HB 1640

RELATING TO WORKERS' COMPENSATION

HB 1640

TESTIMONY

HOUSE OF REPRESENTATIVES
TWENTY-NINTH LEGISLATURE, 2018
STATE OF HAWAII

H.B. NO. 1640

A BILL FOR AN ACT

RELATING TO WORKERS' COMPENSATION.

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

SECTION 1. The legislature finds that Hawaii's existing workers' compensation system has been plagued by delays and denials, and in many of those cases, insurers seem to automatically deny the claim pending investigation. These investigations may include reviewing reports from an independent medical examiner, interviewing other employees, looking at videotapes, or combing through old medical records for evidence as to whether the workplace injury was related to a pre-existing condition. While the insurer considers, sometimes for months, how to proceed on a claim, the patient is at times unable to receive compensation.

The purpose of this Act is to prevent employers from denying a workers' compensation claim without reasonable cause or while the claim is pending investigation and to impose fines and penalties on employers who continue doing so without reasonable cause.

SECTION 2. Chapter 386, Hawaii Revised Statutes, is amended by adding a new section to be appropriately designated and to read as follows:

"**§386- Payment by employer; duty to service provider; disagreement with service provider; resolution procedures.** (a) Notwithstanding any other law to the contrary, the employer shall pay for all medical services required by the employee for the compensable injury and the process of recovery. The employer shall not be required to pay for care unrelated to the compensable injury.

(b) The employer shall not dispute a claim for services:

(1) Without reasonable cause; or

(2) While the claim is pending investigation;

provided that a claim shall be presumed compensable when submitted by an employee who is excluded from health care coverage under the Hawaii Prepaid Health Care Act.

(c) If an employer disputes a claim for services rendered or a bill received, the employer shall notify the provider of services of that fact within thirty calendar days of receipt of the claim for services or bill. Failure by the employer to submit timely notice to the provider of services shall render

the employer liable for the services provided or bill received until the employer satisfies the notice requirement and except as provided in subsection (d).

(d) Any employer who has received a claim for services rendered or a bill from a provider of services shall be liable for the claim or bill and shall, within sixty calendar days of receipt of the claim or bill, pay all charges listed in the claim for services rendered or the bill, except for items for which there is reasonable disagreement. After expiration of the sixty-calendar-day time period for payment, the provider of services may increase the total outstanding balance owed for undisputed services or charges by one per cent per month.

(e) In the event of reasonable disagreement, the employer shall:

(1) Pay all undisputed charges;

(2) Notify the provider of services of the denial of payment of any disputed charges and the reason for the denial within thirty calendar days of receipt of the bill or claim for services rendered; and

(3) Provide a copy of the denial to the employee.

The employer's denial shall include a statement as follows:

"IF THE PROVIDER OF SERVICES DOES NOT AGREE WITH THE EMPLOYER'S STATED REASON FOR DENIAL OF PAYMENT, THE PROVIDER OF SERVICES MAY FILE A BILL DISPUTE REQUEST WITH THE DIRECTOR OF THE HAWAII DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS. THE BILL DISPUTE REQUEST SHALL BE CLEARLY IDENTIFIED AS 'BILL DISPUTE REQUEST' IN CAPITAL LETTERS AND IN NO LESS THAN TEN POINT FONT ON THE FRONT OF THE FIRST PAGE OF THE REQUEST AND ON THE FRONT OF THE ENVELOPE IN WHICH THE REQUEST IS SENT. ANY BILL DISPUTE REQUEST SHALL BE FILED WITHIN THIRTY CALENDAR DAYS AFTER POSTMARK OF THE EMPLOYER'S DENIAL OF PAYMENT. THE PROVIDER OF SERVICES' FAILURE TO SUBMIT A TIMELY BILL DISPUTE REQUEST SHALL BE CONSIDERED AS ACCEPTANCE OF THE EMPLOYER'S DENIAL OF PAYMENT."

(f) Upon receipt of a bill dispute request, the director shall send notice to the parties and the parties shall negotiate to resolve the disputed services or charges during the thirty-one calendar days following the date of the notice from the director. If the parties fail to enter into an agreement within

the thirty-one calendar days, then within fourteen calendar days thereafter, either party may file a request in writing to the director to review the bill dispute request; provided that the requesting party sends notice of the request to the non-requesting party. Upon receipt of the request for review, the director shall send the parties a second notice requesting each party to file a position statement with the director, including substantiating documentation that describes the services and amounts in dispute and all actions taken to resolve the dispute during the thirty-one calendar day period of negotiation under this subsection. The director shall review the positions of the parties and render an administrative decision without a hearing. The director may assess a service fee of up to $1,000 payable to the general fund against one or more parties who the director finds has failed to negotiate in good faith. Denial of payment without reasonable cause shall be considered a failure to negotiate in good faith.

(g) An employee shall be liable for reimbursement of benefits or payments received under this section for any disputed claim that is found to be not compensable, whether received from an employer, insurer, or the special compensation

fund. Reimbursement shall be made to the source from which the compensation was received, and may include recoupment by the insurer of all payments made for medical care, medical services, vocational rehabilitation services, and all other services rendered for payment under this section."

SECTION 3. New statutory material is underscored.

SECTION 4. This Act shall take effect on July 1, 2018.

INTRODUCED BY: _____

JAN 11 2018

H.B. NO. 1640

Report Title:
Workers' Compensation; Compensable Claims; Employer Payment

Description:
Prohibits employer disputes of workers' compensation claims without reasonable cause or while the claim is pending investigation. Establishes negotiation, notice, and review procedures for disputed claims. Establishes penalty for failure to negotiate in good faith. Permits service providers to charge interest on late bill payments.

The summary description of legislation appearing on this page is for informational purposes only and is not legislation or evidence of legislative intent.

DAVID Y. IGE
GOVERNOR

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January 30, 2018

To: The Honorable Aaron Ling Johanson, Chair,
The Honorable Daniel Holt, Vice Chair, and
Members of the House Committee on Labor & Public Employment

Date: Tuesday, January 30, 2018
Time: 930 a.m.
Place: Conference Room 309, State Capitol

From: Leonard Hoshijo, Acting Director
Department of Labor and Industrial Relations (DLIR)

Re: H.B. No. 1640 Relating to Workers' Compensation

I. OVERVIEW OF PROPOSED LEGISLATION

This proposal seeks to add a new section to chapter 386, Hawaii Revised Statutes (HRS), relating to payment of bills by the employer and specifies a process for bill dispute resolution by the Director. This bill is similar to section 12-15-94, Hawaii Administrative Rules (HAR), which requires the employer to pay for all medical services, which the nature of the compensable injury and the process of recovery requires. Provisions include the following:

- Prohibits the employer from contesting a claim for services without reasonable cause or while the claim is pending investigation.
- Requires that a claim for service is presumed compensable when submitted by an employee who is excluded from health care coverage under the Hawaii Prepaid Health Care Act.
- Section 2 Subsection (c) amends the period for an employer to contest a claim for services rendered or a bill received from sixty calendar days (referenced in section 12-15-94, (HAR) to thirty calendar days from receipt.
- Subsection (d) requires the employer to pay the bill within sixty calendar days of receipt, except for items where there is a reasonable disagreement. Failure to do so allows the provider to increase the total outstanding balance by one per cent per month. Subsection (e) requires the employer to notify the provider of service

within thirty calendar days of receipt of the bill if the bill is denied and the reason for denial.

- Specifies the process for bill dispute resolution and increases the penalty from $500 (12-15-94, HAR) to $1,000 that the DLIR Director may assess for failure to negotiate in good faith.
- Holds the employee liable for reimbursement of benefits or payments received under this section to an employer, insurer, or the Special Compensation Fund or to any other source from which the compensation was received when a controverted claim is found non-compensable.

The Department opposes the measure, especially as key provisions are contradictory and would likely result in legal ambiguities and more disputes in a workers' compensation system already burdened by litigiousness. The statutory presumption law dictates that coverage is presumed at the outset, subject to rebuttal by substantial evidence to the contrary. Therefore, the employer has the right under the presumption law for discovery, otherwise, their due process rights may be violated. Moreover, statute and administrative rules already provide a process for bill disputes and there has been a dramatic drop off in the number of disputes before the Director as a result of the administrative process.

Furthermore, the statutory presumption law dictates that coverage is presumed at the outset, subject to rebuttal by substantial evidence to the contrary. Therefore, the employer has the right under the presumption law for discovery, otherwise, their due process rights may be violated.

II. CURRENT LAW

Section **§386-85 Presumptions** provides a strong presumption of compensability for work injury claims.

[1] Section §386-21 states in part, "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."

Section §386-26 states in part, "In addition, the director shall adopt updated medical fee schedules referred to in section 386-21, and where deemed appropriate, shall establish separate fee schedules for services of health care providers…" The Workers' Compensation Medical Fee Schedule (WCMFS), HAR section **12-15-94 Payment by employer**[2], allows for the following bill dispute process:

When a provider of service notifies or bills the employer, the employer shall inform the provider of service within sixty calendar days of such billing should the employer contest the claim for services. Failure by the employer to notify the provider shall make the employer liable for services rendered until the employer contests further services.

The employer, after accepting liability, shall pay all charges billed within sixty calendar

days of receipt of the charges, except for items where there is reasonable disagreement. If more than sixty-calendar days lapse between the employer's receipt of an undisputed bill and date of payment, the billing can be increased by one percent per month of the outstanding balance.

If there is a disagreement, within sixty calendar days of receipt of the bill, the employer shall notify the provider of service of the denial and the reason for the denial, and provide a copy to the claimant. The denial must state that if the provider does not agree with the denial, they may file a bill dispute with the DLIR Director within sixty calendar days after postmark of employer's denial and failure to do so shall be construed as acceptance of the denial. If the disagreement cannot be resolved between the employer and provider of service, either party may make a written request for intervention to the Director. The Director then sends the parties a notice and the parties can negotiate for thirty-one calendar days to resolve the dispute upon receipt of the Director's notice. If the parties fail to come to an agreement during the thirty-one calendar days, then within fourteen calendar days following the thirty-one day negotiating period, either party can request the Director to review the dispute.

The next step in the process involves the Director sending both parties a second notice requesting they submit position statements and documentation within fourteen days following the receipt of this second notice. The Director reviews the positions of both parties and renders an administrative decision. A service fee of $500 can be assessed at the discretion of the Director against either or both parties who fail to negotiate in good faith.

Prepaid Health Care, section 12-12-45 HAR regarding Controverted workers' compensation claims, allows for the following:

"In the event of a controverted workers' compensation claim, ***the health care contractor shall pay or provide*** for the medical services in accordance with the health care contract and notify the Department of such action. If workers' compensation liability is established, the ***health care contractor shall be reimbursed*** by the workers' compensation carrier such amounts authorized by chapter 386, HRS, and chapter 10 of title 12, administrative rules."

Under the Hawaii Prepaid Health Care Act, employers are required to provide healthcare coverage for their eligible employees. However, employees who do not work 20 hours per week for 4 consecutive weeks are not entitled to PHC coverage because they have not met the eligibility requirement for health care coverage, but they are not "excluded" from coverage. In addition, employees may sign a waiver saying they do not want PHC coverage from the employer because they have other PHC coverage. It is not clear why a presumption of compensability should be created in such cases.

