SB-1002 Workers' compensation: licensed clinical social workers. (2021-2022)

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Senate Bill No. 1002

CHAPTER 609

An act to amend Sections 3209.5, 4600, 4600.3, and 4616 of, and to add Section 3209.11 to, the Labor Code, relating to workers' compensation.

[Approved by Governor September 27, 2022. Filed with Secretary of State September 27, 2022.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1002, Portantino. Workers' compensation: licensed clinical social workers.

Existing law establishes a workers' compensation system, administered by the Administrative Director of the Division of Workers' Compensation, that generally requires employers to secure the payment of workers' compensation for injuries incurred by their employees that arise out of, and in the course of, employment. Existing law requires an employer to provide medical, surgical, chiropractic, acupuncture, and hospital treatment reasonably required to cure or relieve the injured worker from the effects of the injury. Existing law includes in the meaning of medical treatment services and supplies by physical therapists, chiropractic practitioners, and acupuncturists, that are licensed and within the scope of their practice. Existing law authorizes an insurer, employer, or entity that provides physician network services to establish or modify a medical provider network for the provision of medical treatment to injured employees, and requires that a network include an adequate number and type of physicians or other providers, as defined.

This bill would include a licensed clinical social worker (LCSW) as treatment the employer is reasonably required to provide, would expand the meaning of medical treatment to include the services of an LCSW, and would authorize an employer to provide an employee with access to an LCSW, as defined, acting within the scope of their practice. The bill would authorize medical provider networks to add LCSWs to the physician providers listing, authorize an LCSW to treat or evaluate an injured worker only upon referral from a physician, as defined, and prohibit an LCSW from determining disability, as specified. This bill would make legislative findings and declarations in support of allowing licensed clinical social workers to treat work-related mental and behavioral health issues.

Existing law requires that when a self-insured employer, group of self-insured employers, or the insurer of an employer contracts with a health care organization for health care services to be provided to injured employees, those employees subject to the contract are to receive medical services in the manner prescribed in the contract. Existing law requires that each contract provide all medical, surgical, chiropractic, acupuncture, and hospital treatment that is reasonably required to cure or relieve the effects of the injury.

This bill would include an LCSW as treatment that the contract is required to provide.

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: no

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. It is the intent of the Legislature to authorize qualified licensed clinical social workers to assess, evaluate, and treat the behavioral and mental health needs of injured workers within the workers' compensation system, thereby providing additional and readily available resources to injured employees who need mental health services.

SEC. 2. Section 3209.5 of the Labor Code is amended to read:

3209.5. Medical, surgical, and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches, and apparatus, includes, but is not limited to, services and supplies by physical therapists, licensed clinical social workers, chiropractic practitioners, and acupuncturists, as licensed by California state law and within the scope of their practice as defined by law.

SEC. 3. Section 3209.11 is added to the Labor Code, to read:

3209.11. (a) An employer, workers' compensation insurer, self-insured employer, or agent of an employer, insurer, or self-insured employer may provide an employee with access to the services of a licensed clinical social worker acting within their scope of practice.

(b) Medical provider networks may add licensed clinical social workers to the physician providers listing in the networks established or modified pursuant to Section 4616.

(c) For purposes of this section, "licensed clinical social worker" means a licensed clinical social worker with a master's degree in clinical social work, or a degree deemed equivalent for licensure by the Board of Behavioral Sciences pursuant to Article 4 (commencing with Section 4996) of Chapter 14 of Division 2 of the Business and Professions Code, and who either has at least two years of clinical experience in a recognized health setting or has met the standards of the Association of Social Work Boards.

(d) This section does not authorize licensed clinical social workers to determine disability for the purposes of Article 3 (commencing with Section 4650) of Chapter 2 of Part 2, or under Section 2708 of the Unemployment Insurance Code.

(e) This section authorizes a licensed clinical social worker to treat or evaluate an injured worker only upon referral from a physician as defined in Section 3209.3.

SEC. 4. Section 4600 of the Labor Code is amended to read:

4600. (a) Medical, surgical, chiropractic, acupuncture, licensed clinical social worker, and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches, and apparatuses, including orthotic and prosthetic devices and services, that is reasonably required to cure or relieve the injured worker from the effects of the worker's injury shall be provided by the employer. In the case of the employer's neglect or refusal reasonably to do so, the employer is liable for the reasonable expense incurred by or on behalf of the employee in providing treatment.

