Office of Administrative Hearings
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This January 2002 Compilation of ATX & MVI Headnotes replaces all previous editions of the "no-fault" insurance headnotes (MVI docket) and "personal injury protection" (ATX docket) insurance headnotes through December 31, 2001. Earlier, outdated compilations should now be discarded.

The headnotes provide ready access to authoritative information on selected topics, and persons involved in the process of obtaining, providing, or denying no-fault benefits – particularly persons appearing in contested case proceedings conducted by the Office of Administrative Hearings – should be familiar with the case law reflected in them. In addition, although considerable care has been exercised in preparing this material, users are encouraged to further their understanding of the law by reading the underlying cases.

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HEADNOTE TOPICS

January 2002

ADMINISTRATIVE COSTS

Administrative Costs – "A pattern of issuing repeated denials of no-fault benefits on a basis which has consistently been held to be invalid flaunts the law, wrongs persons entitled to its benefits, and constitutes abusive conduct which warrants the assessment of civil penalties. . . . Such conduct also warrants the assessment of administrative costs pursuant to the provisions of HRS § 431:10C-212(d) which state that, 'The commissioner may assess the cost of the hearing upon either or both of the parties.'"
Lucas v. AIG Hawaii, MVI-94-165 (CFO October 30, 1996) [Note: affirmed by summary dispositional order - S.C. No. 21464 (December 28, 1998)].

Administrative Costs – Parties should attempt to identify, articulate, and resolve issues which are procedural in nature either directly or by prehearing motions where the applicable law has been clearly set out in statutes, rules, or previous case law. The failure of either party to pursue an appropriate resolution of applicable issues during prehearing stages of contested proceedings may result not only in the absence of any award for attorney's fees but also in the imposition of administrative costs under HRS § 431:10C-212(d) for the expenses associated with a subsequent hearing.
Valdez v. GEICO, MVI-94-340-C+ (CFO January 10, 1996) and *Pecson v. GEICO*, MVI-94-254-C (CFO September 15, 1995).

Administrative Costs – "If further proceedings are required to determine the single issue of the dollar value of reasonable attorney's fees and/or costs, either or both of the parties may be subject to an assessment of administrative costs under HRS § 431:10C-212(d); an award of further attorney's fees and/or costs under HRS § 431:10C-211; or an imposition of sanctions under HRS § 431:10C-117."
Martinez v. AIG Hawaii, MVI-94-250 (CFO September 15, 1995).

Administrative Costs – The conduct of a respondent which manifests repeated disregard for legal precedent that has been well established by prior cases is contrary to the spirit and letter of the Hawaii motor vehicle insurance law (HRS Chapter 431, Article 10C) and is a valid basis for the imposition of both civil penalties under HRS § 431:10c-117 and administrative costs under HRS § 431:10C-212.
Siu v. AIG Hawaii, MVI-92-4 (CFO August 28, 1992).

Administrative Costs – The conduct of a claimant in pursuing an administrative hearing under circumstances where the claimant knew or should have known that the claim was clearly without merit (especially where the claimant failed to demonstrate good faith by not even replying to a Respondent's settlement proposal) is abusive of the hearing process and is a valid basis for assessing the cost of the hearing against the claimant for having brought a frivolous claim.
Lissauer v. AIG Hawaii, MVI-92-5 (CFO July 28, 1992).

Administrative Costs – A pattern of disregard for existing law and precedent by a respondent - contrary to the provisions of the no-fault statutes and detrimental to those persons rightfully claiming health care benefits - is inappropriate and abusive of the administrative process which was legislatively established to provide an efficient and equitable system of reparations. Such conduct by a respondent is a valid basis for assessing the cost of the hearing against the respondent under the provisions of HRS § 431:10C-212(d) as well as for the imposition of civil penalties under HRS § 431:10C-117(b) and (c).
Bagaoisan v. AIG Hawaii, MVI-90-40 (CFO December 17, 1990).

Administrative Costs – A respondent's premature or unwarranted denial of benefits based upon clearly insubstantial evidence is one of the bases upon which "the Commissioner may assess the cost of the hearing upon either or both of the parties" pursuant to HRS § 294-31.5(d) [431:10C-212(d)]. Such a denial, even if not procedurally invalid on its face, is substantively inappropriate and abusive of the administrative process which was legislatively established to provide an efficient and equitable system of reparations.
Huynh v. State Farm, MVI-88-9 (CFO June 26, 1989).

Administrative Costs – A pattern of disregard for existing law and precedent, contrary to the provisions of the no-fault statutes and detrimental to persons rightfully claiming benefits, is one of the bases upon which "the Commissioner may assess the cost of the hearing upon either or both of the parties" pursuant to HRS § 294-31.5(d) [HRS §431:10C-212(d)].
Daoang v. State Farm, MVI-88-38 (CFO December 4, 1988).