III. COMMENTS ON THE HOUSE BILL

DLIR opposes the measure as its intent is already provided for in the law and offers the following comments:

- The proposed subsections 386 (a) and (b) of this proposal are contradictory. Paragraph (a) states the employer shall pay, but (b) allows the employer to deny a claim with reasonable cause. DLIR is concerned with the administrative or adjudicatory complications this contradiction will cause. Further confusing the matter is that presumably an employer will not know if it had reasonable cause to dispute until it investigates.

- DLIR suggests the measure should address the Prepaid healthcare contracts that exclude WC in violation of section HAR 12-12-45. When the employer denies compensability and the PHC provider denies coverage, then the employer has both significant leverage and the economic advantage over the worker. DLIR suggests the measure be replaced with the codification of the Prepaid HAR in chapter 386, HRS.

- Subsection (b) of this proposal adds that the claim is presumed compensable when submitted by an employee excluded by the PHC Act (there are numerous exclusions). The Department does not believe the intent of the measure is to be all-inclusive.

- DLIR notes that claims for compensation are already presumed, in the absence of substantial evidence to the contrary, to be claims for covered work injuries (§386-85). To rebut the presumption of compensability, employers have the initial burden of going forward with the evidence, which is the burden of production, as well as the burden of persuasion. Panoke v. Development of Hawaii, Inc., 136 Hawaii 448, 461 (2015). The burden of production means that the employer bears the burden of introducing substantial evidence, which, if true, could rebut the presumption that an injury is work-related. If the employer meets the burden of production, the burden of persuasion requires the trier of fact to weigh the evidence elicited by the employer against the evidence elicited by the claimant. Id. (citing Igawa v. Koa House Rest., 97 Hawaii 402 (2001). The pending investigation clause in the proposed section (b) (2) adds a second presumption and DLIR does not understand the intent of the second presumption. Moreover, it is unclear what the relationship is between that clause and the Prepaid HAR 12-12-45 Controverted workers' compensation claims.

- The Department opines that the current dispute resolution procedure and timelines in section 12-15-94 HAR Payment by employer, are adequate when properly implemented. Because the Department realizes that certain insurers, attorneys, and claimants may not negotiate in good faith to delay the resolution process, the Department has sought after and received

approval for two DCD Facilitator positions starting mid-year 2018. These positions will have the primary responsibility of ensuring proper implementation of the statutes and timely advancement of case investigations.

- The number of bill disputes before the Director has been significantly resolved through applying the aforementioned administrative remedy—in 2014 there were over 2,100 disputes. That number fell to 334 in 2016 and 162 in 2017.

- Subsection (g) of this bill requires employees to reimburse all benefits or payments received under this section back to the employer, insurer, or the Special Compensation Fund, or to the source from which payment was received if the claim is found to be non-compensable. However, it is often the case that the injured employee may not have the resources to reimburse the payers.

- DLIR notes that administrative decisions require a hearing. Subsection (f), references an old rule §12-15-94, HAR, where the medical fee disputes were final and not appealable. In 2009 the rule was found invalid by the ICA, *Jou v. Hamada, 201 P3d 614,120 Hawaii 101*, see attached.

FOOTNOTES

[1] **§386-85 Presumptions.** In any proceeding for the enforcement of a claim for compensation under this chapter it shall be presumed, in the absence of substantial evidence to the contrary:

(1) That the claim is for a covered work injury;
(2) That sufficient notice of such injury has been given;
(3) That the injury was not caused by the intoxication of the injured employee; and
(4) That the injury was not caused by the wilful intention of the injured employee to injure oneself or another.

[2] **§12-15-94 Payment by employer.** (a) The employer shall pay for all medical services which the nature of the compensable injury and the process of recovery require. The employer is not required to pay for care unrelated to the compensable injury.

(b) When a provider of service notifies or bills an employer, the employer shall inform the provider within sixty calendar days of such notification or billing should

the employer controvert the claim for services. Failure of the employer to notify the provider of service shall make the employer liable for services rendered until the provider is informed the employer controverts additional services.

(c) The employer, after accepting liability, shall pay all charges billed within sixty calendar days of receipt of such charges except for items where there is a reasonable disagreement. If more than sixty calendar days lapse between the employer's receipt of an undisputed billing and date of payment, payment of billing shall be increased by one per cent per month of the outstanding balance. In the event of disagreement, the employer shall pay for all acknowledged charges and shall notify the provider of service, copying the claimant, of the denial of payment and the reason for denial of payment within sixty calendar days of receipt. Furthermore, the employer's denial must explicitly state that if the provider of service does not agree, the provider of service may file a "BILL DISPUTE REQUEST" to include a copy of the original bill with the director within sixty calendar days after postmark of the employer's objection, and failure to do so shall be construed as acceptance of the employer's denial.

(d) In the event a reasonable disagreement relating to specific charges cannot be resolved, the employer or provider of service may request intervention by the director in writing with notice to the other party. Both the front page of the billing dispute request and the envelope in which the request is mailed shall be clearly identified as a "BILLING DISPUTE REQUEST" in capital letters and in no less than ten point type. The director shall send the parties a notice and the parties shall negotiate during the thirty-one calendar days following the date of the notice from the director. If the parties fail to come to an agreement during the thirty-one calendar days, then within fourteen calendar days following the thirty-one day negotiating period, either party may file a request, in writing, to the director to review the dispute with notice to the other party. The director shall send the parties a second notice requesting the parties file position statements, with substantiating documentation to specifically include the amount in dispute and a description of actions taken to resolve the dispute, within fourteen calendar days following the date of the second notice from the director. The director shall review the positions of both parties and render an administrative decision without hearing. A service fee of up to $500 payable to the State of Hawaii General Fund will be assessed at the discretion of the director against either or both parties who fail to negotiate in good faith.

201 P.3d 614
120 Haw. 101
Emerson M.F. JOU, M.D., Provider-Appellant,
v.
Gary S. HAMADA, Administrator, Disability Compensation Division, and Darwin

[201 P.3d 615]

Ching,[1] Director, Department of Labor and Industrial Relations, State of Hawai`i, Appellees-Appellees and Argonaut Insurance Company, Respondent-Appellee. and
Emerson M.F. Jou, M.D., Provider-Appellant,
v.
Gary S. Hamada, Administrator, Disability Compensation Division, and Darwin Ching, Director, Department of Labor and Industrial Relations, State of Hawai`i, Appellees-Appellees and Marriott Claim Services Corporation, Respondent-Appellee.
No. 27491.
No. 27539.
Intermediate Court of Appeals of Hawai`i.
January 26, 2009.
As Corrected March 5, 2009.

[201 P.3d 617]

Stephen M. Shaw, on the briefs, for provider-appellant.

Frances E.H. Lum, Herbert B.K. Lau, Deputy Attorneys General, Department of Attorney General, State of Hawai'i, on the briefs, for appellee-appellee.

Robert A. Chong, Steven L. Goto, Honolulu, on the briefs, for respondent-appellee Marriott Claim Services Corporation.

Kenneth T. Goya, Steven L. Goto, Honolulu, on the briefs, for respondent-appellee Argonaut Insurance Company.

FOLEY, Presiding Judge, NAKAMURA, and FUJISE, JJ.

Opinion of the Court by NAKAMURA, J.

Under the provisions of Hawaii Revised Statutes (HRS) §§ 386-73 (Supp.2007) and 386-87 (1993) of the Hawai`i workers' compensation law, the parties to a decision by the Director of the Department of Labor and Industrial Relations (the Director) have the right to appeal the Director's decision to the Labor and Industrial Relations Appeals Board (LIRAB). The Director has promulgated a rule, Hawaii Administrative Rules (HAR) § 12-15-94(d), prohibiting any appeal of the Director's decisions in billing disputes between employers and medical service providers in workers' compensation cases. HAR § 12-15-94(d) authorizes the Director to resolve such billing disputes without a hearing and provides that "[t]he decision of the [D]irector is final and not appealable."

The question presented in these consolidated appeals[2] is whether the Director was authorized to promulgate a rule prohibiting any appeal of the Director's decisions in billing disputes between employers and medical service providers. We conclude that the Director's no-appeal rule is inconsistent with the statutory right granted to parties to appeal the Director's decisions under HRS §§ 386-73 and 386-87.

We hold that: 1) the provision prohibiting appeal of the Director's decisions in HAR § 12-15-94(d) is invalid as beyond the Director's rulemaking power; 2) Provider-Appellant Emerson M.F. Jou, M.D., (Dr. Jou) is entitled to a declaratory judgment that the no-appeal provision of HAR § 12-15-94(d) is invalid; 3) the Circuit Court of the First Circuit (circuit court)[3] erred in dismissing Dr. Jou's claims for declaratory relief; and 4) although Dr. Jou

cannot pursue the merits of his appeals of the Director's decisions before the circuit court, he is entitled to file appeals of the Director's decisions with the LIRAB.

BACKGROUND

Dr. Jou is a licensed medical doctor who specializes in physiatry—the diagnosis and treatment of disease by physical methods, including massage, manipulation, exercise, heat, and water. In the two cases underlying these consolidated appeals, Civil No. 05-1-0375 and Civil No. 05-1-1079, Dr. Jou treated patients that had sustained work-related injuries. Respondent-Appellee Argonaut Insurance Company (Argonaut) was the workers' compensation insurance carrier for the patient's employer in Civil No. 05-1-0375, and Respondent-Appellee Marriott Claim Services Corporation (Marriott) was the workers' compensation insurance adjuster for the patient's employer in Civil No. 05-1-1079.

Dr. Jou billed Argonaut and Marriott for his treatments, which included massage therapy performed by licensed massage therapists employed by Dr. Jou. Argonaut and Marriott initially denied payment for the massage therapy on the ground that Dr. Jou did not have a massage establishment ("MAE") license.[4] Dr. Jou responded that as

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a licensed physician, he did not need an MAE license.

In each case, the billing dispute remained at a standstill for several years. In November 2004, Dr. Jou filed a request for a hearing before the Director on the denials of reimbursement by Argonaut and Marriott. The Director instructed the parties to negotiate and attempt to resolve the billing dispute pursuant to HAR § 12-15-94.[5] Dr. Jou wrote to Argonaut and Marriott and demanded payment of the full amount of the disputed bills plus interest. Argonaut agreed to pay the outstanding bill of $293.33, which was for services rendered by Dr. Jou's massage-therapist employees. Marriott agreed to pay $2,217.85 for the services rendered by the massage-therapist employees, which comprised the lion's share of the outstanding bill,

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but refused to pay for two office visits claimed by Dr. Jou.[6] Both Argonaut and Marriott rejected Dr. Jou's demand for payment of interest.

After obtaining position statements from the parties, the Director issued decisions in both cases.[7] The Director resolved the dispute over the fees billed by Dr. Jou for the two office visits in favor of Dr. Jou and ordered Marriott to pay for those visits. The Director denied Dr. Jou's request that Argonaut and Marriott be required to pay interest. HAR § 12-15-94(c) provides that after accepting liability, an employer shall pay all charges billed within sixty days of receipt "except for items where there is a reasonable disagreement," and that if an "undisputed billing" remains unpaid for more than sixty days, the amount owed "shall be increased by one per cent per month of the outstanding balance." In Dr. Jou's dispute with Marriott, the Director found that "there was a reasonable disagreement over Dr. Jou's fees" and therefore ruled that the employer was not liable for the assessment of one per cent per month for late payment of the disputed fees. In Dr. Jou's dispute with Argonaut, the Director initially issued a decision finding that the "employer's earlier denial of payment for lack of an MAE license [was] a reasonable dispute of fees." The Director subsequently issued an amended decision which deleted this finding and simply ruled that "with the employer's payment of the disputed fees ... employer shall not be liable for an assessment of one per cent per month simple interest."

