THE SENATE
TWENTY-THIRD LEGISLATURE, 2006
STATE OF HAWAII

JAN 25 2006

S.B. NO. 3012

A BILL FOR AN ACT

RELATING TO MOTOR VEHICLE INSURANCE.

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

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

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

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

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

"(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[~~,~~] after a period of sixty days pursuant to paragraph (2), 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. The requirements of this section supersede the requirements of section 431:10C-304(3) with respect to all disputes about the amount of a charge or the correct fee and procedure code to be used under the workers' compensation medical fee schedule. An insurer who disputes the amount of a charge or the correct fee or procedure code under this section shall not be deemed to have denied a claim for benefits under section 431:10C-304(3)."

S.B. NO. 3072

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

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

INTRODUCED BY: _____

By Request

SB. NO. 3072

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.