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November 19, 2008

MEMORANDUM 2008-6A

TO: Motor Vehicle Insurance Companies

FROM: J.P. Schmidt, Insurance Commissioner

RE: Personal Injury Protection Benefits –
Charges for Emergency Services and Payment of General Excise Tax

Your attention is directed to the attached Commissioner's Final Order in Khaw v. Allstate Ins. Co., ATX-2007-5-P (Oct. 16, 2008).

The decision in Khaw re-affirms the Insurance Code provisions that charges for treatment rendered for emergency services during the initial seventy-two hours following the motor vehicle accident shall be based on the provider's usual and customary fee and shall be appropriate, reasonable and necessarily incurred. The Insurance Code exempts the charges for emergency services from adherence to the workers compensation supplemental fee schedule, that is, Medicare fee schedule plus 10%. The Khaw decision explains that the prior case Hawaii Emergency Physicians Assoc, Inc. v. Hawaiian Ins. Guar. & Co. Ltd., ATX-99-79-P (2000) that awarded medical fees equal to 200% of the Medicare fee schedule was not intended to establish a rule of universal application. The Insurance Code cannot be interpreted to limit emergency medical providers' fees to an arbitrarily set fixed multiple of the Medicare fee schedule.

Finally, the Commissioner ruled in Khaw that insurers shall pay providers of personal injury protection benefits the permissible charge plus the applicable general excise tax.

If you have any questions, please contact Mark K. Morita at 586 2790.

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INSURANCE DIVISION
OFFICE OF ADMINISTRATIVE HEARINGS
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
STATE OF HAWAII

In the Matter of the Request for Payment of MILLICENT KHAW, M.D., As Provider for Antony Gross, Provider, vs. ALLSTATE INS. CO., Respondent.	)	ATX-2007-5-P COMMISSIONER'S FINAL ORDER

COMMISSIONER'S FINAL ORDER

On July 25, 2008, the duly appointed Hearings Officer submitted his Findings of Fact, conclusions of Law, and Recommended Order in the above-captioned matter. Copies of the recommended decision were also sent to the parties at their last known address. Although the parties were provided with the opportunity to file written exceptions, no exceptions were filed.

Upon review of the entire record of this proceeding, the Insurance Commissioner, Department of Commerce & Consumer Affairs ("Commissioner"),

adopts in part, modifies in part, and reverses in part the Hearings Officer's recommended decision as the Commissioner's Final Order.

I. SUPPLEMENTAL FINDINGS OF FACT

Hearings Officer's Findings of Fact shall be modified with the addition of the following findings of fact:

7. On November 11, 2006, Mr. Antony Gross was involved in a motor vehicle accident in Hilo, Hawaii that resulted in multiple fatalities.

8. Mr. Gross was evacuated to Queens Medical Center for surgery on that same day. Queens Medical Center is the only hospital in Hawaii that provides medical care for complex fractures suffered by trauma patients.

9 Mr. Gross was in the operating room for six hours and required internal fixation and intramedullary nailing of the tibia, fibula, and femur. Dr. Khaw was present during the entire surgery and she provided emergency trauma anesthesia care.

10. Dr. Khaw's claim for the emergency anesthesia care she provided on November 11, 2006 was 35 relative value units, $2,600.00 fees plus $108.16 general excise tax; a total of $2,708.16.

11. No evidence contradicts the facts that Dr. Khaw was present during the entire time of the surgery and that she performed the 35 relative value units of service.

12. Dr. Khaw presented corroborating statements of practicing anesthesiologists Bryan Smith, M.D. and Curtis Lavatai, M.D. Dr. Smith declared that his usual and customary fee for a similar case would have been $2,765. Dr. Lavatai declared that his usual and customary fee for a similar case involving similar high medical risk and critical attention would have been $2,708.16.

II. CONCLUSIONS OF LAW

Hearings Officer's Recommended Conclusions of Law are modified and reversed as follows:

Provider Dr. Khaw correctly cites Hawaii Administrative Rules ("HAR") § 16-23-93 to support her contention that her usual and customary fee of $2708.16 for the emergency services she provided to Mr. Gross on November 11, 2006 is not tied to the workers compensation fee schedule.[1] HAR § 16-23-93 provides in part:

> Charges and treatment rendered for emergency services during the initial seventy-two hours following the motor vehicle accident resulting in injury **shall not be subject** to this subchapter; provided, however, that charges for emergency treatment shall not exceed the

[1] Workers compensation fee schedule is the higher of the workers compensation supplemental fee schedule or the Medicare fee schedule plus 10%.