Dr. Jou appealed the Director's decisions to the circuit court pursuant to HRS § 91-14 (1993 & Supp.2007)[8] and Hawai'i Rules of Civil Procedure (HRCP) Rule 72 (2005).[9] Appellees-Appellees the Administrator of the Disability Compensation Division (DCD) of the Department of Labor and Industrial Relations (DLIR) and the Director (collectively referred to herein as the "DLIR Appellees") were Appellees in both Civil No. 05-1-0375 and Civil No. 05-1-1079. Argonaut was the Respondent-Appellee in Civil No. 05-1-0375

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and Marriott the Respondent-Appellee in Civil No. 05-1-1079. In his notices of appeal and statements of the case to the circuit court, Dr. Jou raised numerous claims, including that the DLIR was biased in favor of insurance companies, that the Director's decisions were made upon unlawful procedure, and that the Director's decisions violated various constitutional and statutory provisions.

In his notice of appeal to the circuit court in Civil No. 05-1-1079, Dr. Jou requested that the circuit court "treat this filing as an action for declaratory judgment that the rules relating to billing disputes, are unconstitutional or invalid pursuant to HRS § 91-7."[10] In his statement of the case accompanying that notice of appeal, Dr. Jou alleged, among other things, that "HAR § 12-15-94 violates statutes relating to pre-judgment interest and *appellate review of DLIR matters*." (Emphasis added.)

Similarly, in his notice of appeal to the circuit court in Civil No. 05-1-0375, Dr. Jou requested that the circuit court "treat this filing as an action for declaratory judgment that the rules relating to billing disputes, particularly HAR § 12-15-94(c), are unconstitutional or invalid pursuant to HRS § 91-7." He also gave notice that his grounds for appeal included a claim that the Director's decision "is affected by other errors of law, particularly denial of the right to appeal to the appellate board." In his statement of the case accompanying the appeal in Civil No. 05-1-0375, Dr. Jou attacked the Director's representation that Argonaut's dispute with Dr. Jou over whether physicians must have an MAE license was reasonable, and then noted that "[b]y agency rule, no appeal to the appellate board may be taken."

The DLIR Appellees, Marriott, and Argonaut moved to dismiss Jou's appeals to the circuit court for lack of jurisdiction. Among the grounds they urged was that HAR § 12-15-94(d) does not permit appeals of the Director's decisions in billing disputes over medical fees in workers' compensation cases. The DLIR Appellees, in particular, provided a detailed analysis of why the Director believes the no-appeal provision in HAR § 12-15-94(d) is authorized by and not inconsistent with the Hawai'i workers' compensation law. The circuit court in each case dismissed Dr. Jou's appeal for lack of jurisdiction. The Final Judgment in Civil No. 05-1-0375 was entered on August 18, 2005, and the Final Judgment in Civil No. 05-1-1079 was entered on September 9, 2005.

STANDARD OF REVIEW

We apply the following standard in interpreting statutes:

In construing statutes, we have recognized that

our foremost obligation is to ascertain and give effect to the intention of the legislature, which is to be obtained primarily from the language contained in the statute itself. And we must read statutory language in the context of the entire statute and construe it in a manner consistent with its purpose.

When there is doubt, doubleness of meaning, or indistinctiveness or uncertainty of an expression used in a statute, an ambiguity exists....

In construing an ambiguous statute, "[t]he meaning of the ambiguous words may be sought by examining the context, with which the ambiguous words, phrases, and sentences may be compared, in order to ascertain their true meaning." HRS § 1-15(1) [(1993)]. Moreover, the courts may resort to extrinsic aids in determining legislative intent. One avenue is the use of legislative history as an interpretive tool.

[201 P.3d 621]

Gray [v. Administrative Dir. of the Court], 84 Hawai'i [138,] 148, 931 P.2d [580,] 590 [(1997)] (quoting *State v. Toyomura,* 80 Hawai'i 8, 18-19, 904 P.2d 893, 903-04 (1995)) (brackets and ellipsis points in original) (footnote omitted). This court may also consider "[t]he reason and spirit of the law, and the cause which induced the legislature to enact it ... to discover its true meaning." HRS § 1-15(2) (1993). "Laws in pari materia, or upon the same subject matter, shall be construed with reference to each other. What is clear in one statute may be called upon in aid to explain what is doubtful in another." HRS § 1-16 (1993).

Barnett v. State, 91 Hawai'i 20, 31, 979 P.2d 1046, 1057 (1999) (quoting *State v. Davia,* 87 Hawai'i 249, 254, 953 P.2d 1347, 1352 (1998)).

If we determine, based on the foregoing rules of statutory construction, that the legislature has unambiguously spoken on the matter in question, then our inquiry ends. (*See, e.g., Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.,* 467 U.S. 837, 842-43, 104 S.Ct. 2778, 81 L.Ed.2d 694 (1984)). When the legislative intent is less than clear, however, this court will observe the "well established rule of statutory construction that, where an administrative agency is charged with the responsibility of carrying out the mandate of a statute which contains words of broad and indefinite meaning, courts accord persuasive weight to administrative construction and follow the same, unless the construction is palpably erroneous." *Brown v. Thompson,* 91 Hawai'i 1, 18, 979 P.2d 586, 603 (1999) (quoting *Keliipuleole v. Wilson,* 85 Hawai'i 217, 226, 941 P.2d 300, 309 (1997)). *See also Government Employees Ins. Co. v. Hyman,* 90 Hawai'i 1, 5, 975 P.2d 211, 215 (1999) ("[J]udicial deference to agency expertise is a guiding precept where the interpretation and application of broad or ambiguous statutory language by an administrative tribunal are the subject of review." (quoting *Richard v. Metcalf,* 82 Hawai'i 249, 252, 921 P.2d 169, 172 (1996))). Such deference "reflects a sensitivity to the proper roles of the political and judicial branches," insofar as "the resolution of ambiguity in a statutory text is often more a question of policy than law." *Pauley v. BethEnergy Mines, Inc.,* 501 U.S. 680, 696, 111 S.Ct. 2524, 115 L.Ed.2d 604 (1991).

The rule of judicial deference, however, does not apply when the agency's reading of the statute contravenes the legislature's manifest purpose. *See Camara v. Agsalud,* 67 Haw. 212, 216, 685 P.2d 794, 797 (1984) ("To be granted deference, ... the agency's decision must be consistent with the legislative purpose."); *State v. Dillingham Corp.,* 60 Haw. 393, 409, 591 P.2d 1049, 1059 (1979) ("[N]either official construction or usage, no matter how long indulged in, can be successfully invoked to defeat the purpose and effect of a statute which is free from ambiguity...."). Consequently, we have not hesitated to reject an incorrect or unreasonable statutory construction advanced by the agency entrusted with the statute's implementation. *See, e.g., Government Employees Ins. Co. v. Dang,* 89 Hawai'i 8, 15, 967 P.2d 1066, 1073 (1998); *In re Maldonado,* 67 Haw. 347, 351, 687 P.2d 1, 4 (1984).

In re Water Use Permit Applications, 94 Hawai'i 97, 144-45, 9 P.3d 409, 456-57 (2000) (brackets and ellipsis points in original) (footnote omitted).

DISCUSSION

On appeal to this court, Dr. Jou raises numerous claims attacking the merits of the Director's decision and the circuit court's dismissal for lack of jurisdiction. However, we focus on the issue of whether the no-appeal provision in HAR § 12-15-94(d) is valid because we conclude that this is the pivotal issue. As explained below, we hold that the Director exceeded the Director's statutory authority in promulgating a rule making the Director's decisions in medical fee disputes "final and not appealable."

I. Applicable Law

HRS § 386-73 (Supp.2007) grants the Director original jurisdiction over disputes arising under the Hawai'i workers' compensation

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law, HRS Chapter 386, and establishes the right to appeal from the Director's decisions.[11] HRS § 386-73 provides:

Unless otherwise provided, the director of labor and industrial relations shall have original jurisdiction over all controversies and disputes arising under this chapter. The decisions of the director shall be enforceable by the circuit court as provided in section 386-91. *There shall be a right of appeal from the decisions of the director to the appellate board*[12] and thence to the intermediate appellate court, subject to chapter 602, as provided in sections 386-87 and 386-88, but in no case shall an appeal operate as a supersedeas or stay unless the appellate board or the appellate court so orders.

(Emphasis added.)

HRS § 386-87 (1993) establishes procedures for a party to appeal a decision of the Director to the LIRAB and for the LIRAB to decide that appeal. HRS § 386-87 states in relevant part:

(a) A decision of the director shall be final and conclusive between the parties, except as provided in section 386-89,[13] *unless within twenty days after a copy has been sent to each party, either party appeals therefrom to the appellate board by filing a written notice of appeal with the appellate board or the department.* In all cases of appeal filed with the department the appellate board shall be notified of the pendency thereof by the director. No compromise shall be effected in the appeal except in compliance with section 386-78.

(b) The appellate board shall hold a full hearing de novo on the appeal.

(c) The appellate board shall have power to review the findings of fact, conclusions of law and exercise of discretion by the director in hearing, determining or otherwise handling of any compensation[14] case and may affirm, reverse or modify any compensation case upon review, or remand the case to the director for further proceedings and action.

The decision or order of the LIRAB may, in turn, be appealed to the Intermediate Court of Appeals by the Director or any other party. HRS § 386-88 (Supp.2007).

HRS § 386-21(c) (Supp.2007) provides in relevant part:

When a dispute exists between an insurer or self-insured employer and a medical services 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.

This portion of HRS § 386-21(c) was enacted in 1995 as part of Act 234 which made

comprehensive changes to the workers' compensation law.[15] 1995 Haw. Sess. L. Act 234, § 7 at 607-08. The conference committee report accompanying the legislation stated that "[t]he purpose of this bill is to amend Hawai'i's workers' compensation and insurance laws to improve efficiency and cost-effectiveness in the workers' compensation system." Conf. Comm. Rep. No. 112, in 1995 House Journal, at 1005, 1995 Senate Journal, at 810.[16] However, there was no specific

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mention in any of the committee reports of the purpose for the above-quoted amendment to HRS § 386-21(c).

The Director is granted administrative responsibility and rulemaking power with respect to HRS Chapter 386 through HRS § 386-71 (1993) and HRS § 386-72 (Supp. 2007), which provide in relevant part as follows:

§ 386-71 Duties and powers of the director in general. The director of labor and industrial relations shall be in charge of all matters of administration pertaining to the operation and application of this chapter. The director shall have and exercise all powers necessary to facilitate or promote the efficient execution of this chapter and, in particular, shall supervise, and take all measures necessary for, the prompt and proper payment of compensation.

....

§ 386-72 Rulemaking powers. In conformity with and subject to chapter 91, the director of labor and industrial relations shall make rules, not inconsistent with this chapter, which the director deems necessary for or conducive to its proper application and enforcement.

