

§12-15-32 Physicians. (a) Frequency and extent of treatment shall not be more than the nature of the injury and the process of a recovery requires. Authorization is not required for the initial fifteen treatments of the injury during the first sixty calendar days.

(b) If the physician believes treatments in addition to that allowed by subsection (a) are required, the physician shall transmit a treatment plan to the employer by mail or facsimile under separate cover at least seven calendar days prior to the start of the additional treatments to an address or facsimile number provided by the employer. A treatment plan shall be for one hundred twenty calendar days and shall not exceed fifteen treatments within that period. Treatments provided with less than seven calendar days notice are not authorized. A complete treatment plan shall contain the following elements:

- (1) Projected commencement and termination dates of treatment;
- (2) A clear statement as to the impression or diagnosis;
- (3) A specific time schedule of measurable objectives to include baseline measurements at the start of the treatment plan and projected goals by the end of the treatment plan;
- (4) Number and frequency of treatments;
- (5) Modalities and procedures to be used;
- and
- (6) An estimated total cost of services.

Treatment plans which do not include the above specified elements but which are reasonable and necessary may not be denied by the employer, but upon written notification from the employer, the physician shall correct the deficiency(s) and the employer's liability is deferred as long as the treatment plan

remains deficient. Neither the injured employee nor the employer shall be liable for services provided under a treatment plan that remains deficient. Both the front page of the treatment plan and the envelope in which the plan is mailed or the cover sheet if the plan is sent by facsimile shall be clearly identified as a "WORKERS' COMPENSATION TREATMENT PLAN" in capital letters and in no less than ten point type.

(c) A treatment plan shall be deemed received by an employer when the plan is sent by mail or facsimile with reasonable evidence showing that the treatment plan was received.

(d) The employer may file an objection to the treatment plan with documentary evidence supporting the denial and a copy of the denied treatment plan with the director, copying the physician and the injured employee. Both the front page of the denial and the envelope in which the denial is filed shall be clearly identified as a "TREATMENT PLAN DENIAL" in capital letters and in no less than ten point type. The employer shall be responsible for payment for treatments provided under a complete treatment plan until the date the objection is filed with the director. Furthermore, the employer's objection letter must explicitly state that if the attending physician or the injured employee does not agree with the denial, they may request a review by the director of the employer's denial within fourteen calendar days after postmark of the employer's denial, and failure to do so shall be construed as acceptance of the employer's denial.

(e) The attending physician or the injured employee may request in writing that the director review the employer's denial of the treatment plan. The request for review shall be filed with the director, copying the employer, within fourteen

calendar days after postmark of the employer's denial. A copy of the denied treatment plan shall be submitted with the request for review. Both the front page of the request for review and the envelope in which the request is filed shall be clearly identified as a "REQUEST FOR REVIEW OF TREATMENT PLAN DENIAL" in capital letters and in no less than ten point type. For cases not under the jurisdiction of the director at the time of the request, the injured employee shall be responsible to have the case remanded to the director's jurisdiction. Failure to file a request for review of the employer's denial with the director within fourteen calendar days after postmark of the employer's denial shall be deemed acceptance of the employer's denial.

(f) The director shall issue a decision, after a hearing, either requiring the employer to pay the physician within thirty-one calendar days in accordance with the medical fee schedule if the treatments are determined to be reasonable and necessary or disallowing the fees for treatments determined to be unreasonable or unnecessary. Disallowed fees shall not be charged to the injured employee.

(g) The decision issued pursuant to subsection (f) shall be final unless appealed pursuant to section 386-87, HRS. The appeal shall not stay the director's decision.

(h) The psychiatric evaluation or psychological testing with the resultant reports shall be limited to four hours unless the physician submits prior documentation indicating the necessity for more time and receives pre-authorization from the employer. Fees shall be calculated on an hourly basis as allowed under Medicare.

(i) For physical medicine, treatments may include up to four procedures, up to four modalities, or a

combination of up to four procedures and modalities, and the visit shall not exceed sixty minutes per injury. When treating more than one injury, treatments may include up to six procedures, up to six modalities, or a combination of up to six procedures and modalities, and the entire visit shall not exceed ninety minutes.

(j) Any physician who exceeds the treatment guidelines without proper authorization shall not be compensated for the unauthorized services.

(k) No compensation shall be allowed for preparing treatment plans and written justification for treatments which exceed the guidelines.