> health care . . . provider's usual and customary fee and shall be appropriate, reasonable, and necessarily incurred. . . .

Furthermore, HAR § 16-23-93 reflects the intent of Hawaii Revised Statutes ("HRS") § 431:10C-308.5(b) which expressly exempts emergency services provided within the first seventy-two hours from adherence to the workers compensation supplemental fee schedule. Thus, fees for emergency services cannot be tied to the workers compensation fee schedule or an arbitrary fixed multiple of the same.

Provider Dr. Khaw offered satisfactory proof that her usual and customary fee was reasonable by producing the statements of two fellow professionals, Bryan Smith, M.D. and Curtis Lavatai, M.D., who declared that their usual and customary charge for similar services would have been $2,765 and $2,708.16, respectively. Dr. Khaw's usual and customary fee is comparable to her fellow professional emergency room anesthesiologists and Mr. Gross would have incurred a comparable expense at any other emergency treatment hospital, if another facility was available. The standard for reasonableness of a charge for emergency services within the first seventy-two hours of a motor vehicle accident resulting in injury is the comparable usual and customary charges for similar emergency services offered by other emergency providers. Emergency medical services bear extra-ordinary costs in order to be available at-all-times and to be prepared for all eventualities. The expense to, at a moment's notice, medically treat complex injuries, and to be prepared to accept any number of patients suffering complex injuries at any one time must be considered in the cost to provide emergency treatment. Respondent has not shown how its arbitrary fixed multiple considers all of the costs that providers must bear to make available and provide emergency services.

Provider Dr. Khaw billed 35 relative value units of service as appropriate and necessary treatment, but Respondent Allstate countered with 29 units of treatment. Respondent Allstate alleges that the treatment rendered corresponds to a Medicare fee schedule standard code that permits the billing of only 29 relative value units as reasonable for the type of treatment description provided. Respondent's position is rejected because the statute and rule prohibit the application of workers compensation medical fee standard or by analogy the Medicare standard to emergency room procedures. *See*, HRS § 431:10C-308.5(b); HAR § 16-23-93. Standard medical codes that are applied with the benefit of hindsight do not accurately capture the high-risk environment of the emergency treatment room. Standard code relative value unit allocation may reward efficiency and conservation of time, but that goal cannot be expected to realistically receive the highest priority in the emergency room. The exemptions from the standard medical schedules expressed by the statute and rule have ample justification.

Provider attests that she attended to Mr. Gross for injuries sustained on November 11, 2006 including the six-hour surgery and emergency trauma anesthesia care in relation to the complex and traumatic injuries and provided 35 relative value units of service. There is no contradictory Finding of Fact. No Finding of Fact alleges that Dr. Khaw billed for inappropriate or unnecessary treatment. In emergency circumstances involving complex traumatic injuries that could likely result in permanent injury, disability, or death, greater deference must be shown to the attending medical provider's judgment as to appropriate and necessary treatment. Therefore,

Provider Dr. Khaw has demonstrated by a preponderance of the evidence that Respondent Allstate's denial of the relative value units billed and the dollar amount billed was improper.

Dr. Khaw's support of her usual and customary fees has not been refuted by any credible evidence and, therefore, she is entitled to her usual and customary fee of $2,600.00 plus general excise tax of $108.16, a total of $2,708.16.

Many motor vehicle insurers have incorrectly cited HRS § 431:10C-308.5(b) language "shall not exceed the charges . . . permissible under the workers' compensation supplemental medical fee schedule" to deny payment of Hawaii state general excise tax ("GET") to medical providers. GET is an unavoidable cost of business for the medical provider, but some insurers refuse to reimburse the provider for the GET that is levied on the eligible charge. Motor vehicle insurers incorrectly argue that the medical charge including GET must be less than the fee schedule. As a result, medical providers of no-fault benefits could never realize the full amount of the medical fee schedule. Their fee is always reduced by the amount of the unpaid GET levy.

The unwarranted position taken by some motor vehicle insurers fosters unacceptable situations. For example, since the county of Honolulu has the highest GET rate, actual compensation received by Honolulu providers is lower than that received by neighbor island providers for the same services. Furthermore, since workers compensation insurers pay the GET, a medical provider receives higher compensation for treating workers compensation injuries than for treating motor vehicle injuries.