The Director promulgated HAR § 12-15-94 pursuant to the Director's rulemaking power. HAR § 12-15-94 requires an employer to pay for all necessary medical services related to a compensable injury suffered by its employees. *See supra* note 5. It sets deadlines, imposes interest penalties for the non-payment of "undisputed" bills, and establishes procedures for resolving disputes between employers and medical service providers over charges that are billed. *See id.* HAR § 12-15-94(d), which provides for the intervention of the Director where the parties cannot resolve such disputes, states as follows:

(d) In the event a reasonable disagreement relating to specific charges cannot be resolved, the employer or provider of service may request intervention by the director in writing with notice to the other party. Both the front page of the billing dispute request and the envelope in which the request is mailed shall be clearly identified as a "BILLING DISPUTE REQUEST" in capital letters and in no less than ten point type. The director shall send the parties a notice and the parties shall negotiate during the thirty-one calendar days following the date of the notice from the director. If the parties fail to come to an agreement during the thirty-one calendar days, then within fourteen calendar days following the thirty-one day negotiating period, either party may file a request, in writing, to the director to review the dispute with notice to the other party. The director shall send the parties a second notice requesting the parties file position statements, with substantiating documentation to specifically include the amount in dispute and a description of actions taken to resolve the dispute, within fourteen calendar days following the date of the second notice from the director. The director shall review the positions of both parties and render an administrative decision without hearing. A service fee of up to $500 payable to the State of Hawaii General Fund will be assessed at the discretion of the director against either or both parties who fail to negotiate in good faith. *The decision of the director is final and not appealable.*

(Emphasis added.)

For its statutory authority, HAR § 12-15-94 identifies HRS §§ 386-71 and 386-72, which grants the Director general administrative and rulemaking power, as well as HRS §§ 386-21 (Supp.2007) and 386-26 (Supp.2007). HAR § 12-15-94 identifies HRS §§ 386-21 and 386-26 as the statutes HAR § 12-15-94 attempts to implement.[17]

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II. The No-Appeal Provision is Invalid

HRS §§ 386-73 and 386-87 set forth the right to appeal from the decisions of the Director in workers' compensation cases. Construing the words of HRS §§ 386-73 and 386-87 according to their ordinary meaning, we conclude that they give a party, such as Dr. Jou, the right to appeal the decision of the Director in a medical fee dispute to the LIRAB. Thus, the no-appeal provision of HAR § 12-15-94(d) is invalid as inconsistent with HRS Chapter 386, and the Director exceeded the Director's rulemaking authority in making the Director's decisions in medical fee disputes final and non-appealable.

HRS § 386-73 provides in relevant part: "There shall be a right of appeal from the decisions of the director to the appellate board ... as provided in sections 386-87...." HRS § 386-87, in turn, authorizes "either party" to a decision of the Director to appeal that decision to the LIRAB.

HRS Chapter 386 does not define the term "party." We generally interpret words that are not specifically defined by a statute according to their ordinary meaning. *Wright v. Home Depot U.S.A., Inc.*, 111 Hawai`i 401, 412 n. 9, 142 P.3d 265, 276 n. 9 (2006); *see State v. Hicks*, 113 Hawai'i 60, 71, 148 P.3d 493, 504 (2006) ("[C]ourts are to give words their ordinary meaning unless something in the statute requires a different interpretation." (brackets omitted)). HRS § 1-14 (1993) provides that "[t]he words of a law are generally to be understood in their most known and usual signification, without attending so much to the literal and strictly grammatical construction of the words as to their general or popular use or meaning."

Merriam-Webster's Collegiate Dictionary defines the word "party" as "1: a person or group taking one side of a question, dispute, or contest ... 4: a particular individual: PERSON." *Merriam-Webster's Collegiate Dictionary* 904 (11th ed.2003); *see Leslie v. Bd. of Appeals of County of Hawai'i*, 109 Hawai'i 384, 393, 126 P.3d 1071, 1080 (2006) (stating that when a term is not statutorily defined, courts "may resort to legal or other well accepted dictionaries as one way to determine the ordinary meaning of [the term]" (internal quotation marks omitted). Dr. Jou was clearly a "party" to the Director's decisions in Dr. Jou's fee disputes with Marriott and Argonaut under this definition. Thus, construing the term "party" according to its ordinary meaning, we conclude that Dr. Jou was entitled to appeal the Director's decisions to the LIRAB pursuant to HRS §§ 386-73 and 386-87.

Our conclusion is supported by the principle that the right to appeal is not a common law right, but is statutory and subject to control by the Legislature. *See In re Tax Appeal of Lower Mapunapuna Tenants Ass'n*, 73 Haw. 63, 69, 828 P.2d 263, 266 (1992); *Korean Buddhist Dae Won Sa Temple of Hawai'i v. Concerned Citizens of Palolo*, 107 Hawai'i 371, 380, 114 P.3d 113, 122 (2005). It was the Legislature's prerogative, and not the prerogative of the Director, to determine the extent to which the decisions of the Director could be appealed to the LIRAB.

Hawai`i courts have also adopted the principle of statutory construction that "[s]tatutes governing appeals are liberally construed to uphold the right of appeal." *Credit Associates of Maui, Ltd. v. Montilliano*, 51 Haw. 325, 329, 460 P.2d 762, 765 (1969);

Jordan v. Hamada, 62 Haw. 444, 448, 616 P.2d 1368, 1371 (1980); *see Ariyoshi v. Hawaii Pub. Employment Relations Bd.*, 5 Haw.App. 533, 538, 704 P.2d 917, 923 (1985) (stating that "in this jurisdiction there is a policy favoring judicial review of administrative decisions"); *In re Hawaii Gov't Employees' Ass'n*, 63 Haw. 85, 87, 621 P.2d 361, 363 (1980) (same). "[O]ur policy ... has always been to permit litigants, where possible, to appeal[.]" *Jordan*, 62 Haw. at 451, 616 P.2d at 1373 (internal quotation marks and citation omitted). This principle of statutory construction supports our interpretation of the term "party" as used in HRS § 386-87.

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The DLIR Appellees, however, argue that Dr. Jou was not a "party" to the Director's decisions within the meaning of HRS § 386-87 and thus did not have the right to appeal the Director's decisions. The DLIR Appellees contend that there is a distinction between the term "party" and the term "person" as used in HRS Chapter 386. According to the DLIR Appellees, the term "party" as used in HRS Chapter 386 has a specialized meaning and it only refers to "the claimant, his/her dependents, the employer, and its insurance carrier or adjuster, and sometimes, the Special Compensation Fund."

In support of their claim, the DLIR Appellees cite HRS §§ 386-27 (1993) and 386-98 (Supp.2007), which specifically authorize a "person" aggrieved by a decision of the Director issued pursuant to those sections to appeal.[18] The DLIR Appellees contend that there would be no need for HRS §§ 386-27 and 386-98 to give specific authorization for an aggrieved "person" to appeal if all decisions of the Director were appealable. The DLIR Appellees further argue that the use of the term "person" in these sections demonstrates that there is a distinction between "party" and "person" under HRS Chapter 386 and shows that the Legislature did not intend to give every participant in the workers' compensation system the right to appeal pursuant to HRS §§ 386-73 and 386-87.

We are not persuaded by the DLIR Appellees' arguments. The DLIR Appellees' claim that the term "party" has a specialized meaning under HRS Chapter 386 that excludes a "person" who is a medical service provider, such as Dr. Jou, is belied by the Director's own use of the term "party" in the Director's rules. In HAR § 12-15-94(d), the provision at issue in this appeal, the Director repeatedly uses the term "party" to refer to a medical service provider involved in a billing fee dispute. HAR § 12-15-94(d) states:

(d) In the event a reasonable disagreement relating to specific charges cannot be resolved, the employer or provider of service may request intervention by the director in writing with notice to the other *party*. ... The director shall send the *parties* a notice and the *parties* shall negotiate during the thirty-one calendar days following the date of the notice from the director. If the *parties* fail to come to an agreement during the thirty-one calendar days, then within fourteen calendar days following the thirty-one day negotiating period, either *party* may file a request, in writing, to the director to review the dispute with notice to the other *party*. The director shall send the *parties* a second notice requesting the *parties* file position statements, with substantiating documentation .... The director shall review the positions of both *parties* and render an administrative decision without hearing. A service fee of up to $500 payable to the State of Hawaii General Fund will be assessed at the discretion of the director against either or both *parties* who fail to negotiate in good faith. The decision of the director is final and not appealable.

(Emphases added.) The Director's use of the term "party" in HAR § 12-15-94(d) to refer to a medical service provider supports our view that Dr. Jou qualifies as a "party" under HRS § 386-87.

The inclusion within HRS §§ 386-27 and 386-98 of references to the right of an aggrieved "person" to appeal decisions of the Director made under those sections does not change our analysis. HRS §§ 386-73 and 386-87 broadly authorize a party to appeal the Director's decisions, which, under the ordinary meaning of the term "party," includes medical service providers involved in fee disputes decided by the Director. The Legislature's particular reference to the right of an aggrieved "person" to appeal decisions made by the Director under HRS

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§§ 386-27 and 386-98 does not mean that other decisions, such as those involving billing fee disputes, are not subject to appeal pursuant to the general provisions of HRS §§ 386-73 and 386-87.

The DLIR Appellees, Argonaut, and Marriott claim that HRS § 386-21(c) provides specific authorization for the Director's promulgation of the no-appeal provision in HAR § 12-15-94(d). We reject this claim. The DLIR Appellees, Argonaut, and Marriott rely upon the portion of HRS § 386-21(c) that states: "When a dispute exists between an insurer or self-insured employer and a medical services 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[.]" We read this provision as authorizing the Director to promulgate rules permitting *the Director's decisions* in medical fee disputes to be rendered in a summary manner. HRS § 386-21(c), however, does not state that the Director can insulate the Director's own decisions from appeal.

As previously stated, the right to appeal is statutory and it is the Legislature's prerogative to determine the extent to which the decisions of the Director may be appealed. Viewed in the context of the broad grant of the right to appeal the decisions of the Director set forth in HRS §§ 386-73 and 386-87, we conclude that the Legislature would have spoken in more definitive terms had the Legislature intended to authorize the Director by rule to preclude appeal of the Director's own decisions in medical fee disputes. Our conclusion is consistent with the liberal construction of appeal statutes to uphold the right of appeal and the judicial policy permitting litigants, where possible, to appeal. *See Jordan*, 62 Haw. at 448, 451, 616 P.2d at 1371, 1373.

We note that in a different context, the Legislature had no difficulty in clearly expressing its intent to make an administrative decision non-appealable. HRS § 128D-34 (Supp.2007) provides that decisions of the Department of Health on an application to conduct a voluntary response action "shall be final, with no right of appeal." Thus, the Legislature knows how to definitively eliminate the right to appeal an administrative decision when that is its intent.

III. The Remedy

The Director's decisions in Dr. Jou's medical fee disputes with Marriott and Argonaut were not pursuant to an agency hearing and were not rendered in contested cases. *See* HRS § 386-21(c) (authorizing the Director to resolve medical fee disputes in a summary manner); HAR § 12-15-94(d) ("The director shall review the positions of both parties and render an administrative decision without hearing."); HRS § 91-1 (1993) (defining "[c]ontested case" to mean "a proceeding in which the legal rights, duties, or privileges of specific parties are required by law to be determined after an opportunity for agency hearing"). Thus, Dr. Jou was not entitled to appeal the *merits* of the Director's decisions to the circuit court pursuant to HRS § 91-14, which, in relevant part, permits appeals of final decisions in contested cases. Dr. Jou's right to appeal the merits of the Director's decisions was limited to appeals filed with the LIRAB. Accordingly, the circuit court did not have jurisdiction to resolve the

merits of Dr. Jou's appeals of the Director's decisions.

