ACT 138

H.B. NO. 2476

A Bill for an Act Relating to Insurance.

Be It Enacted by the Legislature of the State of Hawaii:

SECTION 1. Section 431:10C-304, Hawaii Revised Statutes, is amended to read as follows:

"§431:10C-304 Obligation to pay personal injury protection benefits. For purposes of this section, the term "personal injury protection insurer" includes personal injury protection self-insurers. Every personal injury protection insurer shall provide personal injury protection benefits for accidental harm as follows:

(1) Except as otherwise provided in section 431:10C-305(d), in the case of injury arising out of a motor vehicle accident, the insurer shall pay, without regard to fault, to the provider of services on behalf of the following persons who sustain accidental harm as a result of the operation, maintenance, or use of the vehicle, an amount equal to the personal injury protection benefits as defined in section 431:10C-103.5(a) payable for expenses to that person as a result of the injury:
   (A) Any person, including the owner, operator, occupant, or user of the insured motor vehicle;
   (B) Any pedestrian (including a bicyclist); or
   (C) Any user or operator of a moped as defined in section 249-1;

   provided that this paragraph shall not apply in the case of injury to or death of any operator or passenger of a motorcycle or motor scooter as defined in section 286-2 arising out of a motor vehicle accident, unless expressly provided for in the motor vehicle policy;

(2) Payment of personal injury protection benefits shall be made as the benefits accrue, except that in the case of death, payment of benefits under section 431:10C-302(a)(5) may be made immediately in a lump sum payment, at the option of the beneficiary;

(3) (A) Payment of personal injury protection benefits shall be made within thirty days after the insurer has received reasonable proof of the fact and amount of benefits accrued, and demand for payment thereof. All providers must produce descriptions of the service provided in conformity with applicable fee schedule codes;

(B) If the insurer elects to deny a claim for benefits in whole or in part, the insurer shall, within thirty days, notify the claimant in writing of the denial and the reasons for the denial. The denial notice shall be prepared and mailed by the insurer in triplicate copies and be in a format approved by the commissioner. In the case of benefits for services specified in section 431:10C-103.5(a) the insurer shall also mail a copy of the denial to the provider; and

(C) If the insurer cannot pay or deny the claim for benefits because additional information or loss documentation is needed, the insurer shall, within the thirty days, forward to the claimant an itemized list of all the required documents. In the case of benefits for services specified in section 431:10C-103.5(a) the insurer shall also forward the list to the service provider;

(4) Amounts of benefits which are unpaid thirty days after the insurer has received reasonable proof of the fact and the amount of benefits accrued, and demand for payment thereof, after the expiration of the thirty days, shall bear interest at the rate of one and one-half per cent per month;

(5) No part of personal injury protection benefits paid shall be applied in any manner as attorney's fees in the case of injury or death for which the benefits are paid. The insurer shall pay, subject to section 431:10C-211, in addition to the personal injury protection benefits due, all attorney's fees and costs of settlement or suit necessary to effect the payment of any or all personal injury protection benefits found due under the contract. Any contract in violation of this provision shall be illegal and unenforceable. It shall constitute an unlawful and unethical act for any attorney to solicit, enter into, or knowingly accept benefits under any contract; [and

(6) Any insurer who violates this section shall be subject to section 431:10C-117(b) and (c).]

(6) Disputes between the provider and the insurer over the amount of a charge or the correct fee or procedure code to be used under the workers' compensation supplemental medical fee schedule shall be governed by section 431:10C-308.5; and

(7) Any insurer who violates this section shall be subject to section 431:10C-117(b) and (c)."