Neither the statute nor the rule prohibits the reimbursement of the GET. Refusal to pay GET does, however, deny the medical provider the maximum permissible charge for the services she provides. Therefore, in this case, as well as in all other personal injury protection benefit cases, the medical provider shall be compensated per HRS § 431:10C-308.5(b) plus GET.

Respondent cites Hawaii Emergency Physicians Assoc, Inc. v. Hawaiian Ins. Guar. & Co. Ltd., ATX-99-79-P (2000) ("HEPA") for the proposition that reasonable and appropriate charges for emergency room services cannot exceed 200% of Medicare fee schedule. Respondent misconstrues the intent of that case. Hearings Officer's Conclusions of Law in HEPA stated:

> Evidence presented by Respondent established that Respondent's reimbursement of a total of $341.40 for Provider's original bill of $546.84; which was reimbursement at 200% of Medicare for CPT code 99825; was considered reasonable and appropriate **in this instance**.

HEPA, at p. 6 (emphasis added). HEPA was never intended to create a rule of universal applicability. The conclusion reached for the HEPA case was correct only **in that instance**. *See*, Shoreline Trans., Inc. v. Robert's Tours and Trans., 70 Haw. 585, 595, 779 P.2d 868, 874 (1989)(*recon. denied* 1989). Furthermore, the conclusion of law indicates that the HEPA Respondent had actually proven that $341.40 was reasonable and appropriate for that case and in HEPA, $341.40 just happened to correspond to 200% of the Medicare standard.

For the instant case, Respondent Allstate's attempt to assert that 200% of the Medicare standard is reasonable and appropriate is insufficient to support its denial of Provider Dr. Khaw's fee for emergency services. First, as explained above, statute and rule prohibit binding these services to the Medicare standards. Second, Respondent Allstate did not present any other substantial evidence to refute the reasonableness, appropriateness, or necessity of the services provided and fee charged.

III. ORDER

The Commissioner finds and concludes that Millicent Khaw, M.D., as provider for Anthony Gross has established by a preponderance of the evidence that Respondent Allstate Insurance Company's denial was improper. Dr. Khaw is entitled to her usual and customary fee of $2,600.00 plus general excise tax of $108.16, a total of $2,708.16. Dr. Khaw is due the balance plus interest. The Commissioner further orders that Respondent, the only party represented by an attorney, bears its own attorney's fees incurred in this matter.

DATED: Honolulu, Hawaii, October 15, 2008.

J.P. SCHMIDT
INSURANCE COMMISSIONER
Insurance Division
Department of Commerce and Consumer Affairs
State of Hawaii

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INSURANCE DIVISION
OFFICE OF ADMINISTRATIVE HEARINGS
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
STATE OF HAWAII

In the Matter of the Request for Payment of MILLICENT KHAW, M.D., as Provider for Antony Gross, Provider, vs. ALLSTATE INSURANCE COMPANY, Respondent.	)	ATX-2007-5-P HEARINGS OFFICER'S FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDED ORDER

HEARINGS OFFICER'S FINDINGS OF FACT,
CONCLUSIONS OF LAW, AND RECOMMENDED ORDER

I. BACKGROUND

By letter dated January 17, 2007, Millicent Khaw, M.D., ("Provider") as the Provider for Antony Gross ("Gross"), filed a request with the Insurance Commissioner, Department of Commerce and Consumer Affairs, State of Hawaii ("Commissioner"), for review of a denial of personal injury protection benefits dated December 18, 2006, which had been issued by Allstate Insurance Company ("Respondent"). The request for hearing was transmitted to the Office of Administrative Hearings and a Notice of Status Conference and Order Regarding Pre-Hearing Statements was duly served on the parties.

On April 11, 2008, this matter came before the undersigned Hearings Officer with the Provider present and appearing *pro se*, and Respondent represented by its attorney, Patricia Kehau Wall, Esq.

The Hearings Officer, having reviewed and considered the argument of the parties, together with the exhibits, records and files herein, hereby renders the following findings of fact, conclusions of law, and recommended order.

II. FINDINGS OF FACT

1. On November 11, 2006, while under the personal injury protection insurance coverage of Respondent Gross was involved in a motor vehicle accident in Hilo, Hawaii.

2. As a result of injuries sustained in the accident, Gross was evacuated to Queen's Medical Center in Honolulu for emergency surgery and treatment of multiple open fractures. Provider was present during the six-hour surgery and provided emergency trauma anesthesia care.

3. The Provider subsequently issued a billing statement dated November 15, 2006 to Respondent for the services she performed during the surgery. The bill reflected a total charge of $2,708.16.

