timing, and procedural compliance is now more critical than ever.

Strategic decision framework: This report identifies three viable approaches: (1) strict procedural compliance mode, where claims administrators invest in robust UR infrastructure to ensure all timelines and documentation requirements are met; (2) deferral strategy, where disputes regarding liability for specific conditions or courses of treatment are deferred under Labor Code Section 4610(l) pending liability resolution; and (3) prospective authorization planning, where claims administrators establish prior authorization processes under their UR plans to streamline treatment approvals. Each approach carries distinct risk profiles and requires different implementation timelines.

I. Statutory Framework Governing Utilization Review

A. Labor Code Section 4610: Core Statutory Requirements

Labor Code Section 4610 establishes the foundational requirement that every employer must establish and maintain a utilization review process.^{[1][36][1]} The statute defines utilization review as "utilization review or utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, based in whole or in part on medical necessity to cure and relieve, treatment recommendations by physicians."^[1] This definition encompasses three temporal dimensions of review: prospective (before services are rendered), concurrent (during ongoing inpatient care), and retrospective (after services have been provided).

The statute explicitly vests the authority to approve treatment requests in multiple persons but restricts the authority to modify, delay, or deny requests to licensed physicians alone.^{[1][36]} Labor Code Section 4610(e) provides that "[n]o person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice, requested by the physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve."^[36] This restriction operates as a critical jurisdictional boundary: when a non-physician makes a modification, delay, or denial determination, the UR decision is procedurally defective and may be invalidated.

Labor Code Section 4610(f) mandates that the criteria or guidelines used in the utilization review process must satisfy four conditions: they must be developed with involvement from actively practicing physicians; they must be consistent with the Medical Treatment Utilization Schedule (MTUS) adopted under Labor Code Section 5307.27; they must be evaluated at least annually and updated if necessary; and they must be disclosed to the physician and employee when used as the basis for a decision to modify, delay, or deny services in a specific case.[1][36][1] These requirements ensure that UR decisions rest on medically defensible, evidence-based standards rather than cost-containment objectives.

B. Mandatory Timelines and Extendable Periods

Labor Code Section 4610(i) prescribes mandatory decision timelines with specified extension procedures.[1][36] For prospective or concurrent review, decisions must be made in a timely fashion appropriate to the nature of the injured worker's condition, not to exceed five working days from the date of receipt of the written request for authorization.[1][4][36] This five-working-day requirement is jurisdictionally significant: failure to meet this deadline renders the UR determination untimely and invalid, stripping the claims administrator of the UR shield and restoring WCJ authority over medical necessity.

The statute permits extensions under specified circumstances. Pursuant to Labor Code Section 4610(i)(1), the timeframe may be extended if the claims administrator is not in receipt of all necessary medical information reasonably requested, if the reviewer has asked for additional examination or testing, or if the reviewer needs consultation from a specialist.[1][36] When any of these conditions apply, the claims administrator must notify the treating physician, injured worker, and the injured worker's attorney (if represented) in writing within five business days, specifying what information, testing, or specialist consultation is required and identifying an anticipated date for the decision.[36]

For expedited review, Labor Code Section 4610(i)(3) requires that decisions be made in a timely fashion appropriate to the injured worker's condition, not to exceed seventy-two hours after receipt of the written information reasonably necessary to make the determination.[1][4][26][36] Expedited review is triggered when the injured worker faces an imminent and serious threat to his or her health, or when the timeframe for non-expedited review would be detrimental to the injured worker's condition or could jeopardize the injured worker's ability to regain maximum function.[26][36] The requesting physician must certify in writing and document the need for expedited review; a request that is not reasonably supported by evidence establishing an imminent and serious threat shall be reviewed under the standard five-working-day timeframe.[26]

For retrospective review-review of services already provided-the statute does not specify a timeline in the statutory language, but the implementing regulations in Title 8, California Code of Regulations Section 9792.9.1(c)(5) provide that retrospective decisions must be made within thirty days of receipt of the request for authorization and medical information reasonably necessary to make a determination.[4]

C. Deferral of Utilization Review and the Role of Liability Disputes

Labor Code Section 4610(l) provides that "[u]tilization review of a treatment recommendation shall not be required while the employer is disputing liability for injury or treatment of the condition for which treatment is recommended pursuant to Section 4062." [1][14] This deferral provision reflects a policy judgment that it is inefficient to conduct medical necessity review when the threshold question of whether the injury or treatment is compensable remains unresolved.

The implementing regulation, California Code of Regulations Section 9792.9.1(b), elaborates on deferral mechanics.[2][14] If the claims administrator disputes liability for either the occupational injury for which treatment is recommended or the recommended treatment itself on grounds other than medical necessity, it may issue a written decision deferring utilization review, but only if this deferral is issued no later than five business days from receipt of the request for authorization (unless the requesting physician has previously been notified of a dispute over liability for a specific course of treatment).[2][14] The written deferral decision must include: the date of receipt of the request for authorization; a description of the specific course of proposed medical treatment being requested; a clear, concise, and appropriate explanation of the reason for the dispute of liability for either the injury, claimed body part or parts, or the recommended treatment; and a plain-language statement advising the injured employee that any dispute shall be resolved either by agreement of the parties or through the Workers' Compensation Appeals Board.[2][6]

If utilization review is deferred, the time for conducting retrospective utilization review shall begin on the date the determination of the claims administrator's liability becomes final (whether by Workers' Compensation Appeals Board decision or agreement of the parties).[2][14] Once liability is determined, the time for conducting prospective utilization review shall commence from the date of the claims administrator's receipt of a request for authorization after the final determination of liability.[2][14] This deferral mechanism prevents UR from becoming a de facto liability determination but does not eliminate the obligation to conduct UR once liability is established.

D. The Requirement for Medical Director Oversight

Labor Code Section 4610(d) requires that every employer, insurer, or other entity subject to the statute must employ or designate a medical director who holds an unrestricted license to practice medicine in California.[1][36] The medical director's responsibility is to ensure that the process by which the employer reviews and approves, modifies, delays, or denies requests by physicians complies with the requirements of Labor Code Section 4610 and the implementing regulations.[36] The medical director is responsible for all decisions made in the utilization review process.[41] This requirement ensures that UR determinations are subject to ultimate oversight by a licensed physician accountable to the Medical Board of California for the adequacy and propriety of UR decisions.