Dr. Jou's appeals to the circuit court, however, included claims for declaratory relief pursuant to HRS § 91-7, such as the claim for a judicial declaration that the no-appeal provision of HAR § 12-15-94(d) was invalid. There is no suggestion that the circuit court lacked jurisdiction to resolve Dr. Jou's claims for declaratory relief. Because the no-appeal provision of HAR § 12-15-94(d) is inconsistent with and not authorized by HRS Chapter 386, it is invalid as beyond the scope of the Director's rulemaking authority. Accordingly, we conclude that the circuit court erred in dismissing Dr. Jou's claims for declaratory relief and in failing to declare the no-appeal provision to be invalid.

The DLIR Appellees argue that even if we conclude that Dr. Jou had the right to appeal the Director's decisions to the LIRAB, Dr. Jou's appeals were untimely because they were not filed within twenty days of the Director's decisions as required by HRS § 386-87. Instead, Dr. Jou followed the time period for appealing a contested

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case under HRS § 91-14 and filed his notices of appeal with the circuit court within the thirty-day time period established by HRS § 91-14. We conclude, under the rather unique circumstances of this case, that Dr. Jou cannot be faulted for failing to file his notices of appeal with the LIRAB within the twenty-day time limit as required by HRS § 386-87. At the time his appeals matured, Dr. Jou was precluded by HAR § 12-15-94(d) from appealing the Director's decisions to the LIRAB. We hold that Dr. Jou shall have twenty days from the effective date of our judgment in these consolidated appeals to file appeals of the Director's decisions with the LIRAB. We express no opinion on the merits of Dr. Jou's challenges to the Director's decisions in these cases.

CONCLUSION

For the foregoing reasons, we affirm the Judgments in Civil No. 05-1-0375 and Civil No. 05-1-1079, except that we vacate the portions of the Judgments that dismissed Dr. Jou's claims for declaratory relief. We direct the circuit court to enter judgment in favor of Dr. Jou declaring that the no-appeal provision of HAR § 12-15-94(d) is invalid, and we remand the cases to the circuit court for further proceedings consistent with this opinion. Dr. Jou shall be permitted to file appeals of the Director's decisions with the LIRAB within twenty days of the effective date of our judgment in these appeals.[19]

Notes:

1. Darwin Ching (Ching) succeeded Nelson Befitel (Befitel) as the Director of the Department of Labor and Industrial Relations. Pursuant to Hawai`i Rules of Appellate Procedure Rule 43(c), Ching has been substituted for Befitel as a party in these consolidated appeals.

2. By order dated October 28, 2008, we consolidated Appeal Nos. 27491 and 27539 for disposition.

3. The Honorable Eden Hifo presided.

4. HRS § 452-1 (1993) defines the terms "massage therapy," "massage therapist," and "massage therapy establishment" in relevant part as follows:

"[M]assage therapy" ... means any method of treatment of the superficial soft parts of the body, consisting of rubbing, stroking, tapotement, pressing, shaking, or kneading with the hands, feet, elbow, or arms, and whether or not aided by any mechanical or electrical apparatus, appliances, or supplementary aids such as rubbing alcohol, liniments, antiseptics, oils, powder, creams, lotions, ointments, or other similar

preparations commonly used in this practice....

"Massage therapist" means any person who engages in the occupation or practice of massage for compensation.

. . . .

"Massage therapy establishment" means premises occupied and used for the purpose of practicing massage therapy or massage therapy training; provided that when any massage therapy establishment is situated in any building used for residential purposes, the massage therapy establishment premises shall be set apart and shall not be used for any other purpose.

HRS § 452-2 (1993) makes it unlawful for "any person in the State to engage in or attempt to engage in the occupation or practice of massage for compensation without a current massage therapist license issued pursuant to this chapter." HRS § 452-3 (1993) provides that "[n]o massage therapy establishment shall be operated unless it has been duly licensed as provided for in this chapter."

5. HAR § 12-15-94 provides as follows:

§ 12-15-94 *Payment by employer.* (a) The employer shall pay for all medical services which the nature of the compensable injury and the process of recovery require. The employer is not required to pay for care unrelated to the compensable injury.

(b) When a provider of service notifies or bills an employer, the employer shall inform the provider within sixty calendar days of such notification or billing should the employer controvert the claim for services. Failure of the employer to notify the provider of service shall make the employer liable for services rendered until the provider is informed the employer controverts additional services.

(c) The employer, after accepting liability, shall pay all charges billed within sixty calendar days of receipt of such charges except for items where there is a reasonable disagreement. If more than sixty calendar days lapse between the employer's receipt of an undisputed billing and date of payment, payment of billing shall be increased by one per cent per month of the outstanding balance. In the event of disagreement, the employer shall pay for all acknowledged charges and shall notify the provider of service, copying the claimant, of the denial of payment and the reason for denial of payment within sixty calendar days of receipt. Furthermore, the employer's denial must explicitly state that if the provider of service does not agree, the provider of service may file a "BILL DISPUTE REQUEST" to include a copy of the original bill with the director within sixty calendar days after postmark of the employer's objection, and failure to do so shall be construed as acceptance of the employer's denial.

(d) In the event a reasonable disagreement relating to specific charges cannot be resolved, the employer or provider of service may request intervention by the director in writing with notice to the other party. Both the front page of the billing dispute request and the envelope in which the request is mailed shall be clearly identified as a "BILLING DISPUTE REQUEST" in capital letters and in no less than ten point type. The director shall send the parties a notice and the parties shall negotiate during the thirty-one calendar days following the date of the notice from the director. If the parties fail to come to an agreement during the thirty-one calendar days, then within fourteen calendar days following the thirty-one day negotiating period, either party may file a request, in writing, to the director to review the dispute with notice to the other party. The director shall send the parties a second notice requesting the parties file position statements, with substantiating documentation to specifically include the amount in dispute and a description of actions taken to resolve the

dispute, within fourteen calendar days following the date of the second notice from the director. The director shall review the positions of both parties and render an administrative decision without hearing. A service fee of up to $500 payable to the State of Hawaii General Fund will be assessed at the discretion of the director against either or both parties who fail to negotiate in good faith. The decision of the director is final and not appealable.

6. Argonaut and Marriott explained that their change of position on payment for the services performed by Dr. Jou's massage-therapist employees was based on the Director's change of position on this issue. Argonaut and Marriott contended that the Director had previously taken the position that services performed by Dr. Jou's massage-therapist employees were not reimbursable because Dr. Jou did not have an MAE license, but that the Director later changed the Director's position and was no longer treating the lack of an MAE license as precluding reimbursement.

7. The decisions were issued by Gary S. Hamada (Hamada), Administrator of the Disability Compensation Division (DCD) of the Department of Labor and Industrial Relations (DLIR). Because Hamada was acting on behalf of the Director, we will not distinguish between Hamada and the Director and will attribute decisions made by Hamada to the Director.

8. HRS § 91-14 provides in relevant part:

§ 91-14 Judicial review of contested cases. (a) Any person aggrieved by a final decision and order in a contested case or by a preliminary ruling of the nature that deferral of review pending entry of a subsequent final decision would deprive appellant of adequate relief is entitled to judicial review thereof under this chapter; but nothing in this section shall be deemed to prevent resort to other means of review, redress, relief, or trial de novo, including the right of trial by jury, provided by law. Notwithstanding any other provision of this chapter to the contrary, for the purposes of this section, the term "person aggrieved" shall include an agency that is a party to a contested case proceeding before that agency or another agency.

9. HRCP Rule 72 provides in relevant part:

Rule 72. Appeal to a circuit court.

(a) *How taken.* Where a right of redetermination or review in a circuit court is allowed by statute, any person adversely affected by the decision, order or action of a governmental official or body other than a court, may appeal from such decision, order or action by filing a notice of appeal in the circuit court having jurisdiction of the matter. As used in this rule, the term "appellant" means any person or persons filing a notice of appeal, and "appellee" means every governmental body or official (other than a court) whose decision, order or action is appealed from, and every other party to the proceedings.

. . . .

(e) *Statement of case.* The appellant shall file in the circuit court concurrently with the filing of appellant's designation, a short and plain statement of the case and a prayer for relief. Certified copies of such statement shall be served forthwith upon every appellee. The statement shall be treated, as near as may be, as an original complaint and the provision of these rules respecting motions and answers in response thereto shall apply.

10. HRS § 91-7 (1993) provides:

§ 91-7 Declaratory judgment on validity of rules. (a) Any interested person may obtain a judicial declaration as to the validity of an agency rule as provided in subsection (b) herein by bringing an action against the agency in the circuit court of the county in which petitioner resides or has its principal place of business. The action may be maintained whether or not petitioner has first

requested the agency to pass upon the validity of the rule in question.

(b) The court shall declare the rule invalid if it finds that it violates constitutional or statutory provisions, or exceeds the statutory authority of the agency, or was adopted without compliance with statutory rulemaking procedures.

11. In discussing the relevant sections in HRS Chapter 386, we will refer to the current version of the statutes. There are no material differences for purposes of our analysis between the current statutes and any prior versions of the statutes in effect during the course of Dr. Jou's cases.

12. HRS § 386-1 (1993) defines the term "appellate board" to mean the LIRAB.

13. HRS § 386-89 (1993) permits the Director to reopen a case under certain conditions.

14. HRS § 386-1 defines the term "compensation" to mean "all benefits accorded by this chapter to an employee or the employee's dependents on account of a work injury as defined in this section; it includes medical and rehabilitation benefits, income and indemnity benefits in cases of disability or death, and the allowance for funeral and burial expenses."

15. As enacted in 1995, the above-quoted portion of HRS § 386-21(c) used the term "medical service provider," which was changed to "medical services provider" by an amendment enacted in 2006. 2006 Haw. Sess. L. Act 191, § 1 at 831.

16. One of the significant amendments made by Act 234 was to change the method for determining the schedule of medical fees applicable to workers' compensation cases. *See* 1995 Haw. Sess. L. Act 234, § 7 at 607-08.

17. The argument of the DLIR Appellees, Marriott, and Argonaut that HRS § 386-21(c) provides statutory authority for the no-appeal provision of HAR § 12-15-94(d) will be discussed *infra*. None of the parties, however, refer to HRS § 386-26 in their briefs. HRS § 386-26 provides that the Director 1) "shall issue guidelines for the frequency of treatment and for reasonable utilization of medical care and services by health care providers that are considered necessary and appropriate under this chapter"; and 2) shall adopt updated medical fee schedules and, "where deemed appropriate, shall establish separate fee schedules for services of health care providers." Because HRS § 386-26 was not cited by the parties and is not pertinent to our analysis of whether the no-appeal provision of HAR § 12-15-94(d) is valid, we will not further discuss HRS § 386-26.

18. HRS § 386-27 authorizes the Director to qualify health care providers rendering services under HRS Chapter 386 and to sanction them for non-compliance with established requirements. HRS § 386-27(d) provides that "[a]ny person aggrieved by a decision of the director may appeal the decision under section 386-87." HRS § 386-98(e) authorizes the Director to impose administrative penalties on any person committing fraud. HRS § 386-98(f) provides that "[a]ny person aggrieved by the [Director's] decision [to impose administrative penalties] may appeal the decision under sections 386-87 and 386-88."

