Legal Analysis: California Request for Authorization (RFA) Procedures and Compliance Requirements

(PART-A INJURED WORKERS ANALYSIS)

February 26, 2026

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CALIFORNIA REQUEST FOR AUTHORIZATION (RFA): PROCEDURES AND COMPLIANCE REQUIREMENTS

This report explains how the Request for Authorization (RFA) process works in California's workers' compensation system. The RFA is the official form a doctor must submit to get approval before providing medical treatment for a work injury. Whether you are an injured worker, a treating physician, or a claims administrator, understanding RFA rules protects your rights and helps you avoid costly mistakes.

As of February 27, 2026, California's RFA system operates under Cal. Lab. Code § 4610 (https://law.justia.com/codes/california/2011/lab/division-4/4600-4614.1/4610/) and regulations in Cal. Code Regs. tit. 8, §§ 9792.6.1–9792.9.1 (https://www.dir.ca.gov/t8/979261.html). Major regulatory updates taking effect April 1, 2026, introduce stricter timelines, expanded rights to resubmit after denial, and higher penalties for violations.

Part 1: What Is a Request for Authorization?

This section defines the RFA and explains why it matters in every workers' compensation claim.

Definition of RFA

A Request for Authorization (RFA) is the official form a treating doctor fills out to ask the workers' compensation insurance company (called the claims administrator) for permission to provide medical treatment for a work injury. The form is called DWC Form RFA, and it is required under Cal. Code Regs. tit. 8, § 9785.5 (https://www.dir.ca.gov/t8/9785.5).

Under Cal. Code Regs. tit. 8, § 9792.6.1(t) (https://www.dir.ca.gov/t8/979261.html), a "Request for authorization" means "a written request for a specific course of proposed medical treatment." Unless the claims administrator accepts a different format, the request must be made on the official DWC Form RFA (https://www.dir.ca.gov/dwc/DWCPropRegs/IMR/IMR_FormRFAClean.pdf).

Why the RFA Matters

The RFA is the gateway document that starts the utilization review (UR) process. Utilization review is the process where a medical professional reviews a doctor's treatment request to decide if the treatment is medically necessary to treat the work injury. Without a properly completed RFA, treatment may be delayed or denied, and providers may not get paid.

> ***Important: A doctor cannot simply provide treatment and expect payment. Except for emergency care and certain automatically authorized treatments, the RFA must be submitted and approved before treatment begins.***

What Makes an RFA "Complete"

Under Cal. Code Regs. tit. 8, § 9792.6.1(t)(2) (https://www.dir.ca.gov/t8/979261.html), a completed RFA must meet three requirements:

- Identify the employee and the provider — The form must include the injured worker's name, date of birth, and claim number, plus the doctor's name, license number, and NPI number
- Identify the recommended treatment with specificity — The form must describe exactly what treatment is being requested (for example, "lumbar epidural steroid injection, single level, left side" rather than just "pain management")
- Include documentation proving medical necessity — The form must attach medical reports or records that explain why the treatment is needed

If any of these three elements is missing, the claims administrator may return the RFA as incomplete within five business days. The doctor must then fix the problem and resubmit.

Part 2: The Legal Framework — Statutes and Key Regulations

This section identifies the main laws and regulations that control the RFA process.

The Primary Statute: Labor Code Section 4610

Cal. Lab. Code § 4610 (https://law.justia.com/codes/california/2011/lab/division-4/4600-4614.1/4610/) is the main law governing utilization review and RFA procedures. It requires:

- Every employer must have a utilization review process — either directly, through an insurer, or through a contracted entity (Cal. Lab. Code § 4610(b) (https://law.justia.com/codes/california/2011/lab/division-4/4600-4614.1/4610/))
- Only a licensed physician reviewer (a doctor qualified to evaluate the specific medical issue) may modify, delay, or deny a treatment request based on medical necessity — meaning it is needed to cure or relieve the work injury (Cal. Lab. Code § 4610(e) (https://law.justia.com/codes/california/2011/lab/division-4/4600-4614.1/4610/))
- A UR denial remains effective for 12 months unless the doctor documents that the patient's condition has materially changed (Cal. Lab. Code § 4610(k) (https://law.justia.com/codes/california/2011/lab/division-4/4600-4614.1/4610/))

> ***Important: A non-physician reviewer (someone who is not a doctor) can only approve requests or ask for more information. They cannot deny or modify treatment based on medical necessity.***

Key Regulations

Several regulations in Title 8 of the California Code of Regulations provide the detailed rules:

- Cal. Code Regs. tit. 8, § 9785.5 (https://www.dir.ca.gov/t8/9785.5) — Specifies the official DWC Form RFA
- Cal. Code Regs. tit. 8, § 9792.6.1 (https://www.dir.ca.gov/t8/979261.html) — Defines key terms including "authorization," "completed," "expedited review," and "request for authorization"
- Cal. Code Regs. tit. 8, § 9792.7 (https://www.dir.ca.gov/t8/9792_7.html) — Requires claims administrators to file a written UR plan with the state
- Cal. Code Regs. tit. 8, § 9792.9.1 (https://www.dir.ca.gov/t8/979291.html) — Sets the response deadlines and notice requirements for all RFA types
- Cal. Code Regs. tit. 8, § 9792.12 (https://www.dir.ca.gov/t8/9792_12.html) — Lists the penalties for UR violations

Employer Liability for Initial Treatment

Under Cal. Lab. Code § 5402(c) (https://law.justia.com/codes/california/2011/lab/division-4/4600-4614.1/4600/), employers must pay up to $10,000 in medical treatment costs while deciding whether to accept or deny a claim. This means an injured worker can receive initial treatment even before the employer decides if the injury is covered.

Part 3: Types of RFA Reviews

This section explains the four types of utilization review and when each applies.

Prospective Review

Prospective review happens before treatment is provided. The doctor submits the RFA first, and the claims administrator must respond within five business days (Cal. Code Regs. tit. 8, § 9792.9.1(c)(3) (https://www.dir.ca.gov/t8/979291.html)). This is the most common type of review.

Concurrent Review

Concurrent review happens while an injured worker is hospitalized. The doctor requests authorization for ongoing inpatient treatment. The claims administrator must also respond within five business days (Cal. Code Regs. tit. 8, § 9792.9.1(c)(3) (https://www.dir.ca.gov/t8/979291.html)). Medical care cannot be stopped until the employee and physician agree on a care plan.

Retrospective Review

Retrospective review happens after treatment has already been provided. The doctor submits an RFA after rendering care, typically for emergency treatment or when advance authorization was not obtained. The

claims administrator has 30 calendar days (not business days) to respond (Cal. Code Regs. tit. 8, § 9792.9.1(c)(5) (https://www.dir.ca.gov/t8/979291.html)).

> ***Important: If you received emergency medical care for a work injury, the provider does not need advance authorization. However, the provider must still submit a retrospective RFA afterward to get paid.***

Expedited Review

Expedited review applies when the injured worker faces an immediate and serious threat to health — such as the potential loss of life, limb, or major bodily function — or when the normal five-day timeline would harm the worker's condition. The claims administrator must respond within 72 hours (Cal. Code Regs. tit. 8, § 9792.9.1(c)(4) (https://www.dir.ca.gov/t8/979291.html)).

The requesting doctor must certify in writing why expedited review is needed and attach documentation. If the request is not reasonably supported by evidence, the claims administrator may process it under the standard five-business-day timeline instead.

> ***Note: Recent guidance from the Workers' Compensation Appeals Board (WCAB) makes clear that claims administrators cannot ignore an expedited designation. They must immediately forward the RFA to a physician reviewer within 72 hours (Sullivan on Comp – Expedited Review of Requests for Treatment Revisited (https://www.sullivanattorneys.com/blog/expedited-review-of-requests-for-treatment-revisited)).***

Part 4: How to Complete the RFA Form

This section lists the required information on the DWC Form RFA and what documentation to attach.

Required Information on the Form

The DWC Form RFA (https://www.dir.ca.gov/dwc/DWCPropRegs/IMR/IMR_FormRFAClean.pdf) must include all of the following (Cal. Code Regs. tit. 8, § 9785.5 (https://www.dir.ca.gov/t8/9785.5)):

- Employee information — Name, date of injury, date of birth, claim number, employer name
- Requesting physician information — Name, practice name, address, NPI number, specialty
- Claims administrator information — Name and contact details for the insurance company handling the claim
- Diagnosis — Specific diagnosis with ICD code (for example, "M54.5 – Low back pain" rather than just "pain")
- Treatment requested — Specific service with CPT/HCPCS code, including frequency, duration, and quantity
- Physician signature — The treating doctor must sign the form (electronic signatures are allowed if the claims administrator agrees)

Required Supporting Documentation

You must attach medical records that prove the treatment is medically necessary. Acceptable documents include:

- Doctor's First Report of Occupational Injury or Illness (Form DLSR 5021)
- Treating Physician's Progress Report (DWC Form PR-2)
- An equivalent narrative medical report explaining the need for treatment

If the treatment follows the Medical Treatment Utilization Schedule (MTUS) — California's official evidence-based treatment guidelines — note this in the narrative. If you are requesting treatment not covered by or inconsistent with the MTUS, include peer-reviewed published medical literature supporting the recommendation (DWC Form RFA Instructions (https://www.employers.com/wp-content/uploads/authorization-request-form-california.pdf)).

Special Checkboxes on the Form

The DWC Form RFA includes several checkboxes for special situations:

- New Request — Use this for a first-time treatment request

- Resubmission — Change in Material Facts — Use this when a prior request was denied but the patient's condition has materially changed. You must include documentation of the change
- Expedited Review — Check this if the worker faces an immediate, serious health threat. You must certify the need in writing
- Written Confirmation of Oral Request — Use this when confirming a prior verbal request, which must be confirmed in writing within 72 hours

Form Version and Signature

You must use the current DWC Form RFA (version effective February 2014 or later). Older versions are not accepted. The form must be signed — unsigned RFAs will be returned as incomplete (daisyBill – Request for Authorization and UR (https://kb.daisybill.com/articles/t-request-for-authorization)).

Part 5: Claims Administrator Response Deadlines

This section explains how quickly the claims administrator must respond to each type of RFA.

When the Clock Starts

The response deadline begins the day after the claims administrator receives the completed RFA. If the RFA is faxed or emailed, the receipt date is determined by the electronic date stamp. Faxes received after 5:30 PM Pacific Time are treated as received the next business day (except for expedited or concurrent review) (Cal. Code Regs. tit. 8, § 9792.9.1 (https://www.dir.ca.gov/t8/979291.html)).

A "business day" does not include Saturdays, Sundays, or state holidays (DWC FAQs on UR for Claims Administrators (https://www.dir.ca.gov/dwc/utilizationreview/ur_faq.htm)).

Response Deadlines Summary

Review Type	Deadline	Measured In
Prospective	5 business days	Business days
Concurrent	5 business days	Business days
Expedited	72 hours	Hours
Retrospective	30 days	Calendar days

Communication Requirements

When the claims administrator approves treatment, they must notify the doctor within 24 hours of the decision by phone, fax, or email (Cal. Code Regs. tit. 8, § 9792.9.1(d) (https://www.dir.ca.gov/t8/979291.html)).

When the claims administrator denies or modifies treatment, they must:

- Contact the doctor initially by phone, fax, or email within 24 hours of the decision
- Send a detailed written notice to the doctor, the injured worker, and the worker's attorney (if represented) within:
- 24 hours for concurrent review
- 2 business days for prospective review
- 72 hours from RFA receipt for expedited review

> ***Critical: Failing to meet these deadlines can result in administrative penalties of $1,000 to $15,000 per violation and may invalidate the UR decision entirely (Cal. Code Regs. tit. 8, § 9792.12 (https://www.dir.ca.gov/t8/9792_12.html)).***

Part 6: What the UR Decision Must Include

This section explains what the written UR decision must contain when treatment is approved, denied, or modified.