(b) As used in this division and notwithstanding any other law, medical treatment that is reasonably required to cure or relieve the injured worker from the effects of the worker's injury means treatment that is based upon the guidelines adopted by the administrative director pursuant to Section 5307.27.

(c) Unless the employer or the employer's insurer has established or contracted with a medical provider network as provided for in Section 4616, after 30 days from the date the injury is reported, the employee may be treated by a physician of the employee's own choice or at a facility of the employee's own choice within a reasonable geographic area. A chiropractor shall not be a treating physician after the employee has received the maximum number of chiropractic visits allowed by subdivision (c) of Section 4604.5.

(d) (1) If an employee has notified the employee's employer in writing prior to the date of injury that the employee has a personal physician, the employee shall have the right to be treated by that physician from the date of injury if the employee has health care coverage for nonoccupational injuries or illnesses on the date of injury in a plan, policy, or fund as described in subdivisions (b), (c), and (d) of Section 4616.7.

(2) For purposes of paragraph (1), a personal physician shall meet all of the following conditions:

(A) Be the employee's regular physician and surgeon, licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code.

(B) Be the employee's primary care physician and has previously directed the medical treatment of the employee, and who retains the employee's medical records, including the employee's medical history. "Personal physician" includes a medical group, if the medical group is a single corporation or partnership composed of licensed doctors of medicine or osteopathy,

which operates an integrated multispecialty medical group providing comprehensive medical services predominantly for nonoccupational illnesses and injuries.

(C) The physician agrees to be predesignated.

(3) If the employee has health care coverage for nonoccupational injuries or illnesses on the date of injury in a health care service plan licensed pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, and the employer is notified pursuant to paragraph (1), all medical treatment, utilization review of medical treatment, access to medical treatment, and other medical treatment issues shall be governed by Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code. Disputes regarding the provision of medical treatment shall be resolved pursuant to Article 5.55 (commencing with Section 1374.30) of Chapter 2.2 of Division 2 of the Health and Safety Code.

(4) If the employee has health care coverage for nonoccupational injuries or illnesses on the date of injury in a group health insurance policy as described in Section 4616.7, all medical treatment, utilization review of medical treatment, access to medical treatment, and other medical treatment issues shall be governed by the applicable provisions of the Insurance Code.

(5) The insurer may require prior authorization of any nonemergency treatment or diagnostic service and may conduct reasonably necessary utilization review pursuant to Section 4610.

(6) An employee is entitled to all medically appropriate referrals by the personal physician to other physicians or medical providers within the nonoccupational health care plan. An employee is entitled to treatment by physicians or other medical providers outside of the nonoccupational health care plan pursuant to standards established in Article 5 (commencing with Section 1367) of Chapter 2.2 of Division 2 of the Health and Safety Code.

(e) (1) When at the request of the employer, the employer's insurer, the administrative director, the appeals board, or a workers' compensation administrative law judge, the employee submits to examination by a physician, the employee is entitled to receive, in addition to all other benefits herein provided, all reasonable expenses of transportation, meals, and lodging incident to reporting for the examination, together with one day of temporary disability indemnity for each day of wages lost in submitting to the examination.

(2) Regardless of the date of injury, "reasonable expenses of transportation" includes mileage fees from the employee's home to the place of the examination and back at the rate of twenty-one cents ($0.21) a mile or the mileage rate adopted by the Director of Human Resources pursuant to Section 19820 of the Government Code, whichever is higher, plus any bridge tolls. The mileage and tolls shall be paid to the employee at the time the employee is given notification of the time and place of the examination.

(f) When at the request of the employer, the employer's insurer, the administrative director, the appeals board, or a workers' compensation administrative law judge, an employee submits to examination by a physician and the employee does not proficiently speak or understand the English language, the employee shall be entitled to the services of a qualified interpreter in accordance with conditions and a fee schedule prescribed by the administrative director. These services shall be provided by the employer. For purposes of this section, "qualified interpreter" means a language interpreter certified, or deemed certified, pursuant to Article 8 (commencing with Section 11435.05) of Chapter 4.5 of Part 1 of Division 3 of Title 2 of, or Section 68566 of, the Government Code.