II. Regulatory Framework: Title 8 California Code of Regulations Article 5.5.1

A. Definitions and Foundational Concepts (CCR Section 9792.6.1)

Title 8, California Code of Regulations Section 9792.6.1 provides comprehensive definitions governing the UR system.[5] A "completed" request for authorization must identify both the employee and the provider, identify with specificity a recommended treatment or treatments, and be accompanied by documentation substantiating the need for the requested treatment.[5] This definition means that truncated or vague requests may be returned to the treating physician as incomplete, extending the decision timeline.

The regulation distinguishes between "concurrent review," defined as utilization review conducted during an inpatient stay, and prospective review conducted before treatment delivery.[2][5] It defines "medical director" as the physician and surgeon licensed by the Medical Board of California or the Osteopathic Board of California who holds an unrestricted license to practice medicine in the State of California and who is responsible for all decisions made in the utilization review process.[5]

Notably, the April 1, 2026 amendments delete the prior definition of "delay" as a separate category of UR outcomes.[13] This deletion has technical significance because it clarifies that UR outcomes are limited to three categories: approval, modification, or denial. What was previously characterized as a "delay" is now understood as either a temporary denial pending receipt of additional information or a deferral of UR altogether pending resolution of a threshold liability dispute.

B. Applicability and UR Plan Requirements (CCR Section 9792.7)

Every claims administrator is required to establish and maintain a utilization review process for treatment rendered on or after January 1, 2004, regardless of date of injury, in compliance with Labor Code Section 4610.[25][25] Each UR process must be set forth in a written utilization review plan filed with the Administrative Director of the Division of Workers' Compensation.[25][25] The plan must contain: the name, address, phone number, and medical license number of the employed or designated medical director; a description of the process whereby requests for authorization are reviewed and decisions are made; a description of the process for handling expedited reviews; a description of the specific criteria utilized in the review and decision-making process, including treatment protocols or standards consistent with the MTUS; and a description of the qualifications and functions of personnel involved in decision-making.[25][25]

Effective July 1, 2018, every UR plan that modifies or denies treatment requests must obtain Utilization Review Accreditation Commission (URAC) Workers' Compensation Utilization Management Accreditation unless exempted by the Administrative Director as a nonprofit or public sector internal utilization review program.[41][41] Material modifications to UR plans (defined as changes to UR standards or UR vendors) must be filed with the Administrative Director within thirty calendar days.[25][25]

The April 1, 2026 amendments substantially expanded UR plan review timelines and approval procedures.[13][13] The Administrative Director must now notify organizations within thirty days of whether

a UR plan filing is complete or specify what missing information is needed.[13] For plans that modify or deny treatments, the Administrative Director must issue an approval or denial decision within sixty days of complete submission.[13] Organizations may receive conditional approval for up to six months, with a possible six-month extension if good-faith efforts are shown.[13] If a UR plan is denied, the denial notification must state the reasons and is effective for twelve months unless a shorter period is agreed upon.[13]

C. Medically-Based Criteria (CCR Section 9792.8)

California Code of Regulations Section 9792.8 requires that the criteria used in utilization review must be consistent with the schedule for medical treatment utilization adopted pursuant to Labor Code Section 5307.27, and for conditions not addressed by the ACOEM Practice Guidelines or the official MTUS, authorized treatment must be in accordance with other evidence-based medical treatment guidelines generally recognized by the national medical community.[37][31] Treatment may not be denied on the sole basis that the treatment is not addressed by the ACOEM Practice Guidelines or the MTUS.[37]

The relevant portion of the criteria or guidelines used must be disclosed in written form to the requesting physician, the injured worker, and the injured worker's attorney (if represented) if used as the basis of a decision to modify, delay, or deny services in a specific case.[37][31] The claims administrator may not charge the injured worker, the injured worker's attorney, or the requesting physician for a copy of the relevant portion of the criteria or guidelines used to modify, delay, or deny the treatment request.[37]

D. Timeframe and Procedural Requirements (CCR Section 9792.9.1)

California Code of Regulations Section 9792.9.1 establishes the detailed procedural framework for UR decisions issued for injuries occurring on or after January 1, 2013, or decisions communicated on or after July 1, 2013, regardless of injury date.[4][47] This regulation is the primary vehicle for understanding operational UR timelines and documentation requirements.

Prospective and Concurrent Review Timelines: Prospective or concurrent decisions must be made in a timely fashion appropriate to the nature of the injured worker's condition, not to exceed five normal business days from the date the claims administrator first receives a completed request for authorization.[4][47] The timeframe begins on the day after the date of receipt, with normal business days defined to exclude Saturdays, Sundays, and holidays.[47] If a timeframe falls on a Saturday, Sunday, or holiday, the count resumes on the next normal business day.[4][41]

Expedited Review Timeframes: Prospective or concurrent decisions on expedited review requests must be made in a timely fashion appropriate to the injured worker's condition, not to exceed seventy-two hours after receipt of the written information reasonably necessary to make the determination.[4][26][47] The requesting physician must certify in writing and document the need for expedited review; a request not reasonably supported by evidence of an imminent and serious threat to health shall be reviewed under the standard five-business-day timeframe.[4][26]

Communication of Decisions: Decisions to approve, modify, delay, or deny requests must be communicated to the requesting physician within twenty-four hours of the decision for concurrent review and within two business days for prospective review.[4][36][47] For concurrent review decisions involving modification, delay, or denial, communication initially by telephone or facsimile must be followed by written notice within twenty-four hours; for prospective review, initial communication may be by telephone, facsimile, or electronic mail, followed by written notice within two business days.[4][36][47]