Approval Decisions

When the claims administrator approves a request, the written approval must state (Cal. Code Regs. tit. 8, § 9792.9.1(d) (https://www.dir.ca.gov/t8/979291.html)):

- The date the completed RFA was received
- The specific treatment that was requested
- The specific treatment that was approved
- The date of the decision

The approval must be specific — for example, "physical therapy, twice weekly for four weeks" rather than just "physical therapy."

Denial or Modification Decisions

When treatment is denied or modified, the written decision must include all of the following mandatory elements (Cal. Code Regs. tit. 8, § 9792.9.1(e)(5) (https://www.dir.ca.gov/t8/979291.html)):

- Date the RFA was received
- Date of the decision
- Description of the treatment that was requested
- List of all medical records the reviewer examined
- Description of any treatment that was approved
- A clear explanation of why the request was denied or modified, including the medical reasons and the treatment guidelines used
- If the denial is due to missing information, a description of what information is needed
- A statement telling the injured worker they can file for Independent Medical Review (IMR) within 30 calendar days, along with the DWC Form IMR (https://www.dir.ca.gov/dwc/IMR/IMR_FAQs.htm) application
- Contact information for the claims adjuster
- The reviewer's name, medical specialty, and phone number
- The hours when the reviewer or medical director is available to discuss the decision (at least four hours per week during normal business hours)

> ***Important: If any required element is missing from the written decision, the claims administrator faces penalties of $50 to $500 per missing item (Cal. Code Regs. tit. 8, § 9792.12 (https://www.dir.ca.gov/t8/9792_12.html)).***

Deferral of Utilization Review

A claims administrator may defer (postpone) utilization review if they dispute whether the injury is work-related or dispute the treatment on grounds other than medical necessity. If they dispute medical necessity, they must complete the UR process (Cal. Code Regs. tit. 8, § 9792.9.1(b) (https://www.dir.ca.gov/t8/979291.html)).

Part 7: Automatic Authorization — The 30-Day Exemption

This section explains when certain treatments are automatically authorized without going through prospective utilization review.

When Automatic Authorization Applies

Under Cal. Lab. Code § 4610(c) (https://law.justia.com/codes/california/2011/lab/division-4/4600-4614.1/4610/), treatment qualifies for automatic authorization (meaning no advance UR approval is needed) when all six conditions are met (daisyBill – 3 Facts About Automatic Authorization (https://blog.daisybill.com/3-facts-about-automatic-authorization-for-workers-compensation)):

1. The date of injury is on or after January 1, 2018
2. Treatment is provided within 30 days of the injury
3. The claims administrator has accepted liability for the injury
4. Treatment follows the Medical Treatment Utilization Schedule (MTUS)
5. The doctor is in the employer's Medical Provider Network (MPN) or is the worker's predesignated doctor

6. The treatment is not specifically excluded from automatic authorization

Treatments Excluded from Automatic Authorization

Even within the 30-day window, the following treatments still require prospective UR approval (Enlyte – California UR Regulation Updates (https://www.enlyte.com/insights/news-release/utilization-management/california-utilization-review-regulation-updates-effective-2026)):

- Prescription drugs not exempt under the MTUS Drug Formulary
- Non-emergency surgery
- Spinal injections
- Diagnostic imaging
- Electrodiagnostic medicine
- Any treatment previously denied through UR or IMR (unless the denial was overturned)

Billing Deadlines for Automatically Authorized Treatment

Providers must submit bills for automatically authorized treatment within 30 days of providing care — much shorter than the standard 12-month billing deadline for conventionally authorized treatment. For emergency treatment qualifying as automatic authorization, the billing deadline extends to 180 days (daisyBill – How to Appeal Automatic Authorization but Denied Bill (https://blog.daisybill.com/automatic-authorization-denied-bill-how-to-appeal-denial)).

> ***Note: The claims administrator cannot modify, deny, or take back automatic authorization. However, they may conduct retrospective review and remove a doctor's automatic authorization privileges if that doctor shows a pattern of providing treatment inconsistent with the MTUS.***

Part 8: Emergency Treatment Authorization

This section explains the rules for getting authorization when treatment is needed immediately.

Emergency Treatment Does Not Require Advance Authorization

Under Cal. Code Regs. tit. 8, § 9792.6.1(i) (https://www.dir.ca.gov/t8/979261.html), emergency health care services are treatments for conditions so severe that without immediate care, the patient's health would be in serious danger. This includes situations where a worker could lose life, limb, or a major bodily function.

> ***Critical: A provider never has to wait for authorization before treating a medical emergency. Failure to get advance authorization cannot be used as a reason to deny payment for emergency treatment (daisyBill – RFA for Emergency Treatment (https://kb.daisybill.com/topics/authorization-treatment)).***

What the Provider Must Do After Emergency Treatment

Although advance authorization is not required, the provider must still:

- Submit a retrospective RFA after the emergency treatment
- Include documentation explaining the emergency condition
- The claims administrator then has 30 calendar days to complete retrospective utilization review

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Part 9: Resubmitting an RFA After Denial

This section explains your rights when a treatment request has been previously denied.

The 12-Month Rule

Under Cal. Lab. Code § 4610(k) (https://law.justia.com/codes/california/2011/lab/division-4/4600-4614.1/4610/), a UR denial normally stays in effect for 12 months. During this period, the same doctor cannot request the same treatment again unless they document that the patient's condition has materially changed.

Resubmission When Facts Have Changed

If the patient's condition has genuinely changed — for example, a previously effective treatment is no longer working, or the condition has worsened — the treating doctor may resubmit the RFA by:

- Checking the "Resubmission — Change in Material Facts" box on the DWC Form RFA
- Including medical documentation that explains exactly what has changed

The WCAB confirmed this right in Mario Ramirez v. UNKNOWN, ADJ15193432 (WCAB Panel Decision 2025) (https://www.dir.ca.gov/wcab/Panel-Decisions-2025/Mario-RAMIREZ-ADJ15193432.pdf), holding that the claims administrator cannot ignore a resubmitted RFA when the doctor has documented clinical changes.

April 1, 2026 Regulatory Change

Starting April 1, 2026, new Cal. Code Regs. tit. 8, § 9792.9.5 (https://www.enlyte.com/insights/news-release/utilization-management/california-utilization-review-regulation-updates-effective-2026) makes resubmission rights even stronger:

- A resubmitted RFA cannot be deferred if the doctor expressly documents a change in material facts
- The resubmission must be reviewed by a physician reviewer (not a non-physician)
- Any denial must provide a substantive explanation of why the documented changes are insufficient
- Simply rejecting the resubmission as "duplicative" is no longer allowed

> ***Important: This is one of the most significant changes in the April 2026 regulations. It means injured workers whose conditions have worsened have a real path to getting treatment reconsidered, even within the 12-month denial period.***

Part 10: Penalties for Non-Compliance

This section lists the financial penalties claims administrators face for violating RFA and UR rules.

Penalty Schedule

Cal. Code Regs. tit. 8, § 9792.12 (https://www.dir.ca.gov/t8/9792_12.html) establishes mandatory penalties for UR violations:

Organizational Failures:

- No utilization review plan established: $50,000
- No qualified medical director designated: $50,000
- UR plan not filed with the state: $10,000
- UR plan missing required elements: $5,000

Missed Deadlines:

- Late prospective/concurrent decision (past 5 business days): $1,000 per violation
- Late concurrent decision (non-expedited): $2,000 per violation
- Late expedited decision (past 72 hours): $15,000 per violation
- Late retrospective decision (past 30 days): $500 per violation

Notice Failures:

- Failure to include IMR application form with denial: $2,000 per violation
- Missing required fields in written decision: $50–$500 per instance
- Failure to notify doctor about incomplete RFA: $50 per instance
- Failure to document attempts to get missing information before denying: $50 per instance

URAC Accreditation Requirement (Effective April 1, 2026)

Starting April 1, 2026, any UR operation that modifies or denies treatment must have URAC Workers' Compensation Utilization Management Accreditation — a three-year certification from URAC (https://www.urac.org/accreditation-cert/workers-compensation-utilization-management-accreditation/). Without this accreditation, a claims administrator cannot deny or modify any treatment request and faces penalties and potential loss of UR authority (Enlyte – California UR Regulation Updates

(https://www.enlyte.com/insights/news-release/utilization-management/california-utilization-review-regulation-updates-effective-2026)).

State Audits

The Division of Workers' Compensation conducts UR audits and publishes results. In January 2026, the DWC posted 2025 audit results (https://www.dir.ca.gov/DIRNews/2026/2026-06.html) showing penalty assessments against major insurers. A passing score is 85% or higher.

Part 11: Disputing a Denial — Independent Medical Review (IMR)

This section explains how to challenge a UR decision that denies or modifies your treatment.

What Is IMR?

Independent Medical Review (IMR) is the process where an independent doctor — not connected to the claims administrator — reviews a UR denial to decide whether the treatment is medically necessary. IMR is the only way to challenge a UR denial based on medical necessity. You cannot go to court or to the WCAB to challenge medical necessity instead (Cal. Lab. Code § 4610.5 (https://law.justia.com/codes/california/2011/lab/division-4/4600-4614.1/4610.5/); DWC – Independent Medical Review (https://www.dir.ca.gov/dwc/imr.htm)).

This was confirmed by the California Court of Appeal in Illinois Midwest Insurance Agency LLC v. WCAB (Rodriguez), (Cal. Ct. App., 2d Dist., Nov. 10, 2025) (https://www.sullivanattorneys.com/blog/2nd-district-court-appeal-rejects-patterson-exception-ur-imr), which held that "for any dispute over medical necessity arising from a UR decision, IMR is the sole and exclusive remedy."

How to File for IMR

1. Obtain the Application for Independent Medical Review (DWC Form IMR-1 (https://www.dir.ca.gov/dwc/IMR/IMR_FAQs.htm)), which should be included with the denial notice
2. Complete the form and attach a copy of the UR denial decision
3. Mail or fax the application to Maximus Federal Services, Inc. (the state's designated IMR organization) within 30 calendar days of receiving the UR denial (10 days for drug-only disputes after April 1, 2026)

What Happens After Filing

- The state reviews the application for eligibility (Cal. Code Regs. tit. 8, § 9792.10.1 (https://www.dir.ca.gov/t8/9792101.html))
- If eligible, an independent physician reviewer examines the medical records
- The IMR determination is typically issued within 30 calendar days
- If the IMR reviewer agrees the treatment is medically necessary, the claims administrator must authorize the treatment within 5 business days

> ***Important: The IMR determination is presumed correct. The WCAB rarely overturns IMR decisions, and can only do so for fraud, bias, or serious procedural errors (DWC IMR FAQs (https://www.dir.ca.gov/dwc/IMR/IMR_FAQs.htm)).***

Part 12: Major Regulatory Changes Effective April 1, 2026

This section summarizes the key changes approved on December 30, 2025, taking effect April 1, 2026.

On December 30, 2025, the California Office of Administrative Law approved significant amendments to the UR regulations (DWC Newsline 2025-125 (https://www.dir.ca.gov/DIRNews/2025/2025-125.html)). These changes affect everyone involved in the RFA process.

Key Changes

- Resubmission rights expanded — Resubmitted RFAs documenting material fact changes cannot be deferred and must receive physician-level review (Cal. Code Regs. tit. 8, § 9792.9.5 (eff. Apr. 1, 2026) (https://www.enlyte.com/insights/news-release/utilization-management/california-utilization-review-regulation-updates-effective-2026))

- URAC accreditation mandatory — UR plans that deny or modify treatment must have URAC Workers' Compensation Utilization Management Accreditation
- Non-physician reviewer limits clarified — Non-physicians can only approve requests or discuss criteria with doctors. They cannot deny or modify treatment on medical necessity grounds, and they cannot deny treatment for missing information
- Physician reviewer must engage with doctor's arguments — When a requesting doctor argues that treatment guidelines should not apply, the reviewing physician must explain why the doctor's reasoning is insufficient
- Incomplete RFA handling improved — Claims administrators must either accept an incomplete request or return it marked "not complete" with specific reasons within five business days
- Drug formulary transparency — Approvals of formulary-exempt drugs must state "Exempt per MTUS Drug Formulary" in writing
- UR plan application process updated — New DWC Form UR-01 (https://www.enlyte.com/insights/news-release/utilization-management/california-utilization-review-regulation-updates-effective-2026) is mandatory for filing or modifying UR plans
- Extended review period for UR plans — Organizations get a 60-day extension (total 120 days) to address UR plan deficiencies, with provisional approval if the state takes no action by day 120
- New penalties added — Additional penalties for failure to obtain URAC accreditation, failure to limit non-physician reviewers to approved functions, and failure to obtain state approval for UR plans before operating

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Part 13: Practical Steps for Treating Physicians

This section provides a checklist and action plan for doctors submitting RFAs.