(g) If the injured employee cannot effectively communicate with the employee's treating physician because the employee cannot proficiently speak or understand the English language, the injured employee is entitled to the services of a qualified interpreter during medical treatment appointments. To be a qualified interpreter for purposes of medical treatment appointments, an interpreter is not required to meet the requirements of subdivision (f), but shall meet any requirements established by rule by the administrative director that are substantially similar to the requirements set forth in Section 1367.04 of the Health and Safety Code. The administrative director shall adopt a fee schedule for qualified interpreter fees in accordance with this section. Upon request of the injured employee, the employer or insurance carrier shall pay for interpreter services. An employer shall not be required to pay for the services of an interpreter who is not certified or is provisionally certified by the person conducting the medical treatment or examination unless either the employer consents in advance to the selection of the individual who provides the interpreting service or the injured worker requires interpreting service in a language other than the languages designated pursuant to Section 11435.40 of the Government Code.

(h) Home health care services shall be provided as medical treatment only if reasonably required to cure or relieve the injured employee from the effects of the employee's injury and prescribed by a physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code, and subject to Section 5307.1 or 5307.8. The employer is not liable for home health care services that are provided more than 14 days prior to the date of the employer's receipt of the physician's prescription.

SEC. 5. Section 4600.3 of the Labor Code is amended to read:

4600.3. (a) (1) Notwithstanding Section 4600, when a self-insured employer, group of self-insured employers, or the insurer of an employer contracts with a health care organization certified pursuant to Section 4600.5 for health care services required by this article to be provided to injured employees, those employees who are subject to the contract shall receive medical services in the manner prescribed in the contract, providing that the employee may choose to be treated by a personal physician, personal chiropractor, or personal acupuncturist that they have designated prior to the injury, in which case the employee shall not be treated by the health care organization. Every employee shall be given an affirmative choice at the time of employment and at least annually thereafter to designate or change the designation of a health care organization or a personal physician, personal chiropractor, or personal acupuncturist. The choice shall be memorialized in writing and maintained in the employee's personnel records. The employee who has designated a personal physician, personal chiropractor, or personal acupuncturist may change their designated caregiver at any time prior to the injury. Any employee who fails to designate a personal physician, personal chiropractor, or personal acupuncturist shall be treated by the health care organization selected by the employer. If the health care organization offered by the employer is the workers' compensation insurer that covers the employee or is an entity that controls or is controlled by that insurer, as defined by Section 1215 of the Insurance Code, this information shall be included in the notice of contract with a health care organization.

(2) Each contract described in paragraph (1) shall comply with the certification standards provided in Section 4600.5, and shall provide all medical, surgical, chiropractic, acupuncture, licensed clinical social worker, and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches, and apparatus, including artificial members, that is reasonably required to cure or relieve the effects of the injury, as required by this division, without any payment by the employee of deductibles, copayments, or any share of the premium. However, an employee may receive immediate emergency medical treatment that is compensable from a medical service or health care provider who is not a member of the health care organization.

(3) Insured employers, a group of self-insured employers, or self-insured employers who contract with a health care organization for medical services shall give notice to employees of eligible medical service providers and any other information regarding the contract and manner of receiving medical services as the administrative director may prescribe. Employees shall be duly notified that if they choose to receive care from the health care organization they must receive treatment for all occupational injuries and illnesses as prescribed by this section.

(b) Notwithstanding subdivision (a), no employer which is required to bargain with an exclusive or certified bargaining agent which represents employees of the employer in accordance with state or federal employer-employee relations law shall contract with a health care organization for purposes of Section 4600.5 with regard to employees whom the bargaining agent is recognized or certified to represent for collective bargaining purposes pursuant to state or federal employer-employee relations law unless authorized to do so by mutual agreement between the bargaining agent and the employer. If the collective bargaining agreement is subject to the National Labor Relations Act, the employer may contract with a health care organization for purposes of Section 4600.5 at any time when the employer and bargaining agent have bargained to impasse to the extent required by federal law.

(c) (1) When an employee is not receiving or is not eligible to receive health care coverage for nonoccupational injuries or illnesses provided by the employer, if 90 days from the date the injury is reported the employee who has been receiving treatment from a health care organization or their physician, chiropractor, acupuncturist, or other agent notifies their employer in writing that the employee desires to stop treatment by the health care organization, they shall have the right to be treated by a physician, chiropractor, or acupuncturist or at a facility of their own choosing within a reasonable geographic area.