Request for Additional Information: If the reviewer needs information not provided, the claims administrator must notify the requesting physician, injured worker, and injured worker's attorney (if represented) in writing that the decision cannot be made within the required timeframe.[4] The notification must specify the information requested but not received, the additional examinations or tests required, the specialty of the expert reviewer to be consulted, and an anticipated date for the decision.[4] If information is not received within fourteen days for prospective or concurrent review, or thirty days for retrospective review, the reviewer shall deny the request with the stated condition that the request will be reconsidered upon receipt of the information.[4]

Retrospective Review Timeframes: Retrospective decisions must be made within thirty days of receipt of the request for authorization and medical information reasonably necessary to make a determination.[4][47]

E. Content Requirements for Denial and Modification Decisions (CCR Section 9792.9.1(e))

Written decisions modifying, delaying, or denying treatment authorization must include: the date on which the decision is made; a description of the specific course of proposed medical treatment for which authorization was requested; a specific description of the medical treatment service approved, if any; a clear, concise, and appropriate explanation of the reasons for the claims administrator's decision, including the clinical reasons regarding medical necessity and a description of the relevant medical criteria or guidelines used to reach the decision.[4][36][47] If the decision is based on incomplete or insufficient information, the decision shall specify the reason and specify what information is needed.[4][36]

The decision must also include the name and specialty of the reviewer or expert reviewer, the telephone number in the United States of the reviewer or expert reviewer, and the hours of availability for the treating physician to discuss the decision, which must be at minimum four hours per week during normal business hours (9:00 AM to 5:30 PM Pacific Time) or an agreed-upon scheduled time.[4][36][6] The written notice must advise the injured worker of the right to disagree with the decision and must include information about how to contact the DWC Information and Assistance unit.[4][36][47]

F. Twelve-Month Effectiveness of UR Denials (CCR Section 9792.9.1(o))

A utilization review decision to modify, delay, or deny a request for authorization shall remain effective for twelve months from the date of the decision without further action by the claims administrator with regard to any further recommendation by the same physician, or another physician within the requesting physician's practice group, for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.[4][13][13][6] This provision eliminates the concern that the same treatment will be re-reviewed repetitively; however, it also creates potential disputes when the treating physician asserts that the patient's condition has changed materially.

The April 1, 2026 amendments clarified that a request for authorization that falls within this twelve-month period cannot be deferred under Labor Code Section 4610(k) if the requesting physician expressly and unequivocally indicates or opines in the request that there has been a change in facts material to the basis of the prior denial and includes documentation of such change.[13][13] Such a request must be reviewed by a physician reviewer, and any modification or denial must comply with all applicable requirements.[13][13]

G. Dispute Resolution and Independent Medical Review Access (CCR Section 9792.10.1)

If the request for authorization is not approved, or if it is approved in part, any dispute regarding medical necessity shall be resolved through the Independent Medical Review process established by Labor Code SectionSection 4610.5 and 4610.6.[38] A request for independent medical review must be filed by an eligible party (the injured worker, the injured worker's representative, or the treating physician) within thirty days of service of the written utilization review determination issued by the claims administrator.[38] If the utilization review decision only denies or modifies a drug listed on the MTUS Drug List, the request for independent medical review must be filed within ten days of service of the written utilization review decision.[38]

III. Judicial Jurisdiction Over Medical Necessity: When Workers' Compensation Judges May Decide Treatment

A. The Binding Effect of Timely, Valid UR Determinations

The foundational principle governing WCJ jurisdiction is that a timely and procedurally valid UR determination strips the WCJ of authority to determine medical necessity.[44] This principle flows from legislative intent to remove medical necessity determinations from the judicial arena and vest them in medical professionals (first through UR, then through Independent Medical Review if the UR is disputed).[24][39][44]

In *Dubon v. World Restoration, Inc.* (February 27, 2014 en banc decision), the Appeals Board held that a UR determination is invalid and not subject to Independent Medical Review only if it is untimely or suffers from material procedural defects that undermine the integrity of the UR determination; minor technical or immaterial defects are insufficient to invalidate a UR determination.[8][11] The Appeals Board further held that legal issues regarding the timeliness of a UR decision must be resolved by the WCAB, not by IMR.[8] If

a defendant's UR is found invalid due to timeliness or material procedural defects, the issue of medical necessity is not subject to IMR but is to be determined by the WCAB based upon substantial medical evidence, with the employee bearing the burden of proving the treatment is reasonably required.[8][11]

B. Timing Defects as Jurisdictional Failures

Because the statutory timelines for UR are mandatory, a failure to meet them renders the UR determination invalid and restores WCJ jurisdiction.[46] In *Bodam v. San Bernardino County* (November 20, 2014), the WCAB held that an untimely communication of a UR decision is an invalid decision.[46] In *Shanley v. Henry Mayo Newhall Memorial Hospital* (2014), the WCAB held that UR decisions must be communicated to the treating physician within the precise timeframe specified by statute: within twenty-four hours of the decision for concurrent review, or within two business days for prospective review.[46][64] Mere communication to someone else, or delayed communication, does not satisfy the requirement; the timing must be exact and the communication must reach the requesting physician.[46][64]

The practical consequence is significant: claims administrators must maintain rigorous documentation demonstrating exactly when UR decisions were made and exactly when communication occurred. Failure to produce such documentation leaves the claims administrator unable to defend the validity of the UR determination if challenged.[46][64]

C. Procedural Defects That Restore Judicial Authority

Material procedural defects that "undermine the integrity of the UR determination" render a UR invalid, even if not untimely.[8][11][44] Examples of material procedural defects include the following:

Non-Physician Decision-Maker: If a non-physician approves treatment, that is not a defect because only physicians can approve. But if a non-physician makes a modification, delay, or denial decision on the basis of medical necessity, that is a material procedural defect because Labor Code Section 4610(e) restricts such decisions to licensed physicians.[1][36][44][25][41] Non-physicians may approve requests and may discuss criteria with treating physicians, but they cannot make final denials or modifications.[25][41]

Absence of Physician Review: If the UR decision involves denial or modification but the record shows no physician actually reviewed and made the decision, this is a material procedural defect.[44] The medical director's responsibility includes ensuring that all denials and modifications are made by competent physicians; if this is not documented, the UR determination is defective.[44][41]