Pre-Submission Checklist

Before submitting an RFA, verify the following:

- Treatment is consistent with MTUS guidelines (or you have peer-reviewed literature supporting a non-MTUS approach)
- Patient information is accurate (name, date of birth, claim number, employer)
- Your provider information is complete (name, license, NPI, address, phone, fax, email)
- The correct claims administrator address and fax number are on the form
- Your diagnosis includes a current, specific ICD code
- The requested treatment includes a detailed description with CPT/HCPCS codes, frequency, duration, and quantity
- Supporting medical documentation (Form DLSR 5021, DWC Form PR-2, or narrative report) is attached
- The form is signed
- You are using the current DWC Form RFA version (February 2014 or later)

After Submission

1. Keep your fax confirmation sheet showing successful transmission and the time sent
2. Mark your calendar for 5 business days (prospective) or 30 calendar days (retrospective) to follow up
3. If no response arrives by the deadline, contact the claims administrator by phone and document the conversation
4. If the RFA is returned as "not complete," fix the identified issues and resubmit promptly — the deadline restarts

After Receiving a Denial

You have two main options:

- File for IMR — If you believe the UR denial was medically wrong, file DWC Form IMR-1 within 30 calendar days
- Resubmit the RFA — If the patient's condition has materially changed, check "Resubmission — Change in Material Facts," attach documentation of the changes, and resubmit. After April 1, 2026, this resubmission must receive physician-level review

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Part 14: Practical Steps for Claims Administrators

This section outlines compliance obligations and risk management for claims administrators.

Core Obligations

- Maintain a written UR plan filed with the Administrative Director, including a designated medical director (Cal. Code Regs. tit. 8, § 9792.7 (https://www.dir.ca.gov/t8/9792_7.html))
- As of April 1, 2026, obtain and maintain URAC accreditation if your UR plan modifies or denies treatment
- Ensure only physician reviewers deny or modify treatment based on medical necessity
- Track RFA receipt dates precisely using electronic date stamps
- Meet all response deadlines: 5 business days (prospective/concurrent), 72 hours (expedited), 30 calendar days (retrospective)
- Include all mandatory elements in written denial or modification decisions

Handling Special Situations

- Resubmitted RFAs with material fact changes — After April 1, 2026, these cannot be deferred. Send them to a physician reviewer immediately
- Expedited RFAs — Forward to a physician reviewer within 72 hours. Do not process under standard timelines and argue later that the expedited designation was not supported
- Incomplete RFAs — Return within 5 business days marked "not complete" with specific reasons, or accept as complete and begin UR

Part 15: Rights and Remedies for Injured Workers

This section explains what injured workers should know about the RFA process and their options if treatment is denied.

Your Basic Rights

- Your treating doctor must submit an RFA to your employer's insurance company to get treatment approved
- The insurance company must respond within the required deadlines (usually 5 business days)
- Only a licensed doctor can deny your treatment based on medical necessity — a non-doctor cannot make that decision
- For emergency care, you have the right to immediate treatment without waiting for authorization

If Your Treatment Is Denied

- You (or your attorney) can file for Independent Medical Review within 30 calendar days of receiving the denial
- The IMR process is free and provides a review by an independent doctor
- If the IMR reviewer agrees your treatment is necessary, the insurance company must authorize it within 5 business days
- If your condition has worsened or changed, your doctor can resubmit the RFA with documentation of the changes

If You Have an Attorney

If you are represented by a workers' compensation attorney, your attorney can help you navigate the IMR process, challenge improper denials, and ensure the claims administrator meets all deadlines. If you are not represented and have questions, you can contact the DWC Information & Assistance Unit (https://www.dir.ca.gov/dwc/imr.htm) for free help.

> ***Important: You cannot go directly to court or to the WCAB to challenge whether treatment is medically necessary. IMR is your only option for medical necessity disputes. This was confirmed in Illinois Midwest Insurance Agency LLC v. WCAB (Rodriguez) (Cal. Ct. App., 2d Dist., Nov. 10, 2025).***

Part 16: Key Compliance Deadlines Summary

This table summarizes the most important deadlines as of February 27, 2026.

Action	Deadline	Who Is Responsible
Claims administrator responds to prospective/concurrent RFA	5 business days	Claims Administrator
Claims administrator responds to expedited RFA	72 hours	Claims Administrator
Claims administrator responds to retrospective RFA	30 calendar days	Claims Administrator
Initial phone/fax/email notice of denial	24 hours after decision	Claims Administrator
Written denial notice (concurrent review)	24 hours after decision	Claims Administrator
Written denial notice (prospective review)	2 business days after decision	Claims Administrator
Written denial notice (expedited review)	72 hours from RFA receipt	Claims Administrator
Filing for Independent Medical Review	30 calendar days after denial	Injured Worker / Doctor
IMR filing for drug-only disputes (after Apr. 1, 2026)	10 calendar days after denial	Injured Worker / Doctor
URAC accreditation compliance	April 1, 2026	UR Plan Operators
Resubmission after UR denial (material fact change)	Within 12 months of denial	Treating Physician

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Legal Analysis: California Request for Authorization (RFA) Procedures and Compliance Requirements

(PART-B LEGAL ANALYSIS)

Generated by: Legal AI Assistant

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

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Comprehensive Legal Analysis: California Request for Authorization (RFA) Procedures and Compliance Requirements

Executive Summary

The Request for Authorization for Medical Treatment, designated as DWC Form RFA under California Code of Regulations, Title 8, Section 9785.5, is the mandatory standardized form for initiating the utilization review process in California workers' compensation claims[1]. As of February 27, 2026, California's RFA system operates under Labor Code Section 4610 and implementing regulations in Title 8 CCR SectionSection 9792.6.1 through 9792.9.1. Significant regulatory updates effective April 1, 2026, have reshaped RFA procedures, introducing stricter timelines for plan approval, expanded grounds for resubmission after denial, and enhanced compliance penalties for non-physician reviewer violations[39]. Treating physicians must understand that a completed RFA requires (1) identification of employee and provider, (2) specificity regarding recommended treatment, and (3) accompanying medical documentation substantiating medical necessity[2][43]. Claims administrators face strict response deadlines: five business days for prospective or concurrent requests, 72 hours for expedited requests, and 30 calendar days for retrospective requests[10][31]. The new regulatory framework eliminates prior ambiguities regarding resubmission after denial when material facts change, now requiring that such requests must be reviewed by physician reviewers and cannot be deferred[39]. Non-compliance carries escalating administrative penalties ranging from $50 per instance to $50,000 for structural UR plan failures[25][25]. The system reflects California's legislative intent to remove medical necessity determinations from courts and place them exclusively with medical professionals, as confirmed by recent appellate authority rejecting carve-outs for "ongoing treatment" disputes[53].

I. Introduction and Foundational Context

The California workers' compensation system's medical treatment authorization structure represents a deliberate legislative shift enacted through Senate Bill 863 (effective January 1, 2013) to replace costly litigation over medical necessity with an administrative review process conducted by medical professionals. The RFA serves as the gateway document initiating that process. Understanding RFA requirements is essential for treating physicians seeking authorization to provide medical services, claims administrators establishing compliant utilization review procedures, injured workers navigating treatment approval processes, and medical providers ensuring timely reimbursement. This analysis addresses the procedural framework, compliance obligations, recent regulatory developments, and strategic considerations for all stakeholders within the RFA ecosystem.

II. Legal Framework: Statutory Authority and Regulatory Foundation

A. Statutory Authority

Labor Code Section 4610 establishes the foundational mandate for utilization review and RFA procedures. Under Labor Code Section 4610(a), utilization review is defined 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, as defined in Section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Section 4600."[3][3] Labor Code Section 4610(b) mandates that "[e]very employer shall establish a utilization review process in compliance with this section, either directly or through its insurer or an entity with which an employer or insurer contracts for these services."[3][3] Critically, 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."[3][3][3] This physician-only restriction represents a critical limitation on non-physician reviewer authority.

Labor Code Section 4610(g)(2) addresses expedited review timelines, requiring that when "the employee's condition is such that the employee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process, as described in paragraph (1), would be detrimental to the employee's life or health or could jeopardize the employee's ability to regain maximum function," utilization review decisions "shall be made in a timely fashion that is appropriate for the nature of the employee's condition, but not to exceed 72 hours after the receipt of the information reasonably necessary to make the determination."[3][7][3] Labor

Code Section 4610(k) establishes the twelve-month effectiveness window for UR denials, providing that "[a] utilization review decision to modify or deny a treatment recommendation shall remain effective for 12 months from the date of the decision without further action by the employer with regard to a further recommendation by the same physician 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."[3][3][19]

Labor Code Section 4610(c) establishes automatic authorization for certain treatments, exempting specific treatments from prospective utilization review when rendered within 30 days of injury by a network physician and consistent with the Medical Treatment Utilization Schedule[14][26][28]. Labor Code Section 5402(c) provides that employers remain liable for up to $10,000 in medical treatment costs pending liability decisions, ensuring injured workers receive initial treatment regardless of claim acceptance status[47].

B. Regulatory Framework

California Code of Regulations, Title 8, Section 9785.5 specifies the official DWC Form RFA (version effective February 2014, updated components through 2025) and establishes that treating physicians must use the current approved form to request authorization[1][6][1][43]. The form's mandatory components include employee information (name, date of injury, date of birth, claim number, employer), requesting physician information (name, practice, address, NPI number, specialty), claims administrator information, specific diagnosis with ICD code, service requested with CPT/HCPCS code, frequency/duration/quantity information, requesting physician signature, and claims administrator response section[1][4][6][1].

California Code of Regulations, Title 8, Section 9792.6.1 provides comprehensive definitions applicable to RFA procedures. The regulation defines "Authorization" as "assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury pursuant to section 4600 of the Labor Code, subject to the provisions of section 5402 of the Labor Code, based on either a completed 'Request for Authorization,' DWC Form RFA, as contained in California Code of Regulations, title 8, section 9785.5, or a request for authorization of medical treatment accepted as complete by the claims administrator under section 9792.9.1(c)(2), that has been transmitted by the treating physician to the claims administrator."[51] The regulation defines "Completed," for purposes of RFA compliance and penalty investigations, as "that the 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."[43][51]

California Code of Regulations, Title 8, Section 9792.6 defines "Expedited review" as "utilization review conducted when the injured worker's condition is such that the injured worker faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process would be detrimental to the injured worker's life or health or could jeopardize the injured worker's permanent ability to regain maximum function."[5]

California Code of Regulations, Title 8, Section 9792.7 establishes utilization review plan requirements. All claims administrators must "establish and maintain a utilization review process" with a written plan filed with the Administrative Director[18][31]. The plan must include the medical director's name, address, phone number, and medical license number; description of the request review process; specific criteria used in decision-making consistent with the Medical Treatment Utilization Schedule; qualifications and functions of UR personnel; and description of prior authorization processes, if applicable[18][31]. Critically, as of April 1, 2026, UR plans that modify or deny treatment must provide proof of URAC Workers' Compensation Utilization Management Accreditation[37][37]. Non-physician reviewers may only approve requests or request additional information-they cannot modify or deny authorizations based on medical necessity[18][31][31][31].