SECTION 2. Section 431:10C-308.5, Hawaii Revised Statutes, is amended to read as follows:

"**§431:10C-308.5 Limitation on charges.** (a) As used in this article, the term ["workers' compensation schedules"] "workers' compensation supplemental medical fee schedule" means the [schedules] schedule adopted and as may be

amended by the director of labor and industrial relations for workers' compensation cases under chapter 386, establishing fees and frequency of treatment guidelines[, and contained in sections 12-13-30, 12-13-35, 12-13-38, 12-13-39, 12-13-45, 12-13-85 through 92, and 12-13-94, Hawaii administrative rules]. References in the workers' compensation [schedules] supplemental medical fee schedule to "the employer", "the director", and "the industrial injury", shall be respectively construed as references to "the insurer", "the commissioner", and "the injury covered by personal injury protection benefits" for purposes of this article.

(b) The charges and frequency of treatment for services specified in section 431:10C-103.5(a), except for emergency services provided within seventy-two hours following a motor vehicle accident resulting in injury, shall not exceed the charges and frequency of treatment permissible under the workers' compensation [schedules.] supplemental medical fee schedule. Charges for independent medical examinations, including record reviews, physical examinations, history taking, and reports, to be conducted by a licensed Hawaii provider unless the insured consents to an out-of-state provider, shall not exceed the charges permissible under the [workers' compensation schedules for consultation for a complex medical problem.] appropriate codes in the workers' compensation supplemental fee schedule. The workers' compensation [schedules] supplemental medical fee schedule shall not apply to independent medical examinations conducted by out-of-state providers[; provided that] if the charges for the examination are reasonable. The independent medical examiner shall be selected by mutual agreement between insurer and claimant; provided that if no agreement is reached, the selection may be submitted to the commissioner, arbitration or circuit court. The independent medical examiner shall be of the same specialty as the provider whose treatment is being reviewed, unless otherwise agreed by the insurer and claimant. All records and charges relating to an independent medical examination shall be made available to the claimant upon request. The commissioner may adopt administrative rules relating to fees or frequency of treatment for injuries covered by personal injury protection benefits. If adopted, these administrative rules shall prevail to the extent that they are inconsistent with the workers' compensation [schedules.] supplemental medical fee schedule.

(c) Charges for services for which no fee is set by the workers' compensation [schedules] supplemental medical fee schedule or other administrative rules adopted by the commissioner shall be limited to eighty per cent of the provider's usual and customary charges for these services.

(d) Services for which no frequency of treatment guidelines are set forth in the workers' compensation [schedules] supplemental medical fee schedule or other administrative rules adopted by the commissioner shall be deemed appropriate and reasonable expenses necessarily incurred if so determined by a provider.

(e) In the event of a dispute between the provider and the insurer over the amount of a charge or the correct fee or procedure code to be used under the workers' compensation supplemental medical fee schedule, the insurer shall:

(1) Pay all undisputed charges within thirty days after the insurer has received reasonable proof of the fact and amount of benefits accrued and demand for payment thereof; and

(2) Negotiate in good faith with the provider on the disputed charges for a period up to sixty days after the insurer has received reasonable proof of the fact and amount of benefits accrued and demand for payment thereof.

If the provider and the insurer are unable to resolve the dispute, the provider, insurer, or claimant may submit the dispute to the commissioner, arbitration, or court of competent jurisdiction. The parties shall include documentation of the efforts of the insurer and the provider to reach a negotiated resolution of the dispute.

[(e)] (f) The provider of services described in section 431:10C-103.5(a) shall not bill the insured directly for those services but shall bill the insurer for a determination of the amount payable. The provider shall not bill or otherwise attempt to collect from the insured the difference between the provider's full charge and the amount paid by the insurer.

[(f)] (g) A health care provider shall be compensated by the insurer for preparing reports documenting the need for treatments which exceed the [schedules] workers' compensation supplemental medical fee schedule in accordance with the fee schedule for special reports. The health care provider may assess the cost of preparing a report to the insurer at no more than $20 per page up to a maximum of $75 for each report.''

SECTION 3. Statutory material to be repealed is bracketed. New statutory material is underscored.

SECTION 4. This Act shall take effect upon its approval.

(Approved May 30, 2000.)