Missing Information Requests Without Proper Notice: If the reviewer denies a request because information is missing, but the claims administrator fails to provide notice to the requesting physician specifying what information is needed, this may constitute a procedural defect.[4][44] The regulation requires explicit notice of what additional information is required; vague or incomplete notice may be held defective.[4]

Failure to Use MTUS or Evidence-Based Guidelines: If the UR decision fails to cite to or explain how it applied the MTUS or applicable evidence-based guidelines, this may render the decision procedurally defective.[37][44][31] The written decision must explain the clinical reasons for the denial or modification; a decision that provides no such explanation is vulnerable to challenge.[4][36]

D. The Rodriguez Decision and Elimination of the Patterson Doctrine

In November 2025, the Second District Court of Appeal issued a landmark published decision in *Illinois Midwest Insurance Agency, LLC v. WCAB (Rodriguez)* that dramatically altered the landscape of UR litigation.[24][39] In that case, an injured worker (Orlando Rodriguez) suffered severe head and brain injuries in November 2016. His treating physician requested home health care services, which the claims administrator authorized for approximately one year. In September 2019, the physician submitted a new request for authorization to continue home health care. The claims administrator sent the request to UR, where the UR physician denied the request based on clinical guidelines.

Rather than appeal through the Independent Medical Review process, Rodriguez's attorney requested an expedited hearing, arguing that under the *Patterson v. The Oaks Farm* doctrine (which had held that if an employer previously authorized a course of treatment, it could not deny a later request for the same treatment without showing a change in the employee's condition), the employer had no right to stop the home health care without proving Rodriguez's condition had changed.[24][39][42]

The WCJ and WCAB sided with Rodriguez, relying on Patterson. The employer appealed to the Court of Appeal, arguing that the legislative reforms of 2013 (SB 863) were designed to take medical decisions away from judges and give them to medical professionals through the UR/IMR process.[24][39]

The Court of Appeal agreed. In a decisive opinion, the Court of Appeal held that for injuries on or after January 1, 2013, the exclusive remedy for medical disputes is Independent Medical Review, with no exception for "ongoing" or "maintenance" treatment.[24][39][42] The Court held that whether a request is for initial treatment, continuing treatment, or re-authorization of the same treatment after a prior authorization has expired, the dispute over medical necessity belongs in the UR/IMR system, not before a judge.[24][39][42] The Court rejected Patterson as creating an "extra-statutory" rule that contradicted the Legislature's intent to control costs and streamline cases through medical professionalism rather than judicial second-guessing.[24][39][42]

The practical consequence: claims administrators are no longer locked into approving ongoing or maintenance treatment indefinitely. When a new request for authorization for continuing treatment is submitted, that request can be sent to UR for a fresh determination based on current medical necessity standards and the MTUS, even if the same treatment was previously authorized. The burden shifts to the injured worker to demonstrate through the UR/IMR process that continued treatment remains medically necessary.[24][39][42]

However, on January 21, 2026, the California Supreme Court granted a Petition for Review in the Rodriguez case (Case No. S294463), meaning that the Rodriguez decision is not final and the Supreme Court will reconsider the question of whether the Patterson doctrine applies.[42][42] Practitioners should monitor this case closely as it proceeds through Supreme Court review.

E. The Consequence When UR Is Not Conducted at All

If a claims administrator fails to conduct UR at all-that is, if no UR determination is made within the required timeframe-the WCJ regains authority to determine medical necessity based on substantial medical evidence.[44] This is a critical procedural point: the burden of proof shifts. When UR is invalid or absent, the employee must prove through medical evidence that the requested treatment is reasonably required to cure or relieve the effects of the injury.[44] The WCAB will then decide the medical necessity question, not defer to a medical professional's UR determination.[44]

IV. Independent Medical Review: The Final Administrative Remedy for Medical Necessity

A. Statutory Framework (Labor Code SectionSection 4610.5 and 4610.6)

Independent Medical Review (IMR) became effective July 1, 2013, and applies to all injured workers regardless of injury date.[60] For injuries on or after January 1, 2013, disputes over whether a UR denial, delay, or modification of treatment is medically necessary are resolved exclusively through IMR (except in narrow circumstances where the UR determination itself is invalid due to procedural defects or timeliness failures).[38]

An eligible party (the injured worker, a representative, the treating physician, or in the case of emergency treatment, the emergency provider) may request IMR within thirty days of service of the written utilization review determination.[38][60] For decisions that only involve medication covered under the MTUS Drug List, the deadline is ten days.[38] The request must be made on the DWC Form IMR and submitted with a copy of the UR decision to Maximus Federal Services, Inc., which administers IMR on behalf of the California Department of Workers' Compensation.[38][60]

B. IMR Process and Timeline

Upon receipt of an IMR application, the Administrative Director's office conducts an eligibility review to determine whether the dispute qualifies for IMR.[60] An IMR is ineligible if the application was not filed timely, if a claim was denied because the insurance contract does not cover the treatment, or if the claims administrator is still disputing liability for an occupational injury or claimed body part.[7][60]

If eligible, the Administrative Director's office assigns the case to Maximus, which notifies the parties that the case has been assigned for either regular or expedited review.[60] For regular review, all relevant medical documentation must be provided to Maximus within fifteen calendar days (or twelve days for electronic notification), and Maximus must issue a decision within thirty days of receipt of complete documentation.[60]

For expedited review (when the injured worker faces an imminent and serious threat to health), documentation must be provided within twenty-four hours, and Maximus must issue a decision within three days if the disputed treatment has not been provided, or within thirty days if treatment has already been provided.[60]

The IMR physician must hold an M.D. or D.O. degree and current certification by a recognized American medical specialty board in the area appropriate to the condition under review.[10][10][60] The IMR decision must be consistent with the California MTUS or, if guidelines do not address the treatment, with other evidence-based medical guidelines.[10][10][60] The IMR decision must be written in simple, understandable terms that reference the medical guidelines followed in agreeing or disagreeing with the UR decision.[10][10]

The IMR organization must keep the names of IMR reviewers confidential in all communications with individuals outside the organization.[60]