(2) When an employee is receiving or is eligible to receive health care coverage for nonoccupational injuries or illnesses provided by the employer, and has agreed to receive care for occupational injuries and illnesses from a health care organization provided by the employer, the employee may be treated for occupational injuries and diseases by a physician, chiropractor, or acupuncturist of their own choice or at a facility of their own choice within a reasonable geographic area if the employee or their physician, chiropractor, acupuncturist, or other agent notifies their employer in writing only after 180 days from the date the injury was reported, or upon the date of contract renewal or open enrollment of the health care organization, whichever occurs first, but in no case until 90 days from the date the injury was reported.

(3) For purposes of this subdivision, an employer shall be deemed to provide health care coverage for nonoccupational injuries and illnesses if the employer pays more than one-half the costs of the coverage, or if the plan is established pursuant to collective bargaining.

(d) An employee and employer may agree to other forms of therapy pursuant to Section 3209.7.

(e) An employee enrolled in a health care organization shall have the right to no less than one change of physician on request, and shall be given a choice of physicians affiliated with the health care organization. The health care organization shall provide the employee a choice of participating physicians within five days of receiving a request. In addition, the employee shall have the right to a second opinion from a participating physician on a matter pertaining to diagnosis or treatment from a participating physician.

(f) Nothing in this section or Section 4600.5 shall be construed to prohibit a self-insured employer, a group of self-insured employers, or insurer from engaging in any activities permitted by Section 4600.

(g) Notwithstanding subdivision (c), in the event that the employer, group of employers, or the employer's workers' compensation insurer no longer contracts with the health care organization that has been treating an injured employee, the employee may continue treatment provided or arranged by the health care organization. If the employee does not choose to continue treatment by the health care organization, the employer may control the employee's treatment for 30 days from the date the injury was reported. After that period, the employee may be treated by a physician of their own choice or at a facility of their own choice within a reasonable geographic area.

SEC. 6. Section 4616 of the Labor Code is amended to read:

4616. (a) (1) An insurer, employer, or entity that provides physician network services may establish or modify a medical provider network for the provision of medical treatment to injured employees. The network shall include physicians primarily engaged in the treatment of occupational injuries. The administrative director shall encourage the integration of occupational and nonoccupational providers. Subject to Section 3209.11, the number of physicians in the medical provider network shall be sufficient to enable treatment for injuries or conditions to be provided in a timely manner. The provider network shall include an adequate number and type of physicians, as described in Section 3209.3, or other providers, as described in Section 3209.5, to treat common injuries experienced by injured employees based on the type of occupation or industry in which the employee is engaged, and the geographic area where the employees are employed.

(2) Medical treatment for injuries shall be readily available at reasonable times to all employees. To the extent feasible, all medical treatment for injuries shall be readily accessible to all employees. With respect to availability and accessibility of treatment, the administrative director shall consider the needs of rural areas, specifically those in which health facilities are located at least 30 miles apart and areas in which there is a health care shortage.

(3) A treating physician shall be included in the network only if, at the time of entering into or renewing an agreement by which the physician would be in the network, the physician, or an authorized employee of the physician or the physician's office, provides a separate written acknowledgment in which the physician affirmatively elects to be a member of the network. Copies of the written acknowledgment shall be provided to the administrative director upon the administrative director's request. This paragraph shall not apply to a physician who is a shareholder, partner, or employee of a medical group that elects to be part of the network.

(4) (A) (i) Commencing July 1, 2021, every medical provider network shall post on its internet website a roster of all participating providers, which includes all physicians and ancillary service providers in the medical provider network, and shall update the roster at least quarterly. Every network shall provide to the administrative director the internet website address of the network and of its roster of participating providers. The roster of participating providers shall include, at a minimum, the name of each individual provider and their office address and office telephone number. If the ancillary service is provided by an entity rather than an individual, then that entity's name, address, and telephone number shall be listed.

(ii) The administrative director shall post, on the division's internet website, the internet website address of every approved medical provider network.

(B) Every medical provider network shall post on its internet website information about how to contact the medical provider network contact and medical access assistants, and information about how to obtain a copy of any notification regarding the medical provider network that is required to be given to an employee by regulations adopted by the administrative director.