California Code of Regulations, Title 8, Section 9792.9.1 establishes critical procedural timelines and notice requirements. For prospective and concurrent reviews, "decisions to approve, modify, delay, or deny a request for authorization shall be made in a timely fashion that is appropriate for the nature of the injured worker's condition, not to exceed five (5) business days from the date of receipt of the completed DWC Form RFA."[10][10][10] For expedited reviews, decisions must be made "in a timely fashion appropriate to the injured worker's condition, not to exceed 72 hours after the receipt of the written information reasonably necessary to make the determination."[10][10][10][10] For retrospective reviews, decisions must be made

"within 30 days of receipt of the request for authorization and medical information that is reasonably necessary to make a determination."[10][10][54] Decisions modifying, delaying, or denying treatment must be communicated initially by phone, fax, or email within 24 hours of the decision, followed by written notice within 24 hours for concurrent review, two business days for prospective review, and 72 hours for expedited review[10][10][31][10].

California Code of Regulations, Title 8, Section 9792.9.5 (effective April 1, 2026) establishes that when a requesting physician expressly and unequivocally indicates in the RFA that there has been a change in facts material to the basis of a prior UR denial and includes documentation of such change, the RFA "cannot be deferred" and "must be reviewed by a physician reviewer, and any modification or denial of the request must comply with applicable requirements."[37][37][37] This represents a significant expansion of resubmission rights compared to prior practice[30].

California Code of Regulations, Title 8, Section 9792.12 establishes an administrative penalty schedule with amounts ranging from $50 per instance for failure to notify about incomplete information ($50 penalty per instance) to $50,000 for failure to establish a compliant UR plan[25][25]. Key penalty triggers include failure to respond to complete RFAs timely ($1,000 for prospective, $2,000 for concurrent, $500 for retrospective, per violation)[25][25], failure to employ or designate a qualified medical director ($50,000)[25][25], and failure to communicate expedited decisions timely ($15,000)[25][25].

III. Current Legal Landscape: Regulatory Developments and Recent Rulings (2025-2026)

A. April 1, 2026 Regulatory Amendments (Finalized December 30, 2025)

On December 30, 2025, the California Office of Administrative Law approved the Division of Workers' Compensation's proposed utilization review regulations with an effective date of April 1, 2026[39]. These amendments significantly reshape RFA procedures and compliance obligations.

Key Changes to RFA Definitions and Terminology: The regulations delete the definition of "Delay" and expand the definition of "Request for Authorization" to replace the phrase "the DWC Form RFA" with "request for authorization," enabling more flexible submission formats while maintaining substantive requirements[37][37]. The definition of "Course of Treatment" has been updated to clarify that prior treatment recommendations remain part of the RFA analysis[37].

Resubmission After Denial and Material Fact Changes: The most significant change addresses Labor Code Section 4610(k)'s twelve-month deferral rule. New Section 9792.9.5 provides explicitly that "a request for authorization of treatment for which UR would otherwise be precluded under Labor Code section 4610(k) cannot be deferred if the requesting physician expressly and unequivocally indicates or opines in the request for treatment that there has been a change in facts material to the basis of the prior denial of such same treatment and includes documentation of such change."[37][37][37] Critically, "Such a request must be reviewed by a physician reviewer, and any modification or denial of the request must comply with applicable requirements as set forth at section 9792.9.1."[37][37][37] This change reverses prior case law suggesting defendants could ignore resubmitted RFAs within twelve months by simply checking a box, and now requires substantive physician-level review whenever documented material changes are alleged[19][30][48].

RFA Plan Application and URAC Accreditation: New Section 9792.7.1 incorporates DWC Form UR-01 ("Utilization Review Plan Application or Modification," effective March 2025) as the mandatory application form for UR plans[37][37]. Critically, "UR plans that modify/deny treatment must provide proof of URAC Workers' Compensation Utilization Management Accreditation" before operation[37][37]. Non-compliance with this accreditation requirement triggers mandatory penalties and potential plan suspension or revocation[37][37][37].

UR Plan Timeline Extensions and Approvals: The regulations add a 60-day extension period after the initial 60-day review period for UR plans, with provisional approval if the Administrative Director takes no action by day 120[37][37][37]. This provides organizations additional time to address compliance deficiencies. The appeal timeframe for rejected or denied plans has been increased from the previous period to 25 days[37][37].

Enhanced Incomplete RFA Procedures: Upon receipt of a request that does not meet the definition of "complete request for authorization," "a claims administrator, non-physician reviewer as allowed, or physician reviewer must either accept the request as a complete request for authorization and comply with the

requirements or mark it 'not complete' and return it to the requesting physician, specifying the reasons for the return of the request, no later than five business days from receipt."[37][37] This clarification accelerates feedback to providers regarding missing documentation.

Non-Physician Reviewer Authority Clarification: The regulations clarify that non-physician reviewers "may approve requests for authorization of medical services" and "may discuss applicable criteria with the requesting physician," but explicitly cannot "modify or deny requests for authorization of medical treatment for reasons of medical necessity to cure or relieve."[18][37][37][31] A non-physician reviewer also cannot deny authorization requests when "necessary information/tests/consultation is missing"-only physician reviewers can make such denials[37][37]. This represents an important codification of physician-only authority that some administrators had previously construed more broadly[18].

Drug Formulary Approvals: For approvals of requests for authorization of drugs exempt on the Drug Formulary, "the written decision approving the request must indicate, 'Exempt per MTUS Drug Formulary' or words to that effect and meaning."[37][37] For approvals of non-drug treatment exempt under the 30-day exemption, the written decision must identify the exemption as "'30-day exemption' or words to that effect and meaning."[37][37] This enhanced transparency prevents subsequent disputes regarding whether treatment was actually authorized or merely approved without UR.

Physician Reviewer Documentation When Requestor Disputes Guidelines: Where "the 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."[37][37][37] This requirement prevents cursory denials when providers challenge guideline applicability and forces substantive engagement with medical arguments.

30-Day Automatic Authorization Criteria and Documentation: The regulations specify detailed requirements for treatment to qualify for automatic authorization (30 days post-injury, MPN provider, MTUS-consistent, liability accepted). The regulations now expressly require that "all treatment or services anticipated to be provided to the injured worker in the first 30 days after the date of injury, including the exempt drugs prescribed to the injured worker under the MTUS Drug Formulary, are set forth in a request for authorization provided to the claims administrator" and "[t]he form must be submitted to the claims administrator concurrent with the Doctor's First Report of Occupational Injury or Illness."[37][37][37] This clarifies that automatic authorization requires detailed upfront planning and documentation.

Expanded Penalty Framework: The regulations establish new monetary penalties for failure to obtain Administrative Director approval for utilization review plans before operation; failure to obtain or maintain URAC accreditation; failure to ensure only physician reviewers modify or deny treatment requests on medical necessity grounds; and failure to ensure only physician reviewers deny authorization requests when necessary information/tests/consultation are missing[37][37]. These represent significantly expanded enforcement mechanisms compared to 2025 procedures.

B. Recent Appellate Authority on RFA Procedures and Ongoing Treatment

On November 10, 2025, the California Court of Appeal, Second District, issued its published decision in Illinois Midwest Insurance Agency LLC v. WCAB (Rodriguez), a landmark ruling clarifying RFA and utilization review finality[53]. The court rejected the WCAB's prior reliance on Patterson v. The Oaks Farm (2014) 79 CCC 910, which had created an exception to utilization review for "ongoing" or "continuing" treatment disputes[50][53]. The Rodriguez court held that "The entire statutory framework evinces a clear legislative purpose: to remove medical necessity determinations from the WCAB and courts and to place such decisions exclusively in the hands of medical professionals."[53] Applying this principle, the court found "no statutory basis for an 'ongoing treatment' exception to the UR/IMR process" and held that "[f]or any dispute over medical necessity arising from a UR decision, IMR is the sole and exclusive remedy."[53] This decision eliminates a prior defense strategy for injured workers seeking to preserve ongoing treatment without submitting to utilization review, effectively reinforcing the RFA/UR/IMR procedural monopoly over all medical necessity disputes[53].

C. Recent WCAB Panel Decisions on Resubmission and Material Facts

The WCAB Panel Decision in Mario Ramirez v. UNKNOWN, ADJ15193432 (2025) addressed the procedures for resubmitting RFAs within the twelve-month window established by Labor Code Section 4610(k) when the requesting physician documents material changes in clinical condition[30]. The panel held that "a documented change in the facts material to the basis of the original UR decision" may override the twelve-month deferral period, noting that the RFA form itself contains a checkbox marked "Resubmission - Change in Material Facts" and that this procedural mechanism enables resubmission when clinical deterioration renders the prior UR decision inapplicable[30]. The panel rejected arguments that the defendant could ignore the resubmitted RFA as duplicative without conducting new utilization review when the physician expressly documented clinical changes (in that case, loss of efficacy of prior epidural injections)[30]. This decision provided foundational authority for the April 1, 2026 regulatory codification of resubmission rights[30].

D. DWC Audit and Enforcement Activity (2025)

In January 2026, the Division of Workers' Compensation posted completed utilization review investigation results for claims administrators audited in 2025[23]. Performance ratings were based on composite scores reflecting failures in (1) timely response to requests for authorization, (2) notice content deficiencies, and (3) failure to serve all appropriate parties with UR decisions[23]. A passing Utilization Review Performance Rating is 85% or greater[23]. This ongoing enforcement activity demonstrates active DWC monitoring of UR compliance and willingness to assess penalties for procedural violations[23].

IV. RFA Definition, Types, and Procedural Classification Framework

A. What Constitutes a Request for Authorization (RFA)?

Under California Code of Regulations, Title 8, Section 9792.6.1(t), "[a] 'Request for authorization' means a written request for a specific course of proposed medical treatment."[51] The regulation specifies that unless the claims administrator accepts the request as complete under Section 9792.9.1(c)(2), "a request for authorization must be set forth on a 'Request for Authorization (DWC Form RFA),' completed by a treating physician, as contained in California Code of Regulations, title 8, section 9785.5."[51] Notably, the regulation uses the term "treating physician" without limitation to "primary treating physician," meaning that secondary physicians, therapists credentialed under the relevant scope of practice, and other non-primary providers authorized to treat within an MPN can submit RFAs[41][43][41].

The RFA "must be signed by the treating physician and may be mailed, faxed or e-mailed to, if designated, the address, fax number, or e-mail address designated by the claims administrator for this purpose."[51] By agreement of the parties, treating physicians may submit RFAs "with an electronic signature."[51]

Critically, the regulation provides that a request "shall be deemed to have been received by the claims administrator or its utilization review organization by facsimile or by electronic mail on the date the form was received if the receiving facsimile or electronic mail address electronically date stamps the transmission when received."[10] If no electronically stamped date is recorded, "then the date the form was transmitted shall be deemed to be the date the form was received."[10] Facsimile transmissions received after 5:30 PM Pacific Time are "deemed to have been received by the claims administrator on the following business day, except in the case of an expedited or concurrent review."[10]

B. Four Types of RFA Based on Timing of Service

California law recognizes four types of utilization review based on when review occurs relative to treatment delivery:

Prospective Review: California Code of Regulations, Title 8, Section 9792.6.1(s) defines prospective review as "any utilization review conducted, except for utilization review conducted during an inpatient stay, prior to the delivery of the requested medical services."[51] In prospective review, the treating physician submits an RFA before providing treatment, seeking authorization before proceeding[14][14]. The claims administrator must respond within five business days[10][10][10]. Prospective review represents the standard RFA procedure and applies when treatment has not yet been rendered[10][31][54].

Concurrent Review: California Code of Regulations, Title 8, Section 9792.6.1(c) defines concurrent review as "utilization review conducted during an inpatient stay."[51] In concurrent review, a treating physician requests authorization while the patient is hospitalized for ongoing inpatient treatment[10][10][10]. Like prospective

review, concurrent review decisions must be made within five business days and communicated within 24 hours, but the statutory framework explicitly contemplates that medical care shall not be discontinued until the employee and physician agree upon an appropriate care plan[3][3]. Concurrent review applies most frequently to hospital-based treatment and inpatient rehabilitation[10].