C. Binding Nature and Limited Appeal Rights

IMR decisions are presumed correct and can only be reversed by clear and convincing evidence of one or more narrow statutory grounds.[45] The five grounds for appealing an IMR determination are: (1) the determination was based on a conflict of interest; (2) the determination was obviously wrong on its face based on the medical evidence; (3) the determination was fraudulent; (4) the determination was the result of gross negligence; and (5) the determination was the result of a plainly erroneous express or implied finding of fact that is a matter of ordinary knowledge based on the information submitted for review and not a matter subject to expert opinion.[45]

If a WCAB reverses an IMR determination on one of these grounds, the dispute must be remanded to the Administrative Director to submit to a different IMR organization for review; if a different organization is not available, to a different reviewer at the original IMR organization.[45] In no event may the WCAB make a determination of medical necessity contrary to the determination of the IMR organization.[45]

V. The Medical Treatment Utilization Schedule (MTUS): The Evidentiary Standard

A. Status and Presumptive Correctness

The Medical Treatment Utilization Schedule is a set of regulations found in Title 8, California Code of Regulations Section 9792.20 through 9792.27.23 that contain medical treatment guidelines and rules for determining what is reasonable and necessary medical care.[31][49][31] The MTUS is based on evidence-based medicine principles, meaning that treatment decisions are guided by recommendations supported by the best-available medical evidence.[31][49][31]

The MTUS has adopted treatment guidelines developed by the American College of Occupational and Environmental Medicine (ACOEM), which are accessible free of charge to California medical providers through the MDGuidelines platform.[34][50][51] ACOEM treatment guidelines are presumed correct on the issue of extent and scope of medical treatment.[31][49][31] This presumption means that treatment consistent with MTUS guidelines should guide treatment decisions in most cases; treating physicians need not prove medical necessity if treatment is consistent with MTUS; and UR reviewers must apply MTUS guidelines as the starting point for their determinations.[31][49][31]

B. Treatment Not Addressed by MTUS: Rebuttal and Exceptions

When a recommended treatment is not addressed by the MTUS guidelines, or when a treating physician wishes to rebut the presumption of correctness of the MTUS, treatment may be authorized when medical circumstances warrant an exception, if supported by best available medical evidence from other nationally recognized, evidence-based medical guidelines.[13][37][31] The burden of proof shifts: the treating physician must submit substantial medical evidence (peer-reviewed articles, clinical studies, expert testimony) establishing that the treatment outside MTUS is medically necessary.[13][37][31]

C. MTUS Drug Formulary

The Division of Workers' Compensation adopted a drug formulary as part of the MTUS to implement Assembly Bill 1124.[19][22][49] The formulary is evidence-based and built on the foundation of MTUS treatment guidelines recommendations.[22][49] Medications are categorized as exempt (not requiring

prospective UR), non-exempt (requiring prospective UR), special fill (requiring authorization), or peri-operative fill (for perioperative pain management).[49]

Disputes regarding whether a prescribed medication is covered by the formulary are subject to UR within five business days, with a simplified IMR process available within ten days (rather than the standard thirty days).[19][38][49]

VI. Recent Regulatory Developments: April 1, 2026 Amendments

A. Approval of Final Regulations by Office of Administrative Law

On December 30, 2025, the California Office of Administrative Law (OAL) approved comprehensive amendments to California's utilization review regulations.[16][13] These amendments, effective April 1, 2026, implement exemptions for UR under Senate Bill 1160 (treatment within the first thirty days of injury) and Assembly Bill 1124 (exempt drugs on the formulary).[16][13][13] They also enforce statutory accreditation requirements, amend UR investigation rules, and enhance coordination of medical treatment.[16][13][13]

B. Key Changes to UR Standards and Definitions (Section 9792.6.1)

The April 1, 2026 amendments delete the prior definition of "delay" as a separate outcome category.[13] The regulations now clarify that UR outcomes are limited to three: approval, modification, or denial.[13] What was previously characterized as a "delay" pending receipt of additional information is now more precisely understood as either a temporary denial pending information or a deferral of UR pending liability resolution.[13]

The definition of "Expert Reviewer" now explicitly states that consultation must be "requested by claims administrator or utilization review organization, necessitating an extension of time, prior to the determination of medical necessity." [13] This clarification narrows the circumstances under which the timeframe for UR may be extended based on expert consultation.[13]

The definition of "Material Modification" has been expanded to include not only changes in utilization review vendor or standards but also "changes in medical director, address, company name or corporate structure." [13] Material modifications must be filed within thirty days with compliance certification.[13]

C. Enhanced UR Plan Review Process (Section 9792.7)

The April 1, 2026 amendments substantially tightened the UR plan approval process.[13][13] The Administrative Director must notify organizations within thirty days of whether a UR plan filing is complete or specify what missing information is needed.[13] For plans that modify or deny treatments, the Administrative Director must issue an approval or denial decision within sixty days of complete submission (plus a possible sixty-day extension after the initial sixty-day period).[13] After ninety days without action, provisional approval is granted.[13]

The appeal timeframe for UR plan rejection/denial has been increased from prior law to twenty-five days.[13]

D. Medically-Based Criteria (Section 9792.8)

The April 1, 2026 amendments clarify that physician reviewers must use criteria consistent with the MTUS, including the methodology for evaluating medical evidence under Section 9792.25.1.[13] Treatment beyond MTUS coverage may be authorized when medical circumstances warrant an exception, if supported by best available medical evidence.[13]

E. UR Decisions to Modify or Deny (Section 9792.9.5)

The amendments establish new requirements for written decisions modifying or denying treatment authorization.[13][13][13][13] Where a requesting physician has expressly opined that prerequisite treatment or criteria, as recommended under applicable treatment guidelines, should be overlooked or is irrelevant to the requested treatment, the reviewing physician must provide an explanation for why the requesting physician's explanation is insufficient.[13][13][13][13]

The amendments clarify that a UR decision to modify or deny medical treatment on the basis of medical necessity must remain effective for twelve months from the date of the decision, without further action by the

claims administrator, regarding further recommendations by the same physician or another physician within the requesting physician's practice group for the same treatment, unless the further recommendation is supported by a documented change in the facts material to the basis of the UR decision.[13][13][13][13]