(l) Failure to comply with the requirements in this section may result in denial of fees.

(m) Treatment, prescribed on an in-patient basis in a licensed acute care hospital where the injured employee's level of care is medically appropriate for an acute setting as determined by community standards, are excluded from the frequency of treatment guidelines specified herein. [Eff 1/1/96; am 1/1/97; am 12/28/17] (Auth: HRS §§386-21, 386-21.2, 386-26, 386-72) (Imp: HRS §§386-21, 386-21.2, 386-26, 386-27)

§12-15-34 Providers of service other than physicians. (a) Frequency and extent of treatment shall not be more than the nature of the injury and the process of a recovery require. Any health care treatment or service performed by a Hawaii licensed or certified provider of service other than a physician shall be directed by the attending physician based on a written prescription signed, dated, and approved by the attending physician. The prescription may authorize up to an initial fifteen treatments of the injury during the first sixty calendar days. For therapists, the prescription may authorize up to an initial twenty treatments of the injury during the first sixty calendar days.

(b) If the attending physician believes treatments in addition to that allowed by subsection (a) are required, the provider of service other than a physician, in lieu of the attending physician, may transmit a treatment plan for review and approval to the attending physician who shall, after approval, transmit the treatment plan to the employer by mail or facsimile under separate cover at least seven calendar days prior to the start of the additional treatments to an address or facsimile number provided by the employer. A treatment plan shall be for one hundred twenty calendar days and shall not exceed fifteen treatments within that period. Treatments provided with less than seven calendar days notice are not authorized. A complete treatment plan shall contain the following elements:

- (1) Projected commencement and termination dates of treatment;
- (2) A clear statement as to the impression or diagnosis;
- (3) A specific time schedule of measurable objectives to include baseline measurements at the start of the

treatment plan and projected goals by the end of the treatment plan;

(4) Number and frequency of treatments;

(5) Modalities and procedures to be used;
and

Treatment plans which do not include the above specified elements but which are reasonable and necessary may not be denied by the employer, but upon written notification from the employer, the physician or the provider of service, with approval by the attending physician, shall correct the deficiency(s) and the employer's liability is deferred as long as the treatment plan remains deficient. Neither the injured employee nor the employer shall be liable for services provided under a treatment plan that remains deficient. Both the front page of the treatment plan and the envelope in which the plan is mailed or the cover sheet if the plan is sent by facsimile shall be clearly identified as a "WORKERS' COMPENSATION TREATMENT PLAN" in capital letters and in no less than ten point type.

(c) A treatment plan shall be deemed received by an employer when the plan is sent by mail or facsimile with reasonable evidence showing that the treatment plan was received.

(d) The employer may file an objection to the treatment plan with documentary evidence supporting the denial and a copy of the denied treatment plan with the director, copying the attending physician, the provider of service and the injured employee. Both the front page of the denial and the envelope in which the denial is filed shall be clearly identified as a "TREATMENT PLAN DENIAL" in capital letters and in no less than ten point type. The employer shall be responsible for payment for treatments provided under a complete treatment plan until the date the objection is filed with the director. Furthermore, the

employer's objection letter must explicitly state that if the attending physician or the injured employee does not agree with the denial, they may request a review by the director of the employer's denial within fourteen calendar days after postmark of the employer's denial, and failure to do so shall be construed as acceptance of the employer's denial.

(e) The attending physician or the injured employee may request in writing that the director review the employer's denial of the treatment plan. The request for review shall be filed with the director, copying the employer, within fourteen calendar days after postmark of the employer's denial. A copy of the denied treatment plan shall be submitted with the request for review. Both the front page of the request for review and the envelope in which the request is filed shall be clearly identified as a "REQUEST FOR REVIEW OF TREATMENT PLAN DENIAL" in capital letters and in no less than ten point type. For cases not under the jurisdiction of the director at the time of the request, the injured employee shall be responsible to have the case remanded to the director's jurisdiction. Failure to file a request for review of the employer's denial with the director within fourteen calendar days after postmark of the employer's denial shall be deemed acceptance of the employer's denial.

(f) The director shall issue a decision, after a hearing, either requiring the employer to pay the provider of service other than a physician within thirty-one calendar days in accordance with the medical fee schedule if the treatments are determined to be reasonable and necessary or disallowing the fees for treatments determined to be unreasonable or unnecessary. Disallowed fees shall not be charged to the injured employee.