Retrospective Review: California Code of Regulations, Title 8, Section 9792.6.1(u) defines retrospective review as "utilization review conducted after medical services have been provided and for which approval has not already been given."[51] In retrospective review, the treating physician submits an RFA after treatment has been rendered, either because the provider did not seek advance authorization or because the treatment was provided on an emergency basis[14][10][14]. Retrospective review decisions must be made within 30 calendar days, not business days, providing claims administrators more flexibility[10][10][54]. Retrospective review is mandatory for emergency medical services, as failure to obtain advance authorization cannot form the basis for denying payment for emergency treatment[14][10][14][3].

Expedited Review: California Code of Regulations, Title 8, Section 9792.6.1(j) defines expedited review as "utilization review conducted when the injured worker's condition is such that the injured worker faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process would be detrimental to the injured worker's life or health or could jeopardize the injured worker's permanent ability to regain maximum function."[51] Expedited review can be prospective or concurrent, but must be completed within 72 hours of receipt of necessary information[10][10][10][10]. The requesting physician "must certify in writing and document the need for an expedited review upon submission of the request," and a request not "reasonably supported by evidence" must be reviewed under standard prospective or concurrent timelines[10][10][10].

C. Special RFA Categories

New vs. Resubmission RFAs: The DWC Form RFA contains a checkbox allowing the requesting physician to designate the submission as either "New Request" or "Resubmission - Change in Material Facts."[1][1] A resubmission is "appropriate if the facts that provided the basis for the initial utilization review decision have subsequently changed such that the decision is no longer applicable to the employee's current condition."[1][1][30] The resubmission checkbox includes a requirement that the physician "[i]nclude documentation supporting your claim" of changed facts[1][1]. As of April 1, 2026, such resubmissions cannot be deferred under Labor Code Section 4610(k) when the physician expressly documents material changes[37][37][37].

Expedited Review RFAs: The form also contains a checkbox for "[e]xpedited Review: Check box if employee faces an imminent and serious threat to his or her health."[1][1][4] A request for expedited review must be supported by documentation substantiating the employee's condition[1][1][7]. If the request is not reasonably supported by evidence, the claims administrator may process it under standard timelines rather than the 72-hour expedited framework[7][10][10].

Written Confirmation of Oral Request: The form includes a checkbox for "[t]he request is a written confirmation of a prior oral request."[1][1] Labor Code Section 4610(h) permits treating physicians to make oral requests for authorization, which must be "followed by a written confirmation of the request within seventy-two (72) hours."[5] Both the oral request and written confirmation must contain substantiation of medical necessity[5]. Under California Code of Regulations, Title 8, Section 9792.6.1(q), oral requests "must be followed by a written confirmation of the request within seventy-two (72) hours. Both the written confirmation of an oral request and the written request must be set forth on the 'Doctor's First Report of Occupational Injury or Illness,' Form DLSR 5021, section 14006, or on the Primary Treating Physician Progress Report, DWC Form PR-2, as contained in section 9785.2, or in narrative form containing the same information required in the PR-2 form."[5]

V. RFA Completion Requirements and Documentation Standards

A. Definition of "Completed" RFA

Under California Code of Regulations, Title 8, Section 9792.6.1(t)(2), a "Completed" RFA, for purposes of compliance investigations and penalties, means that the request for authorization must:

Identify both the employee and the provider[51]

Identify with specificity a recommended treatment or treatments[51]

Be accompanied by documentation substantiating the need for the requested treatment[51]

This three-part definition has been consistently applied by the Division of Workers' Compensation in audit investigations[23][31]. Each element requires specificity: the employee identification must include the injured worker's name, date of birth, and claim number; the provider identification must include the treating physician's name, license number, NPI number, and practice location; the treatment must be identified with specificity sufficient that a reviewer can understand exactly what service or good is being requested (not merely "pain management" but rather "epidural steroid injection, lumbar, left side, single level"); and the documentation must substantiate both the medical necessity and the appropriateness of the specific treatment sought[1][4][6][1].

B. Required and Supplemental Documentation for RFAs

The DWC Form RFA instructions specify that treating physicians must "Attach the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment."[1][1][6] The instructions further provide that "[t]he DWC Form RFA must contain all the information needed to substantiate the request for authorization. If the request is to continue a treatment plan or therapy, please attach documentation indicating progress, if applicable."[1][6][1]

For treatment requests inconsistent with the Medical Treatment Utilization Schedule (MTUS) or for conditions not addressed by the MTUS, "you may include scientifically based evidence published in peer-reviewed, nationally recognized journals that recommend the specific medical treatment or diagnostic services to justify your request."[1][6][1] This provision enables physicians to override MTUS recommendations through evidence-based rebuttal, as permitted under California Code of Regulations, Title 8, Section 9792.21.

The claims administrator cannot require information beyond what is "reasonably necessary" to make a utilization review determination[3][3][31]. Under California Code of Regulations, Title 8, Section 9792.9(b)(2), "[i]f appropriate information which is necessary to render a decision is not provided with the original request for authorization, such information may be requested by a reviewer or non-physician reviewer within five (5) working days from the date of receipt of the written request for authorization to make the proper determination. In no event shall the determination be made more than 14 days from the date of receipt of the original request for authorization by the health care provider."[12] If the information is not received within 14 days for prospective review or 30 days for retrospective review, the claims administrator may deny the request with the condition that it will be reconsidered upon receipt of the requested information[10][10].

Critically, under California Code of Regulations, Title 8, Section 9792.9(n), "[a]uthorization may not be denied on the basis of lack of information without documentation reflecting an attempt to obtain the necessary information from the physician or from the provider of goods or services identified in the request for authorization either by facsimile or mail."[12] This requirement prevents claims administrators from summarily denying RFAs without first requesting supplemental documentation through documented attempts.

C. RFA Form Version Compliance

Treating physicians must use the current DWC Form RFA effective February 2014[1][4][6][24][1][43]. The regulation specifically provides: "[p]rior to March 1, 2014, any version of the DWC Form RFA adopted by the Administrative Director under section 9785.5 may be used by the treating physician to request medical treatment."[51] This means that as of March 1, 2014, only the current (February 2014) version or subsequent authorized versions are compliant. Non-compliance with the form version requirement can result in the RFA being returned as incomplete[24][43].

D. RFA Signature Requirements

The regulation provides that the RFA "must be signed by the treating physician."[51] For treatment provided by a nurse practitioner or physician's assistant under physician supervision, "the supervising physician and the PA/NP must sign the RFA with an original, hand-written signature," according to CWCI guidance[58].

Electronic signatures are permitted by agreement with the claims administrator[51]. The signature requirement is mandatory and cannot be waived; unsigned RFAs will be returned as incomplete[24][43][51].

VI. Claims Administrator Obligations and Response Timelines

A. The Utilization Review Process Initiation

Under California Code of Regulations, Title 8, Section 9792.6.1, "[t]he utilization review process begins when the completed DWC Form RFA, or a request for authorization accepted as complete under section 9792.9.1(c)(2), is first received by the claims administrator, or in the case of prior authorization, when the treating physician satisfies the conditions described in the utilization review plan for prior authorization."[51] This establishes that the "clock" for the five-business-day prospective decision deadline begins on the date the claims administrator (or utilization review organization) receives the completed RFA[10][10][31][31][10][54][31]. Date-stamping becomes critical for disputes regarding compliance with strict timelines[10][31][54].

B. Standard Prospective and Concurrent Review Timelines

California Code of Regulations, Title 8, Section 9792.9.1(c)(3) requires that "[p]rospective or concurrent decisions to approve, modify, delay, or deny a request for authorization shall be made in a timely fashion that is appropriate for the nature of the injured worker's condition, not to exceed five (5) business days from the date of receipt of the completed DWC Form RFA."[10][10][10][54][10] The regulation clarifies that "[t]he first day in counting any timeframe requirement is the day after the receipt of the DWC Form RFA, except when the timeline is measured in hours. Whenever the timeframe requirement is stated in hours, the time for compliance is counted in hours from the time of receipt of the DWC Form RFA."[10][10][10][10]

The Division of Workers' Compensation has clarified that "[p]rospective or concurrent decisions must be made within five normal business days from the date the written RFA was first received, whether by the employer, the claims adjuster or the URO. The date of receipt, if before 5:30 p.m., is counted as day zero, and the next day is counted as day 1."[31][31] A "normal business day" does not include Saturdays, Sundays, or state holidays[31][31]. "If a counted day falls on a Saturday, Sunday, or holiday, then the count resumes on the next normal business day."[31][31]

For California Labor Code Section 4610 purposes, five-business-day timelines for prospective and concurrent review are mandatory, not directory[10][10][10]. Failure to comply subjects the claims administrator to administrative penalties and can render the UR decision invalid, leaving medical necessity determinations to the Workers' Compensation Appeals Board[10][31][10][54].

C. Expedited Review Timelines

California Code of Regulations, Title 8, Section 9792.9.1(c)(4) requires that "[p]rospective or concurrent decisions to approve, modify, delay, or deny a request for authorization related to an expedited review shall be made in a timely fashion appropriate to the injured worker's condition, not to exceed 72 hours after the receipt of the written information reasonably necessary to make the determination."[10][10][10][10] The regulation further specifies that "[t]he requesting physician must certify in writing and document the need for an expedited review upon submission of the request."[10][10][10][10] Importantly, "[a] request for expedited review that is not reasonably supported by evidence establishing that the injured worker faces an imminent and serious threat to his or her health, or that the timeframe for utilization review under subdivision (c)(3) would be detrimental to the injured worker's condition, shall be reviewed by the claims administrator under the timeframe set forth in subdivision (c)(3)."[10][10][10][10]

The WCAB has provided guidance clarifying that expedited review determinations themselves have become the subject of UR disputes. In a recent case, the Board examined whether an RFA marked for expedited review was reasonably supported by evidence and held that reviewing whether an expedited designation was appropriate is itself a medical determination that must be made by a physician reviewer within the 72-hour period[7]. Claims administrators cannot simply ignore expedited designations or defer the determination to later processing[7].

D. Retrospective Review Timelines

California Code of Regulations, Title 8, Section 9792.9.1(c)(5) requires that "[r]etrospective decisions to approve modify, delay, or deny a request for authorization shall be made within 30 days of receipt of the request for authorization and medical information that is reasonably necessary to make a determination."[10][10][54][10] Notably, this timeline is measured in calendar days, not business days, providing claims administrators greater flexibility than prospective review[10][10][54]. Retrospective review is typically applied when providers submit RFAs after treatment, either because advance authorization was not sought or because emergency care was provided[14][10][14].

E. Communication of UR Decisions

The requirements for communicating UR decisions vary by review type. For prospective, concurrent, or expedited reviews, "approvals shall be communicated to the requesting physician within 24 hours of the decision, and shall be communicated to the requesting physician initially by telephone, facsimile, or electronic mail. The communication by telephone shall be followed by written notice to the requesting physician within 24 hours of the decision for concurrent review and within two (2) business days for prospective review."[10][10]

For decisions to modify, delay, or deny, "[a] decision to modify, delay, or deny shall be communicated to the requesting physician within 24 hours of the decision, and shall be communicated to the requesting physician initially by telephone, facsimile, or electronic mail. The communication by telephone shall be followed by written notice to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney within 24 hours of the decision for concurrent review and within two (2) business days of the decision for prospective review and for expedited review within 72 hours of receipt of the request."[10][10][10][10]

For retrospective review, "[w]ritten notice shall be communicated to the requesting physician who provided the medical services and to the individual who received the medical services, and his or her attorney/designee, if applicable."[10][10][10] No specific timeline is imposed for the initial phone/fax/email communication in retrospective review, only the written notice requirement within 30 calendar days[10][10][10].

VII. UR Decision Types and Written Decision Content Requirements

A. Approval Decisions

California Code of Regulations, Title 8, Section 9792.9.1(d) specifies that "[a]ll decisions to approve a request for authorization shall specify the specific the date the complete request for authorization was received medical treatment service requested, the specific medical treatment service approved, and the date of the decision."[10][10][10] The regulation permits claims administrators to approve RFAs at the claims administrator level without formal utilization review, provided the approval decision is clearly documented[10][10][10]. The approval must be specific regarding what treatment is authorized-for example, "physical therapy, twice weekly for four weeks" rather than merely "physical therapy"-to prevent future disputes regarding authorization scope[10][31][10][31].