4. Respondent retained IMS, formerly known as ADP Integrated Medical Services, Inc., to audit the Provider's bill. Based on the audit, IMS recommended a payment of $1,077.27.

5. On December 18, 2006, Respondent issued a Denial of Claim Form to the Provider for the $1,630.89 balance and on December 19, 2006, Respondent paid the Provider the undisputed amount of $1,077.27.

6. The denial was based upon Respondent's determination that the "charge for this service exceeds an amount that would appear reasonable when compared to charges by other providers for similar service." Respondent determined that the Provider was entitled to 200% of the Medicare fee schedule for 29 units and that the balance of the Provider's charge of $1,630.89 was not reasonable.

III. CONCLUSIONS OF LAW

If any of the following conclusions of law shall be deemed to be findings of fact, the Hearings Officer intends that every such conclusion of law shall be construed as a finding of fact.

The issue presented for determination is whether Respondent's denial of the personal injury protection benefits involved here was improper. In order to prevail, the Provider has the burden of proving by a preponderance of the evidence that the amount billed was appropriate, reasonable and necessarily incurred as mandated by Hawaii Administrative Rule ("HAR") §16-23-93.

The Provider contends that pursuant to HAR §16-23-93, she is entitled to her usual and customary fee of $2,708.16 for the emergency services she rendered in the treatment of the injuries resulting from the November 11, 2006 motor vehicle accident. Respondent, on the other hand, argues that the fee that the Provider is entitled to must nevertheless be reasonable and appropriate and that the portion of the Provider's charge which exceeds 200% of the Medicare fee schedule is not reasonable. HAR §16-23-93 provides:

> §16-23-93 Fee schedules. Subject to the time limitations set forth in section 431:10C-315, HRS, this subchapter shall apply to treatment occurring after May 31, 1993. *Charges and treatment rendered for emergency services during the initial seventy-two hours following the motor vehicle accident resulting in injury shall not be subject to this subchapter; provided, however, that charges for emergency treatment shall not exceed the health care or alternative care provider's usual and customary fee and shall be appropriate, reasonable, and necessarily incurred.* Charges for treatment of a primarily palliative nature shall be subject to the requirements of this subchapter in the same manner as any other treatment.

(Emphasis added).

According to the foregoing rule, the Provider is entitled to her usual and customary fee provided that the fee is appropriate, reasonable, and necessarily incurred. In determining whether the fee is reasonable, the Commissioner has previously held that a "community standard", and not what the provider chooses to charge, is the baseline for determining what shall be considered an appropriate and reasonable charge. *Hawaii Emergency Physicians Associated, Inc. as Provider for Bunji Matsuoka v. Hawaiian Insurance*

& Guaranty Company, Limited, ATX-99-79-P (CFO January 25, 2000). In that case, the Hearings Officer had concluded that the respondent's reimbursement at 200% of Medicare for the applicable CPT code was "reasonable and appropriate in this instance." Similarly, in *The Queen's Medical Center, as Provider for Nicole S. Pico v. TIC/CRUM & Forster, et al.(September 9, 2003)*, the arbitrator concluded:

> QUEEN'S MEDICAL CENTER argues that the references to "200% of the Medicare guidelines" and "80% of the usual and customary fees" ought not to be controlling since the Legislature has not tied fees for medical services within 72 hours of the accident to either guidelines for determining the reasonableness of no-fault payments. TIG/CRUM & Forster's use of those measuring sticks were its efforts to quantify what was "reasonable" for no-fault payments. TIG's use of those quantitative measurements to interpret the reasonableness of payments is not unreasonable and is not unjustified.

Consistent with these cases, Respondent reimbursed the Provider at 200% of the Medicare fee schedule, based upon the applicable CPT code, for 29 units. Moreover, there is nothing in the record that justifies a departure from the aforementioned rulings. The Hearings Officer therefore concludes that the Provider has not proven by a preponderance of the evidence that Respondent's denial of the balance of the Provider's bill was improper.

IV. RECOMMENDED ORDER

For the reasons set forth above, the Hearings Officer recommends that the Commissioner find and conclude that the Provider has failed to establish by a preponderance of the evidence that Respondent's denial was improper. The Hearings Officer further recommends that Respondent, the only party represented by an attorney, bear its own attorney's fees incurred in this matter.

DATED: Honolulu, Hawaii, JUL 25 2008

CRAIG H. UYEHARA
Administrative Hearings Officer
Department of Commerce
and Consumer Affairs