
A BILL FOR AN ACT

RELATING TO MOTOR VEHICLE INSURANCE.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

1 SECTION 1. The legislature notes that section
2 431:10C-308.5, Hawaii Revised Statutes, limits the charges and
3 frequency for medical treatment covered by personal injury
4 protection (PIP) benefits. In accordance with this limitation
5 on charges, the motor vehicle insurer has an obligation to limit
6 payment of the insured's benefits for treatment.

7 The legislature finds that, as a result of the Hawaii
8 Supreme Court's ruling in Orthopedic Associates of Hawaii, Inc.
9 v. Hawaiian Insurance & Guaranty Co., Ltd., No. 24634, slip. op.
10 (Dec. 7, 2005), insurers have implemented a process of issuing
11 denial of benefits on all payments that are less than the amount
12 billed. Some of the larger insurers are issuing several
13 thousand denials each month. Copies of these denials are given
14 to both the provider and the insured. This has prompted many
15 calls from insureds who do not understand the process and are
16 concerned that the insurer might be denying them access to
17 medical treatment.

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1 This Act is intended to clarify the process to be followed
2 in any billing adjustment or dispute where an insurer receives
3 and does not dispute the treatment rendered but finds the
4 billing to exceed the permissible charges. This Act is not
5 intended to affect the merits of the amount billed or the amount
6 owed under PIP. Specifically, this Act clarifies that any
7 adjustments to payment of the amount billed is an acceptance of
8 the treatment and not a denial of benefit. Therefore, section
9 431:10C-304(3), which requires a written denial of benefit, is
10 not applicable to an adjustment to the amount payable under PIP
11 benefits. Rather than issue a denial, this Act clarifies that
12 the insurer's obligation is to "pay all undisputed charges" and
13 "negotiate in good faith with the provider on the disputed
14 charges."

15 SECTION 2. Section 431:10C-308.5, Hawaii Revised Statutes,
16 is amended by amending subsection (e) to read as follows:

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

21 (1) Pay all undisputed charges within thirty days after
22 the insurer has received reasonable proof of the fact



1 and amount of benefits accrued and demand for payment
2 thereof; and

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

8 If the provider and the insurer are unable to resolve the
9 dispute[7] after a period of sixty days pursuant to paragraph
10 (2), the provider, insurer, or claimant may submit the dispute
11 to the commissioner, arbitration, or court of competent
12 jurisdiction. The parties shall include documentation of the
13 efforts of the insurer and the provider to reach a negotiated
14 resolution of the dispute. The requirements of this section
15 supersede the requirements of section 431:10C-304(3) with
16 respect to all disputes about the amount of a charge or the
17 correct fee and procedure code to be used under the workers'
18 compensation medical fee schedule. An insurer who disputes the
19 amount of a charge or the correct fee or procedure code under
20 this section shall not be deemed to have denied a claim for
21 benefits under section 431:10C-304(3)."



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1 SECTION 3. Statutory material to be repealed is bracketed
2 and stricken. New statutory material is underscored.

3 SECTION 4. This Act shall take effect upon its approval.
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INTRODUCED BY: *DWL*

JAN 24 2006



HB 2606

Report Title:

Motor Vehicle Insurance; Medical Fee Schedule Payment Procedures

Description:

Clarifies the process of payments for benefits under automobile personal injury protection coverage where the bill for medical services submitted does not conform to the fee schedule or where there is a dispute between the medical provider and insurer on compliance.