For approved drug formulary treatments, "the written decision approving the request must indicate, 'Exempt per MTUS Drug Formulary' or words to that effect and meaning," and for non-drug treatments approved under the 30-day exemption, the decision must identify the exemption as "'30-day exemption' or words to that effect and meaning."[37][37]

B. Modification, Delay, and Denial Decisions

California Code of Regulations, Title 8, Section 9792.9.1(e)(5) requires that written decisions modifying, delaying, or denying treatment authorization shall be provided to the requesting physician, injured worker, injured worker's representative, and attorney (if represented), and must include the following mandatory elements:[10][10][10]

The date on which the DWC Form RFA was first received[10][10][10]

The date on which the decision is made[10][10][10]

A description of the specific course of proposed medical treatment for which authorization was requested[10][10][10]

A list of all medical records reviewed[10][10][10][31]

A specific description of the medical treatment service approved, if any[10][10][10][31]

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[10][10][10][31]

If the decision is due to incomplete or insufficient information, specification of the reason and specification of the information that is needed[10][10][10][31]

A clear statement advising the injured employee that disputes shall be resolved in accordance with Labor Code sections 4610.5 and 4610.6 (independent medical review) and that objection must be made on the enclosed Application for Independent Medical Review (DWC Form IMR) within 30 calendar days[10][10][10]

Mandatory language: "You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me [insert claims adjuster's name] at [insert telephone number]. However, if you are represented by an attorney, please contact your attorney instead of me."[10][10][10]

The name and specialty of the reviewer or expert reviewer and the telephone number in the United States of the reviewer[10][10][10][31]

Hours of availability of the reviewer or medical director for the treating physician to discuss the decision-minimum of four hours per week during normal business hours (9:00 AM to 5:30 PM Pacific Time)[10][10][10][12][31]

Failure to include any required element subjects the claims administrator to administrative penalties ranging from $50 to $500 per violation, depending on the specific omitted element[25][25].

C. Deferral of Utilization Review

California Code of Regulations, Title 8, Section 9792.9.1(b) permits claims administrators to defer utilization review in specific circumstances: "[u]tilization review of a medical treatment request made on the DWC Form RFA may be deferred if the claims administrator disputes liability for either the occupational injury for which the treatment is recommended or the recommended treatment itself on grounds other than medical necessity."[10][10][10] Importantly, the deferral exception applies only to disputes "on grounds other than medical necessity"-if the claims administrator disputes medical necessity, a utilization review determination by a physician reviewer is required[10][10][10].

When deferring UR, "[t]he claims administrator may, no later than five (5) business days from receipt of the DWC Form RFA, issue a written decision deferring utilization review of the requested treatment unless the requesting physician has been previously notified under this subdivision of a dispute over liability and an explanation for the deferral of utilization review for a specific course of treatment."[10][10][10] The written decision must contain: (A) the date on which the DWC Form RFA was first received; (B) a description of the specific course of proposed medical treatment; (C) a clear, concise, and appropriate explanation of the reason for the dispute of liability (injury, body part, or treatment on grounds other than medical necessity); and (D) a plain-language statement advising the employee that disputes must be resolved by agreement or through the Workers' Compensation Appeals Board[10][10][10].

Critically, under the April 1, 2026 amendments, a request cannot be deferred if "the requesting physician expressly and unequivocally indicates or opines in the request for treatment that there has been a change in facts material to the basis of the prior denial of such same treatment and includes documentation of such change."[37][37][37] Such requests "must be reviewed by a physician reviewer, and any modification or denial of the request must comply with applicable requirements."[37][37][37]

VIII. Automatic Authorization Exemption from Prospective Utilization Review

A. Statutory Basis and Conditions for Automatic Authorization

Labor Code Section 4610(c) establishes that certain medical treatment qualifies for automatic authorization, exempting it from prospective utilization review. Treatment qualifies for automatic authorization when all six conditions are satisfied:[14][26][28][14][44]

Date of injury (DOI) is on or after January 1, 2018[14][26][28]

Date of service (DOS) is within 30 days of the DOI[14][26][28]

Liability for body part and condition is accepted by the claims administrator[14][26][28]

Treatment is included in the Medical Treatment Utilization Schedule (MTUS)[14][26][28]

Physician is included in employer's Medical Provider Network (MPN) or is employee's predesignated physician[14][26][28]

Treatment is not excluded from automatic authorization under Labor Code Section 4610(c)[14][26][28]

California Code of Regulations, Title 8, Section 9792.9.7 (effective April 1, 2026) specifies treatments excluded from the 30-day automatic authorization exemption, including "[p]harmaceuticals, to the extent they are not expressly exempt from prospective review under the MTUS Drug Formulary; [n]onemergency surgery and surgical services provided in any setting; [e]lectroacoustic medicine; [s]pinal injections; [d]iagnostic imaging; [e]lectrodiagnostic medicine; [s]pinal injections; and [i]maging procedures requiring authorization."[37] Additionally, excluded services include "any services previously denied by the claims administrator through utilization review or independent medical review, unless the treatment denial has been overturned."[37]

B. Retrospective RFA Requirement and Billing Timelines

While treatments meeting the six automatic authorization conditions are authorized without prospective UR review, the regulations require that the treating physician "must submit the RFA and Doctor's First Report of Initial Injury or Illness within 5 days" of rendering treatment[44]. The claims administrator "must treat the RFA, for all intents and purposes, as an approved retrospective RFA" and "has absolutely no say regarding the authorization's approval. The claims administrator cannot modify, deny, or rescind automatic authorization."[44]

However, billing timelines for automatically authorized treatments are significantly shorter than for conventionally authorized treatments. Labor Code Section 4610 (as amended by Senate Bill 1160) requires that "[p]roviders must submit their original bills within 30 days of any automatically authorized treatment. That is a much, much shorter timeframe than bills for conventionally authorized treatments, for which bills must be submitted within 12 months."[26][44] For emergency treatment qualifying as automatic authorization, the billing deadline extends to 180 days[26][28][14][44].

Critically, "missing those deadlines does not preclude payment" under current law, as "[c]laims administrators are not off the hook for payment unless the bill arrives a full year after the date of service."[26][44] The 30-day and 180-day deadlines appear to be preconditions for certain benefits but do not create absolute payment bars for late submission; however, the absence of regulatory clarification creates substantial litigation risk[26][28][44].

C. Retrospective Utilization Review of Automatically Authorized Treatments

Although claims administrators cannot modify or deny automatically authorized services prospectively, the regulations permit retrospective utilization review to determine MTUS compliance and prevent abuse. California Code of Regulations, Title 8, Section 9792.9.7 provides that "if the claims administrator determines, after retrospective review, that a physician providing treatment has a pattern and practice of failing to render treatment that is consistent with the Medical Treatment Utilization Schedule, including the MTUS Drug Formulary, the claims administrator may: [r]emove the ability of the physician to render treatment exempt from prospective review to any injured worker whose claim is adjusted or administered by the claims administrator."[37][37]

Critically, "the employer still cannot deny or modify the requested treatment, nor can they rescind authorization, even the automatic sort. But if the employer can demonstrate a pattern of treatment not in

accordance with the MTUS, they can remove the provider from the MPN or remove the provider from the MPN in question."[26][44]

IX. Emergency Authorization and Expedited Procedures

A. Emergency Medical Treatment Authorization

California Code of Regulations, Title 8, Section 9792.6.1(i) defines "emergency health care services" as "health care services for a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to place the patient's health in serious jeopardy."[14][14][51] Under this definition, "[p]roviders never have to wait for authorization before providing emergency treatment for an acute medical condition. Never."[14][14] "[f]ailure to obtain authorization in advance cannot be the basis for denying payment for emergency treatment," according to the Division of Workers' Compensation[14][14].

However, "[t]he provider must ultimately obtain authorization for all services, even when the injury is time-sensitive or a medical emergency. While the authorization and utilization review (UR) process should never be an obstacle to such treatment, there are mandated procedures and timelines for submitting the official Request for Authorization (RFA)."[14][14] Emergency treatment falls into the retrospective RFA category, and providers must obtain authorization after the fact through retrospective utilization review[14][14].

B. Expedited Utilization Review Standards and Substantiation

Expedited review applies when "the injured worker's condition is such that the injured worker faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process would be detrimental to the injured worker's life or health or could jeopardize the injured worker's permanent ability to regain maximum function."[7][10][10][10][5]

California Code of Regulations, Title 8, Section 9792.9.1(c)(4) requires that when requesting expedited review, "[t]he requesting physician must certify in writing and document the need for an expedited review upon submission of the request."[10][10][10][10] Further, "[a] request for expedited review that is not reasonably supported by evidence establishing that the injured worker faces an imminent and serious threat to his or her health, or that the timeframe for utilization review under subdivision (c)(3) would be detrimental to the injured worker's condition, shall be reviewed by the claims administrator under the timeframe set forth in subdivision (c)(3)."[10][10][10][10]

Recent WCAB authority has emphasized that claims administrators must take expedited RFA designations seriously. When an RFA is marked for expedited review, the claims administrator cannot conduct the UR using normal timeframes and then later litigate whether the request for expedited review was properly supported; instead, "it must send the RFA to a UR physician immediately, and no later than 72 hours after receipt of the RFA."[7] "If the matter proceeds to trial, a defendant must be prepared to present evidence that the RFA was sent to a UR physician within the 72-hour period" and demonstrate that either the UR decision was made within 72 hours or the request was not reasonably supported by evidence[7]. The burden of proving lack of support cannot be shifted to the injured worker or treated as a post-hoc defense[7].

X. Non-Compliance, Penalties, and Enforcement

A. Administrative Penalty Schedule

California Code of Regulations, Title 8, Section 9792.12 establishes a comprehensive administrative penalty schedule with mandatory penalties for specific UR violations[25][25]. The penalty amounts include:

Structural/Organizational Penalties:

Failure to establish a Labor Code Section 4610 utilization review plan: $50,000[25][25]

Failure to include all requirements of Section 9792.7(a) in the UR plan: $5,000[25][25]

Failure to file the UR plan or letter with the Administrative Director: $10,000[25][25]

Failure to file a modified UR plan within 30 calendar days: $5,000[25][25]

Failure to employ or designate a physician as medical director: $50,000[25][25]

Procedural Timing Penalties:

Failure to make and communicate prospective/concurrent decisions within five working days: $1,000 per violation[25][25]

Failure to make and communicate concurrent (non-expedited) decisions within five working days: $2,000 per violation[25][25]

Failure to communicate expedited decisions in timely fashion: $15,000 per violation[25][25]

Failure to make retrospective decisions within 30 days: $500 per violation[25][25]

Decision Content and Notice Penalties:

Failure to provide Application for Independent Medical Review (Form IMR) with denial/modification notice: $2,000 per violation[25][25]

Failure to complete mandatory fields in written decision: $50-$500 per instance depending on field criticality[25][25]

Failure to disclose reviewer name, specialty, or availability hours: amounts varying[25][25]

Reviewer Authority Penalties:

Failure to ensure only physician reviewers modify, delay, or deny on medical necessity grounds: penalty amounts to be determined under April 1, 2026 amendments[37][37][37]

Failure to ensure only physician reviewers deny when necessary information/tests missing: penalty amounts to be determined under April 1, 2026 amendments[37][37][37]

Information Request Penalties:

Failure to timely notify requesting physician that additional information needed: $50 per instance[25][25]

Failure to document attempts to obtain necessary information before denying: $50 per instance[25][25]

Notably, California Code of Regulations, Title 8, Section 9792.13 provides that "the penalty amounts specified for violations under this section may, in the discretion of the Administrative Director, be reduced after consideration of the factors set out in section 9792.13," but failure to abate violations within specified timeframes results in "assessment of the full original penalty amount."[25][25]

B. URAC Accreditation Requirement (Effective April 1, 2026)

The April 1, 2026 regulatory amendments introduce a mandatory accreditation requirement: "UR plans that modify/deny treatment must provide proof of URAC Workers' Compensation Utilization Management Accreditation."[37][37][37] URAC's Workers' Compensation Utilization Management Accreditation is a three-year program that organizations must obtain before operating a UR function in California[15]. This requirement applies to both internal claims administrator UR programs and external utilization review organizations[15].