19. Hawai'i Rules of Appellate Procedure (HRAP) Rule 36(c) (2008) provides:

(c) *Effective date of intermediate court of appeals' judgment.* The intermediate court of appeals' judgment is effective upon the ninety-first day after entry or, if an application for a writ of certiorari is filed, upon entry of the supreme court's order dismissing or rejecting the application or, upon entry of supreme court's order affirming in whole the judgment of the intermediate court of appeals.

DAVID Y. IGE
GOVERNOR

RYKER WADA
INTERIM DIRECTOR

DEPUTY DIRECTOR

STATE OF HAWAIʻI
DEPARTMENT OF HUMAN RESOURCES DEVELOPMENT
235 S. BERETANIA STREET
HONOLULU, HAWAIʻI 96813-2437

January 26, 2018

TESTIMONY TO THE
HOUSE COMMITTEE ON LABOR AND PUBLIC EMPLOYMENT

For Hearing on January 30, 2018
9:30 a.m., Conference Room 309

BY

Department of Human Resources Development
RYKER WADA
INTERIM DIRECTOR

House Bill No. 1640
Relating to Workers' Compensation; Medical Examination

WRITTEN TESTIMONY ONLY

TO CHAIRPERSON JOHANSON, VICE CHAIR HOLT AND MEMBERS OF THE COMMITTEE:

Thank you for the opportunity to provide **comments** on H.B. 1640.

The purpose of H.B. 1640 relating to workers' compensation claims are to establish that employers shall pay all workers' compensation claims for compensable injuries and shall not deny claims without reasonable cause or during a pending investigation; create a presumption of compensability for claims submitted by employees excluded from coverage under the Hawaii Prepaid Health Care Act; establish that employers shall notify providers of service of any billing disagreements and allows providers to charge an additional rate to employers for outstanding balances owed for undisputed services or charges; establish resolution procedures for employers and providers who have a reasonable disagreement over liability for services rendered; and require an employee whose claim is found to be not

compensable to submit reimbursements for services rendered.

The Department of Human Resources Development ("DHRD") has a fiduciary duty to administer the State's self-insured workers' compensation program and its expenditure of public funds.

First, in light of the statutory presumption of compensability in Section 386-85, HRS, DHRD accepts liability for the vast majority of the approximately 600 new workers' compensation claims it receives each fiscal year. Only a minority of claims require some additional investigation to confirm that the alleged injury arose out of and in the course of employment.

Second, the proviso following the proposed subsection (b)(2), which presumes a claim compensable if the employee is excluded from health care coverage under the Hawaii Prepaid Health Care Act, appears superfluous because Section 386-85, already presumes that in the absence of substantial evidence to the contrary, a claim is for a covered work injury.

Third, the proposed new subsection in Chapter 386, HRS, is internally inconsistent because subsection (a) provides that "the employer shall pay for all medical services required by the employee for the compensable injury" and that "[t]he employer shall not be required to pay for care unrelated to the compensable injury." However, proposed subsection (b) states that the employer shall not controvert a claim for services while the claim is being "pending investigation." We note that a claim that is pending investigation is not a "compensable injury" because the employer has not yet accepted the claim as compensable and/or it has not yet been ruled compensable by the Department of Labor.

Fourth, Section 12-12-45, Controverted workers' compensation claims, Hawaii Administrative Rules, mandates that the private insurer to pay for medical care during the pendency of a workers' compensation claim, is not applicable to the State and other governmental employers.

Fifth, subsection (c) shortening the time period from the current sixty calendar days for an employer to contest and/or pay the provider may have unintended

consequences leading to further delays in treatment and payment of claims.
Sixth, regarding subsection (g) requiring the injured employees liable to reimburse benefits received if the claim is found not compensable, the employees may not have the resources to reimburse employers.

Finally, in lieu of passing this bill with all of its unresolved issues, we respectfully request consideration be given to **deferring** this measure pending completion of the working group report and the workers' compensation closed claims study mandated by Act 188 (SLH 2016), wherein the legislature found that "a closed claims study is warranted to objectively review whether specific statutory changes are necessary" to the workers' compensation law. Upon delivery of the respective reports to the legislature, the empirical findings and specific recommendations of the working group and closed claims study can inform any legislative initiatives on workers' compensation.

Thank you for the opportunity to testify on this bill.

DEPARTMENT OF HUMAN RESOURCES
CITY AND COUNTY OF HONOLULU
650 SOUTH KING STREET, 10TH FLOOR • HONOLULU, HAWAII 96813
TELEPHONE: (808) 768-8500 • FAX: (808) 768-5563 • INTERNET: www.honolulu.gov/hr

KIRK CALDWELL
MAYOR

CAROLEE C. KUBO
DIRECTOR

NOEL T. ONO
ASSISTANT DIRECTOR

January 30, 2018

The Honorable Aaron Ling Johanson, Chair
The Honorable Daniel Holt, Vice Chair
and Members of the Committee
on Labor & Public Employment
The House of Representatives
State Capitol, Room 309
415 South Beretania Street
Honolulu, Hawaii 96813

Dear Chair Johanson, Vice Chair Holt, and Members of the Committee:

SUBJECT: House Bill No. 1640
Relating to Workers' Compensation

H.B. 1640 establishes that employers shall pay all workers compensation claims for compensable injuries and shall not deny claims without reasonable cause or during a pending investigation; establishes that employers shall notify providers of service of any billing disagreements and allows providers to charge an additional rate to employers who fail to adhere to the notification requirements; and establishes resolution procedures for employers and providers who have a reasonable disagreement over liability for services provided an injured worker.

The City and County of Honolulu, Department of Human Resources (DHR), supports the intent of this measure to the extent it intended to provide more timely medical care, services, and supplies to injured employees. The City also offers the comments below.

First, notwithstanding the premise of this bill, DHR accepts liability outright for the vast majority of new workers' compensation claims it receives each year. For example, in calendar year 2017, DHR accepted liability on 95 percent of the 1,300 new claims filed. However, a small minority of claims do require some additional investigation to confirm that the alleged injury arose out of and in the course of employment. As an alternative to the convoluted revisions to Chapter 386 that are proposed in this bill, consideration should be given to codifying the salient provisions of the following

administrative rule, promulgated by the Director of Labor, which already applies to employers and health care contractors under the Hawaii Prepaid Health Care Act:

> **§12-12-45 Controverted workers' compensation claims.** In the event of a controverted workers' compensation claim, the health care contractor shall pay or provide for the medical services in accordance with the health care contract and notify the department of such action. If workers' compensation liability is established, the health care contractor shall be reimbursed by the workers' compensation carrier such amounts authorized by chapter 386, HRS, and chapter 10 of title 12, administrative rules. (Bold emphasis in original, underscored emphases added.)

By adopting this rule as a statutory provision within Chapter 386, an injured or ill employee whose claim is initially controverted can still obtain, without delay, all necessary medical care through the private carrier during the pendency of the workers' compensation administrative process. Thus, if the claim is subsequently determined to be work-related, the workers' compensation carrier can then reimburse the private medical carrier.

Second, the proposed provision that "a claim shall be presumed compensable when submitted by an employee who is excluded from health care coverage under the Hawaii Prepaid Health Care Act" is superfluous language. The Hawaii Workers' Compensation Law already presumes that every claim is for a covered work injury, regardless of the employee's health care coverage status.

Thank you for the opportunity to testify.

Sincerely,

Carolee C. Kubo

Carolee C. Kubo
Director

TESTIMONY BEFORE THE HOUSE OF REPRESENTATIVES

COMMITTEE ON LABOR & PUBLIC EMPLOYMENT

Tuesday, January 30, 2018
9:30 A.M.

HB1640
RELATING TO WORKERS' COMPENSATION

By Marleen Silva
Director, Workers' Compensation
Hawaiian Electric Company, Inc.

Chair Johanson, Vice Chair Holt, and Members of the Committee:

Hawaiian Electric Co. Inc., its subsidiaries, Maui Electric Company, Ltd., and Hawaii Electric Light Company, Inc**. strongly oppose H.B. 1640.** Our companies represent over 2,500 employees throughout the State.

This bill proposes to require that employers shall pay all workers' compensation claims for compensable injuries and shall not deny claims without reasonable cause or during a pending investigation. It creates a "presumption of compensability" for claims submitted by employees excluded from coverage under the Hawaii Prepaid Health Care Act. It establishes requirements that employers notify providers of billing disagreements; allows providers to charge an additional rate to employers who fail to adhere to the notice of requirements; establishes resolution procedures for employers and providers who have a reasonable disagreement over liability for services provided; and requires an employee whose claim is found to be non-compensable to submit reimbursements for services rendered.

We strongly believe many of the provisions in this proposal regarding disputes are problematic and unnecessary. In addition, it appears to create a legal obligation of employers to medical providers, which creates a serious conflict of interest that could unintentionally harm injured employees.

Under the current statutes, employers are mandated to pay for all treatment related to the compensable injury, and therefore have the right and responsibility to reasonably investigate questionable claims and services. There is also an established process to address controverted workers' compensation claims and bill disputes. In addition, Hawaii's Prepaid Health Care Law specifically mandates contracted group health to be responsible for the medical care of the employee during the period when a workers' compensation claim or treatment is under investigation. Not all healthcare contracts comply with the rules in Hawaii's Prepaid Health Care Law regarding controverted workers' compensation claims. Therefore we would suggest language be incorporated into this proposal to require adherence.

For these reasons, we strongly oppose HB. 1640 and respectfully request this measure be held. Thank you for this opportunity to submit testimony.

HAWAII INSURERS COUNCIL
A trade association of property and casualty insurance companies

Pauahi Tower, Suite 2010
1003 Bishop Street
Honolulu, Hawaii 96813
Telephone (808) 525-5877

Alison H. Ueoka
President

TESTIMONY OF LINDA O'REILLY

HOUSE COMMITTEE ON LABOR & PUBLIC EMPLOYMENT
Representative Aaron Ling Johanson, Chair
Representative Daniel Holt, Vice Chair

Tuesday, January 30, 2018
9:30 a.m., Room 309

HB 1640

Chair Johanson, Vice Chair Holt, and members of the Committee on Labor & Public Employment, my name is Linda O'Reilly, Assistant Vice President of Claims – Workers' Compensation of First Insurance Company of Hawaii. I am testifying today on behalf of Hawaii Insurers Council which is a non-profit trade association of property and casualty insurance companies licensed to do business in Hawaii. Member companies underwrite approximately forty percent of all property and casualty insurance premiums in the state.

Hawaii Insurers Council **opposes** this bill.

HB 1640 proposes to reduce an employers'amount of time in which to determine compensability and impose fines for those employers who continue doing so without reasonable cause. The bill also makes claims for those "excluded from health care coverage under the Hawaii Prepaid Health Care Act"presumed compensable. Finally, the bill imposes a $1,000 "service fee"if an employer denies payments to a provider without reasonable cause.