F. First 30-Day Treatment Exemption (SB 1160)

The April 1, 2026 amendments incorporate exemptions from prospective UR for treatment rendered within the first thirty days of injury, subject to specific conditions.[13][13] The initial treating physician must timely submit the "Doctor's First Report of Occupational Injury or Illness" (DIR Form 5021) setting forth in detail the anticipated treatment plan for the injured worker.[13][13] All treatment or services anticipated to be provided in the first thirty days after the date of injury, including exempt drugs prescribed under the MTUS Drug Formulary, must be set forth in a request for authorization provided to the claims administrator, submitted concurrently with the Doctor's First Report.[13][13]

Subsequent treating physicians during the thirty-day period must submit a request for authorization following their first visit indicating all treatment being rendered.[13][13] The treating physician's medical treatment bill for non-emergency treatment must be submitted to the claims administrator within thirty days of the date the service was provided; emergency treatment bills must be submitted within 180 days.[13][13]

The exemption applies to all treatment or services except: surgery; psychological treatment; imaging and radiology services (excluding X-rays); home health care services; durable medical equipment/prosthetics/orthotics/supplies (DMEPOS) where the purchase or rental cost is greater than \$250; electrodiagnostic medicine; and spinal injections.[13][13]

G. Administrative Penalties for Non-Compliance (Section 9792.12)

The April 1, 2026 amendments establish or clarify monetary penalties for various UR violations.[13][13][56][13][13] Penalties are assessed for failures including: failure to obtain Administrative Director approval for a UR plan before operation (\$50,000); failure to obtain or maintain URAC accreditation (\$5,000-\$10,000 depending on circumstance); failure to ensure only physician reviewers deny treatment based on medical necessity (\$10,000-\$50,000); failure to ensure timely decisions within five working days for non-expedited reviews (\$2,000-\$5,000); failure to make or issue written decisions within seventy-two hours for expedited reviews (\$5,000-\$10,000); and failure to prevent non-physician reviewers from denying or modifying treatment requests.[13][13][56][13][13]

For "b" penalties (technical violations), the performance rating determination is made based on a sample of randomly selected requests for authorization; if the claims administrator or URO achieves an eighty-five percent performance rating, "b" penalties are waived.[41]

VII. Deferral of Utilization Review Based on Liability Disputes

A. The Statutory Framework and Regulatory Implementation

Labor Code Section 4610(l) provides that utilization review shall not be required while the employer is disputing liability for injury or treatment of the condition for which treatment is recommended.[1][14][36] This exception reflects a policy judgment that conducting medical necessity review while a threshold liability question remains unresolved is inefficient and potentially wasteful.

The implementing regulation, California Code of Regulations Section 9792.9.1(b), establishes the procedural framework for deferral.[2][14][36] If the claims administrator disputes liability for either the occupational injury for which treatment is recommended or the recommended treatment itself on grounds other than medical necessity, the claims administrator may issue a written decision deferring utilization review, but only if this deferral is issued no later than five business days from receipt of the request for authorization.[2][14]

Significantly, the claims administrator does not need to issue a new deferral notice for each subsequent request for authorization if the requesting physician has been previously notified of a dispute over liability and an explanation for the deferral of utilization review for a specific course of treatment.[2][14] This prevents the administrative burden of issuing repetitive deferral notices, but it also requires that the initial deferral notice be clear and specific about which course of treatment is being deferred.[2][14]

B. Content Requirements for Deferral Notices

The written deferral decision must include: (1) the date on which the request for authorization was first received; (2) a description of the specific course of proposed medical treatment being requested; (3) a clear, concise, and appropriate explanation of the reason for the claims administrator's dispute of liability for either the injury, claimed body part or parts, or the recommended treatment; and (4) a plain-language statement advising the injured employee that any dispute shall be resolved either by agreement of the parties or through the dispute resolution process of the Workers' Compensation Appeals Board.[2][6][14][36]

The requirement for a "clear, concise, and appropriate explanation" means that boilerplate deferral notices are insufficient; the claims administrator must specifically explain why liability is being disputed (for example, whether the injury is being disputed, or whether a particular body part's work-relatedness is being disputed, or whether the connection between the injury and the recommended treatment is being disputed).[2][14]

C. The Transition from Deferral to UR After Liability Is Determined

If utilization review is deferred pursuant to this subdivision, and it is finally determined that the claims administrator is liable for treatment of the condition for which treatment is recommended—either by decision of the Workers' Compensation Appeals Board or by agreement between the parties—the time for conducting retrospective utilization review shall begin on the date the determination of the claims administrator's liability becomes final.[2][14] The time for conducting prospective utilization review shall commence from the date of the claims administrator's receipt of a request for authorization after the final determination of liability.[2][14]

This transition mechanism ensures that once liability is established, UR can proceed. However, for retrospective review (review of services already provided during the deferral period), the UR determination is made based on whether the services rendered were medically necessary, not on what the treating physician recommended.[2][14] The provider bears the burden of submitting sufficient medical documentation to demonstrate that the services provided were medically necessary; if documentation is insufficient, the UR reviewer may deny payment for those services.[2][14]

D. Consequences of Failure to Comply with Deferral Requirements

In *Hough v. CooperVision, Employers Insurance* (2018), the Appeals Board held that failure to comply with the utilization review deferral requirements of CCR 9792.9.1(b) will allow the WCAB to exercise jurisdiction to determine the medical necessity of the requested treatment, rather than deferring to UR/IMR.[14][17] The court found that because the defendant had not properly issued a notice deferring UR when it disputed liability, the defendant was later estopped from conducting retrospective UR without having to prove, through UR/IMR, that the services provided were medically necessary.[14][17]

This holding is significant because it means that strict compliance with the deferral notice requirements is essential; failure to issue a timely, complete deferral notice may result in forfeiture of the right to conduct UR later and restoration of WCJ authority over medical necessity.[14][17]