The accreditation standard includes requirements for initial screenings, clinical review, decision timeframes, utilization policy, appeals, and more[15]. Organizations have 120 days from the April 1, 2026 effective date to obtain accreditation or face suspension/revocation of UR authority and inability to modify or deny treatment requests[37][37][37]. Failure to maintain accreditation results in mandatory penalties and potential permanent loss of UR authority[37][37][37].

C. DWC Audit and Enforcement Investigations

The Division of Workers' Compensation conducts utilization review audits on a five-year cycle targeting claims adjusting locations (labeled "URA" or utilization review audits) and external utilization review organizations[31][31]. Auditors review randomly selected RFA files to assess compliance with timing, notice,

and decision content requirements[23][31][31]. The DWC's audit process specifically examines whether claims administrators:

Made timely decisions on requests for authorization[23][31]

Provided proper notice content in written decisions[23][31]

Served all appropriate parties with UR decisions[23][31]

Performance ratings are composite scores based on percentages of violations found, with passing scores of 85% or greater[23][31][31]. In January 2026, the DWC posted 2025 audit results identifying substantial penalty assessments against major insurers and administrators for UR violations[23].

XI. Dispute Resolution: Independent Medical Review and Appeals

A. Transition from Utilization Review to Independent Medical Review

When a claims administrator denies, modifies, or delays a medical treatment request through UR, the injured worker (or treating physician) may file for Independent Medical Review (IMR) under Labor Code SectionSection 4610.5 and 4610.6[32][34]. The IMR process is the exclusive remedy for disputing UR medical necessity determinations; judicial review of UR decisions through workers' compensation appeals or civil litigation is not available[32][34][53].

The Application for Independent Medical Review (DWC Form IMR-1) must be filed with the Administrative Director (through Maximus Federal Services, Inc., the state's designated IMR organization) within 30 days of service of the UR determination[32][34][55]. For drug-only disputes, the deadline is 10 days[37][37].

B. IMR Eligibility and Process

The Administrative Director reviews the IMR application to determine eligibility based on California Code of Regulations, Title 8, Section 9792.10.1[32][34]. The criteria include: (1) Is the form timely and complete? (2) Has there been a prior IMR request for the same treatment? (3) Does the claims administrator dispute liability for the occupational injury or claimed body part? (4) If further information is needed, are parties providing it within 15 days?[32][34]

If the claims administrator disputes liability at the time of the UR decision (not raised later), the IMR is deferred until the liability issue is resolved[32][34]. This contrasts with the prior RFA deferral rule under Section 9792.9.1(b), which permits deferred UR when liability is disputed on grounds other than medical necessity[32][34].

C. IMR Decision and Burden of Proof

When the Administrative Director determines the dispute is eligible for IMR, Maximus assigns a physician reviewer with appropriate specialty certification to conduct the review[32][34]. The IMR physician reviewer must review documents submitted by both parties and issue a written determination regarding whether the disputed treatment is "medically necessary to cure or relieve" the work injury[32][34]. The determination must reference specific medical guidelines applied and clinical reasons for the decision[32][34].

Critically, California Code of Regulations, Title 8, Section 9792.10.6 establishes that "[t]he final determination is presumed correct and the WCAB cannot make a finding of medical necessity contrary to the final determination."[32] This gives IMR determinations quasi-judicial finality, reversible only on narrow grounds of administrative law violation or bias[32][34].

XII. Strategic Considerations for Key Stakeholders

A. Treating Physician Perspective: RFA Preparation and Strategy

Strategic Considerations:

Treating physicians seeking medical treatment authorization should submit prospective RFAs with maximum documentation substantiating medical necessity before providing treatment whenever possible, as this ensures compliance with the five-business-day decision timeline and demonstrates good faith compliance with the UR process. The RFA should identify treatment with specificity-not "physical therapy" but rather "physical

therapy, 2x/week, 4 weeks, focusing on core stabilization per MTUS low back pain guidelines"-to prevent post-approval disputes regarding scope. If MTUS guidelines do not address the proposed treatment, including peer-reviewed published literature supporting the recommendation significantly strengthens the RFA and may convince the UR reviewer to approve without referring for medical necessity dispute[1][6][1].

For expedited situations, treating physicians should recognize that simply checking the "Expedited Review" box is insufficient; the regulation requires that they "must certify in writing and document the need for an expedited review upon submission of the request."[10][10][10][10] This means including specific clinical documentation explaining why the 5-day prospective or concurrent timeline would be "detrimental to the injured worker's life or health."[10][10][10] Examples might include acute spinal cord compression causing progressive neurological deficit, or acute compartment syndrome requiring urgent surgical intervention[7]. The documentation should be compelling and specific to the individual patient's acute presentation[7].

When a UR decision denies or modifies a requested treatment, treating physicians have two primary options: (1) if the denial appears inconsistent with medical evidence, request independent medical review (IMR) through the Application for Independent Medical Review form (DWC Form IMR-1), which must be filed within 30 days and provides independent physician review by Maximus[32][34]; or (2) if the patient's clinical condition has materially changed (e.g., loss of efficacy of prior conservative treatment), submit a resubmission RFA checking "Resubmission - Change in Material Facts," with detailed documentation of the clinical changes, which must be reviewed by a physician reviewer and cannot be deferred under the April 1, 2026 amendments[30][37][37][37]. The strategic choice depends on whether the treating physician's position is that the prior UR decision was medically wrong (favoring IMR) or that the patient's condition has genuinely deteriorated and the prior treatment plan is no longer appropriate (favoring resubmission)[30][37][37][37].

Risk Factors:

Treating physicians should be aware that non-compliance with RFA requirements can result in bill denials, delays, or disputes. If an RFA is returned as "not complete" within 5 business days, the physician has an opportunity to supplement and resubmit, and the decision timeline restarts upon receipt of the completed RFA[24][10][10]. However, failure to submit an RFA at all (assuming treatment does not qualify for automatic authorization) exposes the provider to payment denial if the claims administrator disputes authorization[26][14][44]. For bills submitted after treatment without prior authorization, claims administrators conduct retrospective utilization review with 30-day timelines, which may result in modification or denial if the treatment does not meet MTUS standards[10][10][54].

B. Claims Administrator Perspective: Compliance and Risk Management

Compliance Obligations:

Claims administrators must establish written UR plans filed with the Administrative Director, including designation of a licensed medical director, description of the review process, and identification of specific criteria used to evaluate medical necessity[18][31][31]. As of April 1, 2026, if the UR plan modifies or denies treatment, the claims administrator must obtain and maintain proof of URAC Workers' Compensation Utilization Management Accreditation[37][37][37]. Failure to maintain accreditation results in inability to modify or deny treatment and substantial penalties[37][37][37].

The claims administrator's response obligations include: (1) receiving RFAs and determining completeness within 5 business days; if incomplete, return marked "not complete" specifying deficiencies[10][10][10]; (2) for complete prospective or concurrent RFAs, conducting utilization review and issuing approval, modification, denial, or deferral decisions within 5 business days of receipt[10][10][10]; (3) for expedited RFAs, issuing decisions within 72 hours of receipt of necessary information[10][10][10][10]; (4) for retrospective RFAs, issuing decisions within 30 calendar days[10][10][54]; and (5) communicating all modification, denial, or deferral decisions initially by phone/fax/email within 24 hours, followed by detailed written notice within specified timeframes[10][10][10][31][10].

The written decision communicating a modification, denial, or deferral must include all nine mandatory elements specified in Section 9792.9.1(e)(5): date RFA received, date decision made, description of treatment requested, list of medical records reviewed, specific treatment approved (if any), clear explanation of reasons including clinical reasons for medical necessity, statement of medical criteria/guidelines applied, information if decision is due to incomplete information, mandatory UR dispute language and DWC Form IMR notice,

and reviewer/medical director contact information[10][10][10][31]. Omission of any element subjects the administrator to $50-$500 penalties per omitted field[25][25].

Risk Mitigation:

Claims administrators should implement date-tracking systems to document exact receipt times for RFAs, establishing that decision timelines are calculated correctly[10][10][31][10]. Facsimiles received after 5:30 PM Pacific Time are deemed received the following business day, and fax/email receipt requires electronic date-stamping[10]. Internal tracking spreadsheets should note RFA receipt date, type of review (prospective/concurrent/retrospective/expedited), date decision made, date verbal communication issued (if required), date written notice mailed, and any extensions requested (with physician/expert reviewer name and date extension notification was issued)[10][10][10].

Claims administrators must be cautious regarding resubmitted RFAs marked "Resubmission - Change in Material Facts." Under the April 1, 2026 amendments, such requests cannot be deferred if the physician has expressly documented material clinical changes; they must be sent to a physician reviewer for medical necessity review, and any denial must provide substantive explanation for why the physician's documentation of changed facts is insufficient[37][37][37]. Simply denying a resubmission as "duplicative" is no longer permissible[37][37][37].

For RFAs marked "Expedited Review," claims administrators must take the designation seriously. The recent WCAB authority makes clear that administrators cannot process expedited RFAs under standard timelines and later defend timeliness by arguing the expedited designation was not supported[7]. Instead, administrators must immediately forward expedited RFAs to a physician reviewer with a 72-hour deadline[7]. Failure to do so leaves the UR decision vulnerable to invalidation by the WCAB, which may then determine medical necessity[7].

C. Injured Worker Perspective: Rights and Remedies

Understanding RFA Processing:

Injured workers should understand that medical treatment in workers' compensation is not automatically authorized; treating physicians must submit RFAs to the claims administrator requesting authorization[3][3][3]. The process takes time: prospective review requires 5 business days minimum (not calendar days), and expedited review requires 72 hours[10][10][10]. During this time, treatment may be delayed unless the provider agrees to render treatment subject to retrospective UR, which carries the risk of later denial[10][10][54].

For emergency medical services (defined as acute conditions creating serious risk to health without immediate care), failure to obtain advance authorization cannot be a basis for denial; providers may treat emergently and submit retrospective RFAs for authorization[14][10][14]. However, all other treatment requires advance UR approval or risk of payment denial[14][14][3].

Challenging Denials:

When an RFA is denied or modified, the injured worker (through their attorney or personally) may file for Independent Medical Review (IMR) within 30 days of service of the UR decision[32][34][55]. The IMR application is relatively straightforward: injured workers sign the DWC Form IMR-1, attach a copy of the UR decision, and mail or fax to Maximus Federal Services (address provided on the form)[32][34][55]. The Administrative Director reviews the application for eligibility; if eligible, Maximus assigns a physician reviewer within days and typically completes the IMR determination within 30 calendar days[32][34].

The IMR physician reviews the same medical records and applies the same MTUS standards as the original UR, but provides an independent perspective. Importantly, if the IMR physician agrees that treatment is medically necessary, the claims administrator must authorize the treatment within 5 business days of receiving the IMR decision[32][34]. The IMR determination is presumed correct, and the only appeal is through the Workers' Compensation Appeals Board (which rarely reverses IMR determinations absent fraud, bias, or material conflict of interest)[32][34].

XIII. Northern California-Specific Context

While RFA procedures are uniform statewide under Labor Code Section 4610 and Title 8 CCR regulations, injured workers and treating providers in Northern California should be aware of several implementation factors specific to the San Francisco Bay Area.

San Francisco Immigration Court (Immigration Law Practice Context Not Applicable Here): This research focuses on workers' compensation RFAs, not immigration law. Northern California immigration courts are not relevant to RFA procedures.

San Francisco Workers' Compensation Court and Judicial Officers: The San Francisco workers' compensation hearing locations (San Francisco, Concord, Oakland) handle disputes over UR decisions that proceed to the Workers' Compensation Appeals Board level, but only after the IMR process is exhausted[32][34]. No judicial determination occurs during the RFA/UR phase; that is exclusively administrative[32][34]. Injured workers cannot file in San Francisco Superior Court to challenge UR denials; the Workers' Compensation Appeals Board is the sole initial forum for non-IMR disputes[32][34][53].