(g) The decision issued pursuant to subsection (f) shall be final unless appealed pursuant to section 386-87, HRS. The appeal shall not stay the director's decision.

(h) The provider of service other than a physician shall submit reports at least monthly to the attending physician and employer regarding an injured employee's progress. The preparation and submission of written reports or progress notes to the employer by the provider of service other than a physician are an integral part of the service fee.

(i) Treatments may include up to four procedures, up to four modalities, or a combination of up to four procedures and modalities, and the visit shall not exceed sixty minutes per injury. When treating more than one injury, treatments may include up to six procedures, up to six modalities, or a combination of up to six procedures and modalities, and the entire visit shall not exceed ninety minutes. This section applies to providers of service other than physicians including physical therapists, occupational therapists, massage therapists, and acupuncturists.

(j) Any provider of service other than a physician who exceeds the treatment guidelines without proper authorization shall not be compensated for the unauthorized services.

(k) No compensation shall be allowed for preparing treatment plans and written justification for treatments which exceed the guidelines.

(l) Failure to comply with the requirements in this section may result in denial of fees.

(m) Therapy by physical therapists and occupational therapists, prescribed on an in-patient basis in a licensed acute care hospital where the injured employee's level of care is medically appropriate for an acute setting as determined by community standards or, prescribed on an out-patient

post-surgery basis not to exceed thirty calendar days, are excluded from the frequency of treatment guidelines specified herein. [Eff 1/1/96; am 1/1/97; am 12/28/17] (Auth: HRS §§386-21, 386-21.2, 386-26, 386-72) (Imp: HRS §§386-21, 386-21.2, 386-26, 386-27)

§12-15-90 Workers' compensation medical fee schedule. (a) Charges for medical services shall not exceed one hundred ten per cent of participating fees prescribed in the Medicare Resource Based Relative Value Scale System fee schedule (Medicare Fee Schedule) applicable to Hawaii or listed in exhibit A, located at the end of this chapter and made a part of this chapter, entitled "Workers' Compensation Supplemental Medical Fee Schedule", dated January 1, 2018. The Medicare Fee Schedule in effect on January 1, 1995 shall be applicable through June 30, 1996. Beginning July 1, 1996 and each calendar year thereafter, the Medicare Fee Schedule in effect as of January 1 of that year shall be the effective fee schedule for that calendar year.

(b) If maximum allowable fees for medical services are listed in both the Medicare Fee Schedule and the Workers' Compensation Supplemental Medical Fee Schedule, dated January 1, 2018, located at the end of this chapter as exhibit A, charges shall not exceed the maximum allowable fees allowed under the Workers' Compensation Supplemental Medical Fee Schedule, dated January 1, 2018, located at the end of this chapter as exhibit A.

(c) If the charges are not listed in the Medicare Fee Schedule or in the Workers' Compensation Supplemental Medical Fee Schedule, dated January 1, 2018, located at the end of this chapter as exhibit A, the provider of service shall charge a fee not to exceed the lowest fee received by the provider of service for the same service rendered to private patients. Upon request by the director or the employer, a provider of service shall submit a statement to the requesting party, itemizing the lowest fee received for the same health care, services, and supplies furnished to any private patient during the one-year period preceding the date of a particular charge. Requests shall be submitted in writing within twenty calendar days of receipt of a

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questionable charge. The provider of service shall reply in writing within thirty-one calendar days of receipt of the request. Failure to comply with the request of the employer or the director shall be reason for the employer or the director to deny payment.

(d) Fees listed in the Medicare Fee Schedule shall be subject to the current Medicare Fee Schedule bundling and global rules if not specifically addressed in these rules. The Health Care Financing Administration Common Procedure Coding System (HCPCS) alphabet codes adopted by Medicare will not be allowed, except for injections and durable medical equipment, unless specifically adopted by the director. The director may defer to a fee listed in the Medicare HCPCS Fee Schedule when a fee is not listed in the Workers' Compensation Supplemental Medical Fee Schedule, Exhibit A.

(e) Providers of service will be allowed to add the applicable Hawaii general excise tax to their billing. [Eff 1/1/96; am 1/1/97; am 11/22/97; am 12/17/01; am 12/13/04; am 11/6/06; am 12/14/07; am 2/28/11; am 12/30/13; am 12/28/17] (Auth: HRS §§386-21, 386-26, 386-72) (Imp: HRS §§386-21, 386-26)