VIII. Expedited Review: Procedure and Jurisdictional Consequences

A. Standards for Expedited Review

Expedited review is available when the injured worker faces an "imminent and serious threat to his or her health," including but not limited to "severe pain, potential loss of life, limb, or other major bodily function," or when "the timeframe for utilization review under subdivision (c)(3) would be detrimental to the injured worker's condition, or could jeopardize the injured worker's ability to regain maximum function." [1][4][26][36]

The requesting physician must certify in writing and document the need for expedited review upon submission of the request.[4][26][36] A request for expedited review that is not reasonably supported by evidence establishing that the injured worker faces an imminent and serious threat to health shall be reviewed by the claims administrator under the standard timeframe set forth in subdivision (c)(3) (five working days for prospective review).[4][26][36]

The burden of proof falls on the requesting physician to establish facts supporting expedited review; if the physician's submission does not reasonably establish the necessity, the claims administrator may treat the request as a standard prospective review, and the five-working-day timeline applies.[4][26]

B. Decision Timeline for Expedited Review

Prospective or concurrent decisions on expedited review requests must be made in a timely fashion appropriate to the injured worker's condition, not to exceed seventy-two hours after receipt of the written information reasonably necessary to make the determination.[4][26][36] This seventy-two-hour deadline is strictly construed; any delay beyond this timeframe renders the UR decision untimely and invalid.[26][36][64]

Recent WCAB decisions have made clear that to comply with expedited review requirements, the claims administrator must actually submit the request to a UR physician within the seventy-two-hour period and document that the physician reviewed and made a determination within that timeframe.[26] Merely receiving an expedited request does not automatically satisfy the requirement; affirmative action by the claims administrator to ensure UR physician review within seventy-two hours is necessary.[26]

C. Jurisdictional Consequences of Failure to Meet Expedited Deadlines

If a claims administrator fails to issue an expedited UR decision within the seventy-two-hour requirement, the UR determination is untimely and invalid.[26][36][64] This invalidation restores WCJ jurisdiction to determine medical necessity.[26][36][44] However, the burden of proof shifts: the employee must demonstrate through substantial medical evidence that the requested treatment is reasonably required to cure or relieve the effects of the injury.[26][44]

In *Diaz v. Pacific Coast Framers Inc.* (2023), the WCAB held that where an expedited review request was submitted but the claims administrator failed to provide evidence that a physician actually reviewed the request and made a determination within seventy-two hours, the UR determination was untimely.[26] The court found that leaving a telephone message or otherwise attempting to contact the UR physician did not constitute compliance; actual review and decision-making within the timeframe were required.[26]

IX. Northern California Practice Considerations: San Francisco Venue

A. San Francisco Immigration Court Locations and Procedural Context

While the present analysis focuses on workers' compensation rather than immigration law, the research parameters include recognition that Northern California practice involves distinct court locations and procedural tendencies.[28] For workers' compensation matters, injured workers in the Northern California region may have cases heard at the San Francisco office of the Workers' Compensation Appeals Board (located at 100 Montgomery Street, Suite 800, and other Bay Area locations).

San Francisco WCAB judges have developed practice patterns regarding UR disputes. Some judges are receptive to challenges to UR timeliness and procedural compliance; others defer more readily to UR determinations if the decision is substantively reasonable. Knowledge of individual judge preferences can inform strategy regarding whether to preserve UR defects for appeal or attempt to overturn the decision at the trial level.[44]

B. DWC Administrative Resources

The California Division of Workers' Compensation (DWC) maintains the Medical Unit to handle UR investigations, IMR eligibility determinations, and UR plan approvals.[3][3][41] The DWC's UR investigations group conducts routine investigations of Utilization Review Organizations (UROs) at least once every five years, and special target investigations based on credible complaints.[3][41][41] Claims administrators are subject to routine investigations at least once every five years, typically conducted as part of Performance Audit Reviews (PARs) by the DWC's Audit Unit.[41][41]

Practitioners in Northern California should be aware that the DWC has established specific technical standards for UR compliance, and violations are assessed according to the penalty schedule in CCR Section 9792.12.[41][41] Knowledge of these penalties can inform settlement negotiations and litigation strategy regarding claims administrators' incentives to comply with UR procedures.[41][41]

C. Ninth Circuit Principles and Choice-of-Law Issues

For cases involving federal or constitutional questions (such as due process challenges to UR procedures), the Ninth Circuit Court of Appeals is the controlling appellate authority.[44][45][65] However, pure workers' compensation statutory interpretation is governed by California law and California appellate authority (the

Second, Third, Fourth, and Fifth Districts of the California Court of Appeal, depending on geography and jurisdiction).[39][44][65]

The Rodriguez decision from the Second District Court of Appeal will be controlling authority in Northern California (Second District) and persuasive authority elsewhere in California, pending Supreme Court review.[39][42]

X. Practical Procedures and Deadlines for Practitioners

A. Request for Authorization Submission and Documentation

The treating physician must submit a request for authorization (RFA) in writing, either on the DWC Form RFA or in narrative form with documentation substantiating the medical necessity of the requested treatment.[2][5][36][53][58] The RFA must identify both the employee and the provider, identify with specificity the recommended treatment or treatments, and be accompanied by documentation substantiating the need for the requested treatment to be deemed "completed." [5][58]

For a request to be considered "complete" for UR purposes, the claims administrator or non-physician reviewer must either accept the request as complete and comply with the UR timeframes, or mark it "not complete" and return it to the requesting physician specifying the reasons for return, no later than five business days from receipt.[13][13]

B. UR Decision-Making and Communication Timeline

Once a completed RFA is received, the claims administrator has five normal business days to make a prospective or concurrent UR decision (extendable to fourteen days if additional information is requested and proper notice is given).[4][36][47] The decision must be communicated to the requesting physician within twenty-four hours for concurrent review or within two business days for prospective review, initially by telephone, facsimile, or electronic mail, followed by written notice.[4][36][47]

For expedited requests, the decision must be made and communicated within seventy-two hours.[4][26][36] For retrospective requests, the decision must be made and communicated within thirty days of receipt of complete documentation.[4][36]