(5) Every medical provider network shall provide one or more persons within the United States to serve as medical access assistants to help an injured employee find an available physician of the employee's choice, and subsequent physicians if necessary, under Section 4616.3. Medical access assistants shall have a toll-free telephone number that injured employees may use and shall be available at least from 7 a.m. to 8 p.m. Pacific standard time, Monday through Saturday, to respond to injured employees, contact physicians' offices during regular business hours, and schedule appointments. The administrative director shall promulgate regulations governing the provision of medical access assistants.

(b) (1) An insurer, employer, or entity that provides physician network services shall submit a plan for the medical provider network to the administrative director for approval. The administrative director shall approve the plan for a period of four years if the administrative director determines that the plan meets the requirements of this section. If the administrative director does not act on the plan within 60 days of submitting the plan, it shall be deemed approved. Commencing January 1, 2014, existing approved plans shall be deemed approved for a period of four years from the approval date of the most recent application or modification submitted prior to 2014. Plans for reapproval for medical provider networks shall be submitted at least six months before the expiration of the four-year approval period. Commencing January 1, 2016, a modification that updates an entire medical provider network plan to bring the plan into full compliance with all current statutes and regulations shall be deemed approved for a period of four years from the modification approval date. An approved modification that does not update an entire

medical provider network plan to bring the plan into full compliance with all current statutes and regulations shall not alter the expiration of the medical provider network's four-year approval period. Upon a showing that the medical provider network was approved or deemed approved by the administrative director, there shall be a conclusive presumption on the part of the appeals board that the medical provider network was validly formed.

(2) Every medical provider network shall establish and follow procedures to continuously review the quality of care, performance of medical personnel, utilization of services and facilities, and costs.

(3) Every medical provider network shall submit geocoding of its network for reapproval to establish that the number and geographic location of physicians in the network meets the required access standards.

(4) Approval of a plan may be denied, revoked, or suspended if the medical provider network fails to meet the requirements of this article. Any person contending that a medical provider network is not validly constituted may petition the administrative director to suspend or revoke the approval of the medical provider network. The administrative director may adopt regulations establishing a schedule of administrative penalties not to exceed five thousand dollars ($5,000) per violation, or probation, or both, in lieu of revocation or suspension for less severe violations of the requirements of this article. Penalties, probation, suspension, or revocation shall be ordered by the administrative director only after notice and opportunity to be heard. Unless suspended or revoked by the administrative director, the administrative director's approval of a medical provider network shall be binding on all persons and all courts. A determination of the administrative director may be reviewed only by an appeal of the determination of the administrative director filed as an original proceeding before the reconsideration unit of the workers' compensation appeals board on the same grounds and within the same time limits after issuance of the determination as would be applicable to a petition for reconsideration of a decision of a workers' compensation administrative law judge.

(c) Physician compensation may not be structured in order to achieve the goal of reducing, delaying, or denying medical treatment or restricting access to medical treatment.

(d) If the employer or insurer meets the requirements of this section, the administrative director may not withhold approval or disapprove an employer's or insurer's medical provider network based solely on the selection of providers. In developing a medical provider network, an employer or insurer shall have the exclusive right to determine the members of their network.

(e) All treatment provided shall be provided in accordance with the medical treatment utilization schedule established pursuant to Section 5307.27.

(f) Only a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, when these services are within the scope of the physician's practice, may modify, delay, or deny requests for authorization of medical treatment.

(g) Every contracting agent that sells, leases, assigns, transfers, or conveys its medical provider networks and their contracted reimbursement rates to an insurer, employer, entity that provides physician network services, or another contracting agent shall, upon entering or renewing a provider contract, disclose to the provider whether the medical provider network may be sold, leased, transferred, or conveyed to other insurers, employers, entities that provide physician network services, or another contracting agent, and specify whether those insurers, employers, entities that provide physician network services, or contracting agents include workers' compensation insurers.

(h) On or before November 1, 2004, the administrative director, in consultation with the Department of Managed Health Care, shall adopt regulations implementing this article. The administrative director shall develop regulations that establish procedures for purposes of making medical provider network modifications.

(i) The administrative director has the authority and discretion to investigate complaints, conduct random reviews, and take enforcement action against medical provider networks, an entity that provides ancillary services, or an entity providing services for or on behalf of the medical provider network or its providers regarding noncompliance with the requirements of this section or Section 4603.2 or 4610.