HOUSE OF REPRESENTATIVES
TWENTY-THIRD LEGISLATURE, 2006
STATE OF HAWAII

H.B. NO. 2629

A BILL FOR AN ACT

RELATING TO WORKERS' COMPENSATION.

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

SECTION 1. Section 386-21, Hawaii Revised Statutes, is amended to read as follows:

"**§386-21 Medical care, services, and supplies.** (a) Immediately after a work injury sustained by an employee and so long as reasonably needed, the employer shall furnish to the employee all medical care, services, and supplies as the nature of the injury requires. The liability for the medical care, services, and supplies shall be subject to the deductible under section 386-100.

(b) Whenever medical care is needed, the injured employee may select any physician or surgeon who is practicing on the island where the injury was incurred to render such care. If the services of a specialist are indicated, the employee may select any such physician or surgeon practicing in the State. The director may authorize the selection of a specialist practicing outside the State where no comparable medical attendance within the State is available. Upon procuring the services of such physician or surgeon, the injured employee

shall give proper notice of the employee's selection to the employer within a reasonable time after the beginning of the treatment. If for any reason during the period when medical care is needed, the employee wishes to change to another physician or surgeon, the employee may do so in accordance with rules prescribed by the director. If the employee is unable to select a physician or surgeon and the emergency nature of the injury requires immediate medical attendance, or if the employee does not desire to select a physician or surgeon and so advises the employer, the employer shall select the physician or surgeon. Such selection, however, shall not deprive the employee of the employee's right of subsequently selecting a physician or surgeon for continuance of needed medical care.

(c) The liability of the employer for medical care, services, and supplies shall be limited to the charges computed as set forth in this section. The director shall make determinations of the charges and adopt fee schedules based upon those determinations. Effective January 1, 1997, and for each succeeding calendar year thereafter, the charges shall not exceed one hundred ten per cent of fees prescribed in the Medicare Resource Based Relative Value Scale system applicable to Hawaii as prepared by the United States Department of Health

and Human Services, except as provided in this subsection. The rates or fees provided for in this section shall be adequate to ensure at all times the standard of services and care intended by this chapter to injured employees.

If the director determines that an allowance under the medicare program is not reasonable, or if a medical treatment, accommodation, product, or service existing as of June 29, 1995, is not covered under the medicare program, the director [~~may,~~], at any time, may establish an additional fee schedule or schedules not exceeding the prevalent charge for fees for services actually received by providers of health care services to cover charges for that treatment, accommodation, product, or service. If no prevalent charge for a fee for service has been established for a given service or procedure, the director shall adopt a reasonable rate that shall be the same for all providers of health care services to be paid for that service or procedure.

The director shall update the schedules required by this section every three years or annually, as required. The updates shall be based upon:

(1) Future charges or additions prescribed in the Medicare Resource Based Relative Value Scale system applicable

to Hawaii as prepared by the United States Department of Health and Human Services; or

(2) A statistically valid survey by the director of prevalent charges for fees for services actually received by providers of health care services or based upon the information provided to the director by the appropriate state agency having access to prevalent charges for medical fee information.

When a dispute exists between an insurer or self-insured employer and a medical service provider regarding the amount of a fee for medical services, the director may resolve the dispute in a summary manner as the director may prescribe; provided that a provider shall not charge more than the provider's private patient charge for the service rendered.

(d) If it appears to the director that the injured employee has wilfully refused to accept the services of a competent physician or surgeon selected as provided in this section, or has wilfully obstructed the physician or surgeon, or medical, surgical, or hospital services or supplies, the director may consider such refusal or obstruction on the part of the injured employee to be a waiver, in whole or in part, of the right to medical care, services, and supplies[~~,~~] and may suspend

the weekly benefit payments, if any, to which the employee is entitled so long as such refusal or obstruction continues.

(e) Such funds as are periodically necessary to the department to implement the foregoing provisions may be charged to and paid from the special compensation fund provided by section 386-151.

(f) In cases where the compensability of the claim is not contested by the employer, the medical services provider shall notify or bill the employer, insurer, or the special compensation fund for services rendered relating to the compensable injury within two years of the date services were rendered. Failure to bill the employer, insurer, or the special compensation fund within the two-year period shall result in the forfeiture of the medical service provider's right to payment. The medical service provider shall not directly charge the injured employee for treatments relating to the compensable injury.

(g) To ensure efficiency through uniformity, the director shall prepare standardized forms for:

(1) Medical excuse forms; and

(2) Workers' compensation routing forms that include all relevant employer and insurance carrier information

that is required to process injured worker claims under this chapter.

(h) All claims for payment from a health care provider to an insurance carrier subject to this chapter and a self-insured group subject to part VI of this chapter shall be made within seven calendar days from the date the claim for payment is received by the insurance carrier or self-insured group. Beginning July 1, 2008, an insurance carrier subject to this chapter and a self-insured group subject to part VI of this chapter shall take not longer than one calendar day to approve claims for payments to health care providers. Notwithstanding any law to the contrary, a request for payment for medical services, goods, or supplies rendered, along with the injured workers' claim progress notes and any necessary authorization submitted by a health care provider to an insurance carrier subject to this chapter, or self-insured group subject to part VI of this chapter, shall be sufficient proof for payment to be made to the health care provider."

SECTION 2. New statutory material is underscored.

SECTION 3. This Act shall take effect upon its approval.

INTRODUCED BY: _____

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Kirk Caldwell

JAN 24 2006

HB2629

Report Title:
Workers' Compensation; Administration; Forms; Payment

Description:
Requires the department of labor and industrial relations to establish standardized medical excuse and routing forms for workers' compensation claims. Requires the timely processing and payment of bills to medical service providers. Establishes that only claim progress notes and authorization be required for payment to medical service providers.