C. Appeals and IMR Procedures

If UR denies or modifies treatment, the injured worker has thirty days (ten days for medication-only disputes) to request Independent Medical Review.[38][60] The IMR application must be submitted on DWC Form IMR with a copy of the UR decision to Maximus Federal Services, Inc.[38][60] Once IMR is requested, the UR determination is stayed (the injured worker may pursue the treatment pending IMR decision, though with potential liability to the claims administrator if IMR reverses).[38][60]

The IMR decision is generally final, subject only to narrow grounds for appeal to the WCAB within thirty days.[45][60]

D. Objection to UR Decisions Under Labor Code Section 4062

For UR decisions issued on or after July 1, 2013 (covering the vast majority of current cases), the exclusive remedy for disputing UR decisions on medical necessity grounds is IMR, not Labor Code Section 4062 objection process.[38][44] However, disputes regarding timeliness or procedural validity of UR may be raised as threshold legal issues to be decided by the WCAB, not IMR.[8][11][44]

XI. Strategic Considerations and Emerging Issues

A. The Rodriguez/Patterson Doctrine Impact on Claims Administration

The Rodriguez decision fundamentally altered claims administration strategy regarding ongoing or maintenance treatment. Prior to Rodriguez, many claims administrators deferred to the "Patterson doctrine" and hesitated to re-evaluate ongoing treatment, fearing WCAB jurisdiction would be restored if they attempted to do so. Post-Rodriguez (assuming it survives Supreme Court review), claims administrators are now empowered to submit requests for continuing treatment to UR for fresh medical necessity determinations, even if the same treatment was authorized previously.[24][39][42]

However, Supreme Court review is pending, and the outcome remains uncertain. Until the Supreme Court renders a decision, prudent claims administrators should proceed with caution, acknowledging the Rodriguez holding while recognizing the possibility of reversal.[24][39][42][42]

B. Regulatory Compliance and Penalty Exposure

The April 1, 2026 regulatory amendments substantially raise the technical bar for UR compliance.[13][13] The tightened definitions, enhanced documentation requirements, and expanded circumstances for material modifications increase the likelihood that UR determinations will be challenged on procedural grounds. Claims administrators and UROs should invest in robust training, compliance systems, and documentation protocols to minimize penalty exposure.[13][13][56]

C. Data Transparency and Legislative Developments

Despite statutory mandates in SB 1160 and SB 537 requiring comprehensive UR data reporting, the DWC has failed to provide transparent UR statistics to the public or to employers.[3][32][35] This lack of transparency creates information asymmetry, with claims administrators having superior information about UR outcomes but the public lacking visibility into whether UR denials are appropriate or excessive.[3][32]

SB 636 (2023-2024), which would have required UR physicians serving private employers to be licensed in California, failed to pass and was vetoed by the Governor.[40][43] This legislative defeat reflects ongoing tension between UR oversight and administrative efficiency. Practitioners should monitor future legislative developments regarding UR accountability.[40][43]

D. Procedural Defect Challenges as Leverage in Settlement Negotiations

Because procedural defects in UR determination can restore WCJ jurisdiction and shift burden of proof, injured worker counsel should carefully audit UR determinations for timing, documentation, and procedural compliance issues. Even minor violations—such as delayed communication, failure to properly document decision-making, or ambiguous notification of requested additional information—can serve as leverage in settlement negotiations.[8][11][44][46][64]

Similarly, defense counsel should audit their own UR determinations for compliance and be prepared to defend procedural validity if challenged, ensuring that comprehensive documentation of decision-making and communication is maintained.[8][11][44][46][64]

XII. Conclusion and Synthesis of Key Principles

The California workers' compensation utilization review system represents a complex administrative framework designed to allocate medical decision-making authority among physicians, medical professionals, and the judiciary based on procedural validity and compliance with statutory timelines. The foundational principles guiding this system are as follows:

First, procedural compliance is jurisdictional. A timely, procedurally valid UR determination strips WCJ jurisdiction to determine medical necessity; an untimely or procedurally defective determination restores it.[8][11][44] This means that practitioners must pay meticulous attention to statutory timelines, notice requirements, and decision-making documentation.[4][36][47]

Second, statutory timelines are mandatory, not directory. The five-working-day prospective UR deadline, the seventy-two-hour expedited review deadline, and the thirty-day retrospective deadline are not suggestions; they are jurisdictional requirements.[4][36][44] Failure to meet them renders UR determinations invalid.[4][36][44][46][64]

Third, only physicians may deny or modify treatment. Labor Code Section 4610(e) restricts modifications and denials to licensed physicians competent to evaluate the specific clinical issues involved.[1][36][44] Non-physician involvement in denial or modification decisions is a material procedural defect that invalidates UR.[1][36][44][25][41]

Fourth, the MTUS is the evidentiary standard. Treatment consistent with MTUS guidelines is presumed reasonable and necessary; treatment outside MTUS requires rebuttal with evidence of medical necessity from other evidence-based guidelines.[31][37][49][31] UR reviewers must apply MTUS; treating physicians seeking treatment outside MTUS must present substantial evidence.[31][37][49][31]

Fifth, Independent Medical Review is the exclusive remedy for medical necessity disputes (with narrow exceptions). For injuries on or after January 1, 2013, disputes over whether UR denials are medically necessary are resolved through IMR, not through WCAB litigation, except in the narrow circumstance where UR itself is invalid due to procedural defects or timeliness failures.[38][44]

Sixth, Rodriguez eliminates the Patterson doctrine. The ongoing or maintenance treatment exception to UR no longer applies; all treatment requests, regardless of whether similar treatment was previously authorized, are subject to prospective UR review if a new request is submitted.[24][39][42] However, the Supreme Court's Petition for Review (pending as of February 2026) may alter this conclusion.[42][42]

Seventh, the April 1, 2026 regulatory amendments substantially enhance technical requirements. Compliance with the updated definitions, documentation standards, UR plan procedures, and administrative penalty schedules is now critical to avoiding violations and penalties.[13][13][13][56][13][13]

Practitioners-whether representing injured workers, treating physicians, claims administrators, or employers-must develop expertise in the procedural nuances of UR to effectively navigate disputes, identify procedural vulnerabilities, and structure settlements and litigation strategy accordingly.

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