Claims Administrator Operations in Northern California: Major insurers and third-party administrators serving Northern California employers are subject to the same RFA compliance requirements as administrators statewide[3][3][3]. However, the quality and speed of RFA processing vary among administrators. Some maintain local UR organizations with 24-hour turnaround on receipt date-stamping; others operate from centralized locations and may experience delays in date-stamping faxes[10][10][31][10]. Treating providers should confirm the correct submission address and fax/email with the specific claims administrator handling the claim[1][4][1].

URAC Accreditation Compliance (Effective April 1, 2026): As of April 1, 2026, all UR operations in California must maintain URAC Workers' Compensation Utilization Management Accreditation[37][37][37]. Northern California-based administrators and UROs must demonstrate compliance or suspend UR operations[37][37][37]. Some smaller administrators may have outsourced UR functions to URAC-accredited external UROs; treating providers should verify whether the claims administrator operates its own UR function or contracts with an external URO[18][31][31].

XIV. Practical Implementation Roadmap for Treating Providers

A. Pre-Service RFA Submission Checklist

Before submitting an RFA, treating providers should verify the following:

Treatment Plan Confirmation: The treatment proposed is medically reasonable and necessary for the work injury, consistent with MTUS guidelines if applicable[1][3][1]

Patient Information Accuracy: Employee name, date of birth, claim number, and employer are correct[1][4][1]

Provider Information Completeness: Treating physician name, license number, NPI number, practice address, phone, fax, and email are current[1][4][1]

Claims Administrator Information: Correct claims administrator name, address, fax, email are identified on the form; if uncertain, verify by phone with the injured worker or employer[1][4][1]

Diagnosis Specificity: ICD code is current and specific to the body part and condition (e.g., not merely "pain" but "pain, lumbar spine, chronic")[1][4][1]

Treatment Specificity: Service requested is described in detail: not "physical therapy" but "physical therapy evaluation and treatment, 2 times weekly for 4 weeks, emphasizing core stabilization and functional restoration per MTUS low back pain guidelines, CPT codes 97110, 97161"[1][4][1]

CPT/HCPCS Codes: Current procedural codes are included, cross-checked for accuracy[1][4][1]

Supporting Documentation: Doctor's First Report (Form DLSR 5021), Treating Physician's Progress Report (Form PR-2), or equivalent narrative substantiating medical necessity is attached[1][4][6][1]

MTUS Guideline Consistency: If treatment is consistent with adopted MTUS guidelines, note this in the narrative (e.g., "Treatment per MTUS Low Back Pain Guideline, initial conservative care phase")[1][6]

Non-MTUS Treatment Evidence: If proposing treatment not addressed by MTUS or inconsistent with MTUS, include peer-reviewed published literature supporting the recommendation[1][6][1]

Signature: RFA is signed by the treating physician (or supervising physician if submitted by PA/NP)[1][1][51]

Correct Form Version: DWC Form RFA version effective February 2014 (or later authorized version) is used[1][4][24][1]

B. RFA Submission and Follow-Up

Submission Method: Fax, email, or mail to the claims administrator address specified on the form[1][4][6][1]

Date Confirmation: For fax submission, maintain a fax confirmation sheet showing successful transmission; note the time (submissions after 5:30 PM are deemed received the next business day)[10][31][10]

Calendar Tracking: Mark the RFA submission date on the practice calendar and set a reminder for 5 business days later (for prospective review) or 30 calendar days later (for retrospective review) to follow up if no decision has been received[10][10][10][54]

Initial Contact: If no response is received within the required timeline, contact the claims administrator by phone and document the conversation (date, time, person contacted, response)[10][10][10]

Incomplete RFA Response: If the RFA is returned marked "not complete" within 5 business days, supplement the missing information and resubmit promptly (the decision timeline restarts upon receipt of the completed RFA)[24][10][10]

C. Decision Receipt and Documentation

Decision Confirmation: Upon receiving a UR decision (approval, modification, denial, deferral, or request for additional information), document the decision in the patient's medical record[10][10][31][10][10]

Approval Scope: If treatment is approved, verify the specific services authorized (especially duration and frequency) to ensure treatment provided falls within authorization scope[10][10][10]

Denial or Modification: If treatment is denied or modified, review the written decision to understand the claims administrator's reasons[10][10][10][10]

If the stated reason is medical necessity, the appropriate response is to file for Independent Medical Review (IMR) within 30 days through the DWC Form IMR-1[32][34][55]

If the stated reason is insufficient information, supplement the documentation and resubmit the RFA with the additional information[24][10][10]

If the patient's clinical condition has materially changed (e.g., loss of treatment efficacy), submit a resubmission RFA marked "Resubmission - Change in Material Facts" with detailed documentation of the changes[30][37][37][37]

XV. Appendices

Appendix A: Statutory Authority (Full Citations)

Labor Code Section 4610 - Utilization Review Process: Establishes mandatory UR procedures, decision timelines, and notice requirements

Labor Code Section 4610.5 - Independent Medical Review: Provides procedure for disputing UR denials through independent physician review

Labor Code Section 4610.6 - Independent Medical Review Procedures: Establishes IMR timeframes and decision standards

Labor Code Section 5402(c) - Presumptive Liability for Initial Treatment: Provides up to $10,000 in automatic medical treatment coverage pending liability decision

Appendix B: California Code of Regulations (Full Citations)

8 CCR Section 9785.5 - Request for Authorization Form: Specifies the official DWC Form RFA and incorporation by reference

8 CCR Section 9792.6 - Utilization Review Standards Definitions (Pre-April 1, 2026): Provides definitions of UR terms

8 CCR Section 9792.6.1 - Utilization Review Standards Definitions (January 1, 2013 Forward): Comprehensive definitions including "request for authorization," "authorization," "reviewer," and expedited review

8 CCR Section 9792.7 - Utilization Review Plan Applicability: Establishes UR plan requirements and URAC accreditation mandate (April 1, 2026)

8 CCR Section 9792.9 - Utilization Review Timeframe, Procedures (Prior to January 1, 2013): Superseded by Section 9792.9.1 for claims with injuries on/after January 1, 2013

8 CCR Section 9792.9.1 - Utilization Review Timeframe and Procedures (January 1, 2013 Forward): Current standard establishing 5-business-day, 72-hour, and 30-day decision timelines

8 CCR Section 9792.9.5 - Resubmission After Material Fact Changes (April 1, 2026): Prohibits deferral of resubmitted RFAs when physician documents material fact changes

8 CCR Section 9792.9.7 - 30-Day Automatic Authorization Exemption (April 1, 2026): Establishes conditions for automatic authorization and excluded services

8 CCR Section 9792.9.8 - MTUS Drug Formulary Review (April 1, 2026): Specifies exempt drugs and authorization requirements

8 CCR Section 9792.10.1 - Independent Medical Review Procedures: Establishes IMR application and decision procedures

8 CCR Section 9792.12 - Administrative Penalty Schedule: Establishes mandatory penalties for UR non-compliance

8 CCR Section 9792.20 et seq. - Medical Treatment Utilization Schedule (MTUS): Establishes evidence-based treatment guidelines

8 CCR Section 9792.27.1 et seq. - MTUS Drug Formulary: Establishes exempt and non-exempt drugs

Appendix C: DWC Forms and Instructions

DWC Form RFA (Request for Authorization) - Version February 2014: Official form with instructions

DWC Form UR-01 (Utilization Review Plan Application/Modification) - Version March 2025: New mandatory form for UR plan filings (effective April 1, 2026)

DWC Form IMR-1 (Application for Independent Medical Review): Form for disputing UR denials

Doctor's First Report (Form DLSR 5021): Supporting documentation for initial RFAs

Treating Physician Progress Report (DWC Form PR-2): Supporting documentation for continued treatment RFAs

Appendix D: Recent Appellate and Administrative Decisions

Illinois Midwest Insurance Agency LLC v. WCAB (Rodriguez), 2d District Court of Appeal, November 10, 2025: Rejects "ongoing treatment" exception to UR/IMR; confirms exclusive remedy for medical necessity disputes

Mario Ramirez v. UNKNOWN, ADJ15193432, WCAB Panel Decision, 2025: Clarifies resubmission rights when material facts materially change post-UR denial

Appendix E: Division of Workers' Compensation Guidance and Notices

DWC Utilization Review FAQs for Claims Administrators: Q&A on RFA procedures, UR timelines, decision content, and non-physician reviewer authority

DWC Independent Medical Review FAQs: Information on IMR application, eligibility, and decision process

DWC Medical Treatment Utilization Schedule (MTUS) Website: Current ACOEM guidelines, administrative orders, drug formulary

DWC Newsline 2025-125 (December 30, 2025): Notice of OAL approval of April 1, 2026 UR regulation amendments

DWC Newsline 2025-75 (July 30, 2025): Notice of OAL disapproval of June 6, 2025 proposed amendments and DWC's commitment to resubmit

DWC Newsline 2026-06 (January 16, 2026): Notice of posting 2025 UR audit results and penalty assessments

XVI. Summary of Key Compliance Deadlines and Action Items (As of February 27, 2026)

| Deadline/Action | Date | Applicable Party | Citation |

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

| RFA Submission Deadline | Within 5 business days of treatment (prospective) or after treatment (retrospective) | Treating Physician | [Labor Code Section 4610][8 CCR Section 9792.9.1(c)] |

| RFA Response Timeline - Prospective/Concurrent | 5 business days of receipt | Claims Administrator | [8 CCR Section 9792.9.1(c)(3)] |

| RFA Response Timeline - Expedited | 72 hours of receipt | Claims Administrator | [8 CCR Section 9792.9.1(c)(4)] |

| RFA Response Timeline - Retrospective | 30 calendar days of receipt | Claims Administrator | [8 CCR Section 9792.9.1(c)(5)] |

| Initial Communication of Denial/Modification | 24 hours of decision (by phone/fax/email) | Claims Administrator | [8 CCR Section 9792.9.1(d)(3), (e)(3)] |

| Written Notice of Denial/Modification | 24 hours (concurrent), 2 business days (prospective), 72 hours from RFA receipt (expedited) | Claims Administrator | [8 CCR Section 9792.9.1(d)(3), (e)(3)] |

| URAC Accreditation Compliance (UR Plans that Modify/Deny) | On or before April 1, 2026 | UR Plan Operator | [8 CCR Section 9792.7.1 (effective April 1, 2026)][39] |

| Modified UR Plan Filing (Material Changes) | Within 30 calendar days of modification | UR Plan Operator | [8 CCR Section 9792.7(c)] |

| IMR Application Filing Deadline | Within 30 calendar days of UR decision service | Injured Worker / Treating Physician | [Labor Code Section 4610.5][8 CCR Section 9792.10.1(b)(1)] |

| IMR Application Filing Deadline (Drug-Only Disputes) | Within 10 calendar days of UR decision service | Injured Worker / Treating Physician | [8 CCR Section 9792.10.1(b)(1)] (effective April 1, 2026) |

| Resubmission After UR Denial (Material Fact Change) | Within 12 months of UR denial (unless material facts documented as changed) | Treating Physician | [Labor Code Section 4610(k)][8 CCR Section 9792.9.5] |

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[58] California Office of Administrative Law - RFA in Foster Care (Not Applicable to Workers' Comp) (https://www.coa.org/docs/2013-Annual-Meeting/MobileApp/DaisyBillRFA.pdf)

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[60] New York Workers' Compensation Board - Medical Billing Disputes (https://www.wcb.ny.gov/content/main/hcpp/request-assistance-unpaid-medical-bills.jsp)

[31] DWC FAQs on UR for claims administrators (Referenced Throughout Report) (https://www.dir.ca.gov/dwc/utilizationreview/ur_faq.htm)

Report Prepared By: Legal AI Assistant

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

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Scope: Comprehensive analysis of California Request for Authorization (RFA) procedures under Labor Code Section 4610 and Title 8 CCR SectionSection 9792.6.1 through 9792.12, including April 1, 2026 regulatory amendments