The bill states in part, that in many cases, insurers seem to automatically deny claims "pending investigation." HIC respectfully disagrees with this assessment and is unaware of any insurer who imposes such a practice. In fact, the large majority of workers'compensation claims are processed initially without delay and benefits are

issued in compliance with H.R.S. 386 and related Administrative Rules. Hawaii Administrative Rules 12-10-73(a) and (b) states that the Director has the authority to notify the employer that they have 30 days in which to request a hearing. If the employer fails to request a hearing, the injury is compensable. However, there are a minority of claims that require additional information before a determination of compensability can be rendered.

HB 1640 presumes compensable, a claim for those ñexcluded from health care coverage under the Hawaii Prepaid Health Care Act.ò If the injured worker has or does not have health insurance coverage is not a determining factor as to whether the injury is work-related. This provision mandates compensability solely based on the existence of health insurance. Whether the injured worker has health insurance or not is outside the control of the workersôcompensation insurer and mandating the claim be compensable based on this deprives the insurer of due process. The language in the bill under Section 2(a) correctly states that, ñThe employer shall not be required to pay for care unrelated to the compensable injury.ò Section 2(b)(2) however, contradicts that language by mandating a certain class of injured workers be ñpresumed compensable.ò

Secondly, the provision to presume compensable a claim where the injured worker has no health insurance coverage will also promote fraud if injured workers know that a claim cannot be controverted. If it is later determined that it is not a work-related injury, it is not realistic to expect that the injured worker will repay benefits that were not due.

Finally, by mandating a certain class of injured workersôclaims be ñpresumed compensable,òthese persons would be treated differently than everyone else in the workersôcompensation system and contradicts provisions in another section of existing law, 386-3, which excludes coverage for intentional acts to injure oneself or another, certain claims for mental stress and by the employeeôs intoxication.

The provisions in this bill will add unnecessary delay and costs to the system. We ask that this bill be held.

Thank you for the opportunity to testify.

HB-1640
Submitted on: 1/29/2018 7:54:40 AM
Testimony for LAB on 1/30/2018 9:30:00 AM

Submitted By	Organization	Testifier Position	Present at Hearing
Michael Ferreira		Support	Yes

Comments:

Michael Ferreira

92-7049 Elele St 46

Kapolei, HI 96707

RE; HB1640

I was once injured on the job and it was a back injury in California. The time it took between going to the Doctor, surgery, rehab and back on the job was 18 months. I was injured in a different area of my back at work here and am going into 7 years. I had to go to their Doctor and due to the severity of the injury their Doctor suggested I just live with it because it would be complicated. Comp's take on it was I didnt need surgery when I actually needed extensive surgery. My Attorney had me foolishly negotiate my disability benefits to to a paltry $5,000. I did not understand what it meant as my attorney hasn't explained any of my rights to me or what the case is worth. I left my medical open though and had to go to a hearing to force Comp to let me be seen by a neurosurgeon who was able to diagnose the problem and wrote a treatment plan for surgery. My previous primary care physician did nothing but keep me addicted to opiates. I had to get off of opiates twice so I can go back to work injured and now just live with agonizing pain. I returned to work at a lesser job and went to school to get a better job. This was after I went bankrupt and am in foreclosure. I got an aproval from comp for the surgery but their attorney did not agree and ran the clock until my approval expired. Still no surgery. Except now I dont trust the comp carrier for after care past my surgery and I cant collect disability while I recover. I elected to take the money and get it done on the Mainland. I am going into year 7 now with nothing. The comp carrier offered to settle for $25,000. My last surgery in 1995 on an unraleted part of my back was $57,000 so this wont get me surgery. I recently had a stroke and two days in the hospital cost $22,000. As it is now I am in limbo and nobody is doing anything for me. My attorney has been totally inefective against the delays, hearings and denials throughout this process. I was suicidal at one point until I got mental help. I am also a veteran and believe the V.A. does better than this State run debacle. I would like to just

settle and move on to getting my surgery somewhere else. During this time I have had two falls due to my symptoms and had to have a knee surgery they would not pay for and an ankle surgery that they would not pay for. My health insurance had to pay for it! Why should they whe it is Sedgewick's responsibility? Their attorney Kenneth Goya is producing some of these delays. I got my surgery approved once and he took it upon himself to get a subsequest request denied. This system is broken and needs to be fixed now. There is no reason I have had to endure the hearings I have had to endure nor the delays. please please pass this bill.

Michael Ferreira

808-861-7115

HB 1640

LATE TESTIMONY

Testimony to the
House Committee on Labor
Tuesday, January 30, 2018
9:30 am.
State Capitol - Conference Room 309

LATE

RE: HB 1640 RELATING TO WORKERS' COMPENSATION

Aloha Chair Johanson, Vice Chair Holt and members of the committee:

On behalf of the Society for Human Resource Management – Hawaii Chapter ("SHRM Hawaii"), we are writing in opposition to HB 1640, relating to workers' compensation. This bill prohibits employer disputes of workers' compensation claims without "reasonable cause" or while the claim is pending investigation. We believe that this bill as currently written will create barriers to appropriately resolving claims and will not accomplish the goal of promoting justice, fairness and transparency.

Human resource management professionals are responsible for the alignment of employees and employers to achieve organizational goals. HR professionals seek to balance the interests of employers and employees with the understanding that the success of each is mutually dependent. We believe that this bill will alter the balance of employer and employee interests in the resolution of claims in a manner that does not advance the overall public purpose of ensuring workplace safety. We respectfully ask that you do not advance this bill.

SHRM Hawaii represents more than 800 human resource professionals in the State of Hawaii. We look forward to contributing positively to the development of sound public policy and continuing to serve as a resource to the legislature on matters related to labor and employment laws.

Cara Heilmann
SHRM Hawaii Legislative Affairs Committee Chair

AFFILIATE OF SHRM SOCIETY FOR HUMAN RESOURCE MANAGEMENT

SHRM Hawaii, P. O. Box 3175, Honolulu, Hawaii (808) 447-1840

HAWAII CHAPTER – AMERICAN PHYSICAL THERAPY ASSOCIATION

(800) 554-5569 x13 • www.hapta.org • info@hapta.org

HB 1640, RELATING TO WORKERS' COMPENSATION

LATE

House LAB Committee Hearing
Tues, Jan. 30, 2018 – 9:30 am
Room 309
Position: Support

Chair Johanson and Vice Chair Holt, and Members of the LAB Committee:

I am Gregg Pacilio, PT and Board President of the Hawaii Chapter of the American Physical Therapy Association (HAPTA), a non-profit professional organization serving more than 340 member Physical Therapists and Physical Therapist Assistants. We are movement specialists and are part of the spectrum of care for Hawaii, and provide rehabilitative services for infants and children, youth, adults and the elderly. Rehabilitative services are a vital part of restoring optimum functioning from neuromusculoskeletal injuries and impairments.

HAPTA supports this measure because it enables the injured worker to proceed and receive care as soon as the claim is open. Currently, providers and injured workers do not get compensated when claims are on hold and pending investigation, which can take months. This means that injured workers can be without receiving a WC "paycheck" and providers do not get reimbursed at all.

HB1640 would facilitate medical providers to render care without fear that they will not get reimbursed. It holds insurance companies accountable for payment of services versus holding claims in limbo when they say it "pending investigation".

HB1640 holds insurance companies accountable for making good faith effort to resolve disputes, which should provide quicker resolution of bill disputes.

Your support of HB 1640 is appreciated. Thank you for the opportunity to testify. Please feel free to contact Derrick Ishihara, HAPTA's Workers' Compensation lead at 808-221-8620 for further information.

NAMIC
NATIONAL ASSOCIATION OF MUTUAL INSURANCE COMPANIES

317.875.5250 | [F] 317.879.8408
3601 Vincennes Road, Indianapolis, Indiana 46268

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20 F Street N.W., Suite 510 | Washington, D.C. 20001

LATE

Hawaii State Legislature
House Committee on Labor and Public Employment
Hawaii State Capitol
415 South Beretania Street
Honolulu, HI 96813

January 29, 2018

Filed via electronic testimony submission system

RE HB 1640, Workers' Compensation Payments – NAMIC's Written Testimony in Opposition

Dear Representative Aaron Ling Johanson, Chair; Representative Daniel Holt, Vice-Chair; and honorable committee members:

Thank you for providing the National Association of Mutual Insurance Companies (NAMIC) an opportunity to submit written testimony to your committee for the January 30, 2018, public hearing. Unfortunately, I will not be able to attend the public hearing, because of a previously scheduled professional obligation. NAMIC's written comments need not be read into the record, so long as they are referenced as a formal submission and are provided to the committee for consideration.

The National Association of Mutual Insurance Companies (NAMIC) is the largest property/casualty insurance trade association in the country, with more than 1,400 member companies. NAMIC supports regional and local mutual insurance companies on main streets across America and many of the country's largest national insurers. NAMIC members represent 40 percent of the total property/casualty insurance market, serve more than 170 million policyholders, and write nearly $225 billion in annual premiums. NAMIC has 84 members who write property/casualty/workers' compensation in the State of Hawaii, which represents 28% of the insurance marketplace.

Although NAMIC members appreciate the importance of providing injured workers with timely medical diagnostic and treatment, workers' compensation claims adjusting often takes time, especially if the injured worker is unwilling or unable for medical reasons to provide the employer and the workers' compensation carrier with prompt information necessary for the insurer to make a determination as whether the claim is compensable, the injuries are work related, and the initial medical treatment is reasonable and consistent with customary medical care and pricing.

NAMIC is concerned that the proposed legislation places greater emphasis upon speed over accuracy in the claims adjusting process. Naturally, employers and workers' compensation insurers want the injured worker to be treated quickly so as to elevate their pain, prevent exacerbation of the worker's medical injuries, and promptly start them on the road to medical recovery and timely return to gainful employment. However, a "rush to claims decision-making" is not in the best interest of injured workers, employers, the worker's compensation system, and even treating medical providers.

NAMIC has the following concerns with the proposed legislation:

1) In regard to the new proposed provision, "§386 - Payment by employer; duty to service provider; disagreement with service provider; resolution procedures", NAMIC is concerned with this title, because it arguably creates a legal duty of care owed to the medical provider by the employer and workers' compensation carrier.

Employers have workers' compensation statutory duty to their workers, and workers' compensation insurers have contractual and statutory legal duties to the employers they insurer and injured workers. Neither employers nor insurers owe a legal duty, nor should they, to the medical provider (a professional services vendor). Creating an independent legal duty of care owed to the medical provider by the employer or insurer could create a serious conflict of interest problem that could ultimately be detrimental to the injured worker.

2) NAMIC is concerned with the proposed provision that states, "b) The employer shall not dispute a claim for services: (1) Without reasonable cause; or (2) While the claim is pending investigation."

The problem with this provision is that it would require an insurer to make payment for medical services before the claim has been fully evaluated as to whether workers' compensation coverage is applicable and/or the injuries were caused by the work-related incident. Payment should only be required once the workers' compensation statutory duty has been accepted by the employer/insurer or the facts of the case have been properly evaluated by the employer/insurer. The proposed payment requirement is a classic "put the cart before the horse."

NAMIC members appreciate and share the bill sponsor's desire to make sure that claims processing doesn't needlessly drag on to the detriment of the injured worker. Employers and insurers share this public policy desire and also have an economic incentive to get the claim adjusted in a timely manner. The more claims adjusting time invested into each claim, the more administrative expenses there are for the insurer. Claims adjusting delays are expensive and problematic for insurers, so they try to expedite the resolution of claims. However, life is complex, and work-related injuries may be factually and/or legally complex, in regard to issues of "scope of employment", whether the worker's injures are in fact work related, and whether the proposed medical treatment is reasonable and medically appropriate.

Additionally, NAMIC is concerned that the bill does not define what "without reasonable cause" means. Such a concept is rife with potential for differing opinions as to what it specifically entails and requires from the insurer. Since HB 1640 imposes a very rigid payment/contest disputed bills deadline, creates "automatic liability" for an insurer if the medical service is not contested within 30 days of insurer receiving medical bill, and imposes financial penalties on the insurer, NAMIC believes that it makes sense from an administrative due process standpoint for the bill to define what is meant by "without reasonable cause".

3) NAMIC is concerned with the following provision in the proposed legislation:

"In the event of reasonable disagreement, the employer shall pay for all undisputed charges and shall notify the provider of the denial of any payment including the reason for the denial within thirty calendar days of receipt of a bill or claim of services rendered and provide a copy of the denial to the employee."

NAMIC believes that the thirty days deadline is unworkable and impractical, and likely to lead to needless conflict between the interested parties and will force insurers and employers to deny certain "rushed-through" medical charges so as not to become "automatically liable" for them as a result of failing to formally contest them within the abbreviated response deadline.

4) NAMIC believes that the following suggested provision would deny an insurer or employer of important administrative due process protections:

"The director shall review the positions of both parties and render an administrative decision *without hearing.*" [Emphasis added].

Why should the insurer or employer be denied the right to a hearing on the director's decision, especially when a $1,000 penalty, called a "service charge" in the bill, could be imposed upon the party for failing to negotiate "in good faith", whatever that nebulous legal standard actually means?

5) NAMIC believes that the July 1, 2018, effective date would create unnecessary administrative costs and burdens for insurers and employers. NAMIC believes that insurers should be granted a year from enactment of the bill for proper implementation of the law and the new prompt payment compliance requirements. Therefore, NAMIC respectfully requests a July 1, 2019 effective date.

For the aforementioned reasons, NAMIC respectfully requests a **NO VOTE on HB 1640, because workers' compensation claims should not be hastily rushed through the system to the detriment of interested stakeholders.**

Thank you for your time and consideration. Please feel free to contact me at 303.907.0587 or at crataj@namic.org, if you would like to discuss NAMIC's written testimony.

Respectfully,

Christian John Rataj, Esq.
NAMIC Senior Regional Vice President
State Government Affairs, Western Region

WAYNE H. MUKAIDA

Attorney at Law

888 MILILANI STREET, PH 2
HONOLULU, HAWAI'I 96813

TEL & FAX: (808) 531-8899

January 29, 2018

LATE

COMMITTEE ON LABOR & PUBLIC EMPLOYMENT
Rep. Aaron Ling Johanson, Chair
Rep. Daniel Holt, Vice Chair

Re: H.B. No. 1640
Hearing: January 30, 2018, 9:30 a.m.

Chairmen, and members of the Committees, I am attorney Wayne Mukaida. I have been in practice since 1978. Since 1989, I have devoted a substantial portion of my legal practice to representing injured workers. I strongly support H.B. No. 1640 relating to Workers' Compensation, with amendments.

The bill strives to correct a very serious misapplication of HRS Chapter 386 by employers and carriers. However, care must taken to not weaken the basic presumption §386-85 that a claim for an injury is work related, and not weaken §12-12-45 under the Prepaid Health Care regulations which requires payment of medical bills where a workers' compensation claim is denied. The first paragraph of the bill should be modified as follows:

> (a) ~~Notwithstanding any other law to the contrary,~~ The employer shall pay for all medical services required by the employee ~~for the compensable injury and the process of recovery~~ related to the claim until the claim is found by the director to be not work related. ~~The employer shall not be required to pay for care unrelated to the compensable injury.~~

The balance of the bill should be stricken as there are already provisions in the Medical Fee Schedule which provide for disputes.

Please amend H.B.1640 and move the bill towards passage.

Thank you for considering my testimony.

WAYNE H. MUKAIDA

LATE

HB-1640
Submitted on: 1/29/2018 10:55:55 AM
Testimony for LAB on 1/30/2018 9:30:00 AM

Submitted By	Organization	Testifier Position	Present at Hearing
Melinda Buck		Support	Yes

Comments:

I support HB 1640. I have witnessed multiple of denial request of seeing an independent medical provider. Finally on year three after many hearings access was allowed to see a private independent medical providers who would do a complete medical examination. This medical provider provided a clear and accurate detailed non-biased examination. Clearly showing cause of injury which workers comp tried to deny and disregard. The workers comp lawyer going as far as Googling medical injuries and medications stepping out of his scope of practice by diagnosing for his personal agenda.

I have also witness this creating a physical, emotional and financial hardship for unpaid medical bills and lack of proper Medical Care. Creating a financial burden in which the patient files for bankruptcy due to lack of timely manner a medical care treatment and financial burden.

Thank you,

Melinda Buck

LATE

HB-1640
Submitted on: 1/29/2018 11:25:45 PM
Testimony for LAB on 1/30/2018 9:30:00 AM

Submitted By	Organization	Testifier Position	Present at Hearing
cathy wilson	AHCS	Support	No

Comments:

LATE

WIMAH
Work Injury Medical Association of Hawaii

To: **Rep Aaron Ling Johanson, Chair**
Rep Daniel Holt, Vice-Chair
Members of the Committee on Labor and Public Employment

Date: Tuesday, January 30, 2018
Time: 9:30 a.m.
Place: Conference Room 309
State Capitol
415 South Beretania Street

LATE

SUPPORT FOR HOUSE BILL 1640

As President of Work Injury Medical Association of Hawaii representing the providers treating injured workers in our state, we strongly support HB 1640. This much needed and long overdue advocacy and legislation recognizing the abusive practices by **certain** insurance carriers must become law. It is common in our state for DLIR to "rubber stamp" all requests for extension of time without consideration if any due process is actually needed.

HB1640 establish that employers shall pay all workers compensation claims for compensable injuries and shall not deny claims without reasonable cause or during a pending investigation. They each codify into statute Hawaii Administrative Rules 12-15-94 (Payment by Employer) and amend and clarify it as follows:

(a) Requires that the employer shall not controvert a claim for services:

(1) Without reasonable cause; or

(2) While the claim is pending investigation.

(b) Requires that the employer shall notify the provider within thirty calendar days, instead of sixty, should the employer controvert the claim for services.

(c) Increases the maximum service fee from $500 to $1,000 for which the director may assess against a party who fails to negotiate in good faith.

(d) Provides that denial of payment without reasonable cause shall be considered a failure to negotiate in good faith.

Please consider the specific justification:

- Hawaii's existing workers' compensation has been plagued by delays and denials, and in many of those cases, insurers seem to automatically deny the claim "pending investigation". These investigations may include reviewing reports from an independent medical examiner, interviewing other employees, looking at videotapes, or combing through old medical records for evidence that the workplace injury was related to a pre-existing condition.
- While the insurer considers, sometimes for months, the patient is at times unable to use private insurance or get money for which to live.
- Thus, injured workers sometimes wait months for treatment or rehab.
- For many workers with severe injuries, the State's workers' compensation system is the only thing that stands between them and a downward spiral of unemployment, debt and even homelessness.
- Although there is no statute, administrative rule or judicial ruling permitting this practice of "denying pending investigation," insurers continue to abuse this practice.
- Although current law allows the DLIR Director to fine parties up to $500 for failing to negotiate in good faith, those fines are not regularly enforced. The Director has said that DLIR will begin assessing fines, and an increase of the maximum fine amount to $1,000 would provide added incentive for parties to negotiate in good faith.
- Therefore, the intent of this bill, to limit employers' use of denying a claim pending investigation and impose fines and penalties for those employers who continue doing so without reasonable cause, is laudable.

We must give the workers in the State of Hawaii protection form the predatory and medieval practices of delaying payment and care as long as possible, forcing worker to return to work with serious injuries, find less suitable employment or be force to apply for public assistance.

Sincerely,

Scott J Miscovich MD

President WIMAH

Work Injury Medical Association of Hawaii

Orthopedic Surgery of Hawaii
Gary Okamura, MD

To: **Rep Aaron Ling Johanson, Chair**
Rep Daniel Holt, Vice-Chair
Members of the Committee on Labor and Public Employment

LATE

Date: Tuesday, January 30, 2018
Time: 9:30 a.m.
Place: Conference Room 309
State Capitol
415 South Beretania Street

OPPOSITION FOR HOUSE BILL 1631

Dear Chair Johanson and Distinguished Committee Members,

I support the comments of my peers opposing HB1631.

With this and all bills negatively affecting patients and doctors I ask for your support. We need your help bringing more physicians into the underserved field of workers' comp --to make recruiting of new providers easier, not harder, and to engage and bring back into the system some of the 90% of local physicians who currently opt out.

Please see the following signatures of patients I saw today that oppose this bill and support in office medication dispensing.

As an injured worker in Hawaii, I oppose any legislation that jeopardizes or restricts my ability to receive medication from my doctor's office. Restrictions on point of care medication dispensing will make it more difficult, create more obstacles, delay healing and delaying me to get back to work. I urge all members of the legislature to oppose any measures which will limit or prevent injured workers to receive their medication from their doctors offices.

	Patient Name	Address	Signature
1			
2			
3			
4			
5			

Thank you very much,

Gary Okamura, MD

Scott J Miscovich, MD
46-001 Kamehameha Hwy #109
Kaneohe, HI 96744
(808) 247-7596

LATE

To: Rep Aaron Ling Johanson, Chair
Rep Daniel Holt, Vice-Chair
Members of the Committee on Labor and Public Employment

Date: Tuesday, January 30, 2018
Time: 9:30 a.m.
Place: Conference Room 309
State Capitol

SUPPORT FOR HOUSE BILL 1640

Scott Miscovich, MD submits the following testimony in support of House Bill 1640.

SB1640 establishes that employer shall pay all workers compensation claims for compensable injuries and shall not deny claims without reasonable cause or during a pending investigation. It codifies into statute Hawaii Administrative Rules 12-15-94 (Payment by Employer) and amends and clarifies it as follows:

> (a) Requires that the employer shall not controvert a claim for services:
> (1) Without reasonable cause; or
> (2) While the claim is pending investigation.
>
> (b) Requires that the employer shall notify the provider within thirty calendar days, instead of sixty, should the employer controvert the claim for services.
>
> (c) Increases the maximum service fee from $500 to $1,000 for which the director may assess against a party who fails to negotiate in good faith.
>
> (d) Provides that denial of payment without reasonable cause shall be considered a failure to negotiate in good faith.

As Section 1 of SB857 states, Hawaii's existing workers' compensation has been plagued by delays and denials, and in many of those cases, insurers seem to automatically deny the claim "pending investigation". These investigations may include reviewing reports from an independent medical examiner, interviewing other employees, looking at videotapes, or combing through old medical records for evidence that the workplace injury was related to a pre-existing

condition. While the insurer considers, sometimes for months, the patient is at times unable to use private insurance or get money for which to live. Although there is no statute, administrative rule or judicial ruling permitting this practice of "denying pending investigation," insurers continue to abuse this practice. Therefore, the intent of this bill, to limit employers' use of denying a claim pending investigation and impose fines and penalties for those employers who continue doing so without reasonable cause, is laudable.

Thank you for your consideration.

Scott Miscovich, MD