APPORTIONMENT

Apportionment – In a situation where the evidence is sufficient to establish that a claimant's injuries are the combined result of multiple motor vehicle accidents, but is insufficient to establish their proportional contributions, the resulting no-fault benefits for qualifying health care are equally apportioned between/among the various accidents.
Todd v. State Farm, MVI-96-1302+ (CFO July 26, 1999).

Apportionment – The issue of causation/apportionment may present an especially difficult question where a claimant has been involved in multiple accidents or incidents and has received health care treatment or evaluation from multiple health care providers.
Martinez v. AIG Hawaii, MVI-94-250 (CFO September 15, 1995).

Apportionment – "The issue of apportionment presents an especially difficult analytical question where a claimant has been involved in numerous traumatic incidents over a considerable period of time, and has participated in various treatment programs or evaluation sessions with multiple health care providers. The interpretation of facts assumes an additional magnitude of difficulty where ... the claimant's injuries are largely "soft tissue" in nature and much of his resulting discomfort can only be measured symptomologically."
Teruya v. AIG Hawaii, MVI-94-58 (CFO March 16, 1995).

Apportionment – "The Insurance Commissioner has previously adopted the position of the Hawaii Supreme Court ... which held that a party would be responsible only for the harm which that party caused, and that if an apportionment was reasonable based upon the preponderance of the evidence, then an apportionment would be made. The Court also held if the finder of fact was unable to determine a precise apportionment of damages, a rough apportionment could be made, and that if the finder of fact was unable to make even a rough apportionment, then the damages were to be apportioned equally."
Teruya v. AIG Hawaii, MVI-94-58 (CFO March 16, 1995); and, *Madden v. GEICO*, MVI-93-131 (CFO May 13, 1994).

Apportionment – A claimant who has a pre-existing condition which is asymptomatic prior to a motor vehicle accident, is entitled to receive no-fault benefits for the treatment of all of the conditions which subsequently manifest themselves as a result of injuries from the motor vehicle accident.
Hanna v. AIG Hawaii, MVI-92-29 (CFO December 30, 1993).

Apportionment – If a claimant suffers injuries from multiple motor vehicle accidents and/or has unresolved preexisting injuries and a specific apportionment of

his overall condition cannot be made, then liability will be apportioned equally between all of the motor vehicle accidents and/or unresolved preexisting injuries.
Menez v. State Farm, MVI-92-200 (CFO November 15, 1993).

Apportionment – Where a claimant with a pre-existing injury or condition that was asymptomatic and/or did not require health care treatments is injured in a motor vehicle accident which aggravates or exacerbates his or her pre-accident status, the claimant is entitled to no-fault benefits for treatment to allow a return to pre-accident status (or until benefits are exhausted).
Frawley v. Colonial Penn, MVI-92-176 (CFO August 26, 1993).

Apportionment – "An apportionment of no-fault benefits is appropriate when a claimant was suffering pain or disability from earlier injuries or a pre-existing degenerative condition prior to the subject accident."
Valasco v. State Farm, MVI-93-9 (CFO July 27, 1993).

Apportionment – If a person suffers injuries from multiple motor vehicle accidents and/or has pre-existing unresolved injuries, and a specific apportionment cannot be made, then liability will be apportioned equally between motor vehicle accidents and/or pre-existing unresolved injuries.
Felisi v. AIG Hawaii, MVI-90-128 (CFO December 2, 1991).

Apportionment – A person who has a preexisting physical condition which is asymptomatic prior to a motor vehicle accident, is entitled to receive full no-fault benefits for the reasonable treatment of symptomology arising out of the injuries sustained in the motor vehicle accident.
Baker v. AIG Hawaii, MVI-91-60 (CFO November 27, 1991).

Apportionment – "It is well established that in no-fault proceedings, as in common law, a party is responsible only for the harm which that party has caused. Accordingly, if an apportionment of causation is appropriate under the circumstances, then a reasonable one should be made based upon a preponderance of the evidence, and if a finder of fact is unable to determine a precise apportionment, then a rough apportionment may be made."
Oslund v. State Farm, MVI-89-101 (CFO March 18, 1991); and, *Raupp v. State Farm*, MVI-83-14 (CFO February 13, 1984).

Apportionment – The issue of causation/apportionment may present an especially difficult question where a claimant has been involved in multiple accidents and has participated in treatment programs or evaluation sessions with numerous health care providers over extended periods of time, especially where no single health care professional has followed the claimant throughout the entire treatment period.
Miyahira v. American Home/GEICO, MVI-90-31+ (CFO December 17, 1990).

Apportionment – "The Insurance Commissioner has consistently followed the position of the Hawaii Supreme Court as set out in the case of *Lewis v. Oakley*, 50 Hawaii 260, 438 Pacific 2nd. 93 (1968) which held that a party would be responsible only for the harm which that party had caused. If an apportionment was reasonable based upon a preponderance of the evidence then an apportionment would be made, and if a finder of fact was unable to determine a precise apportionment of damages, a rough apportionment could be made."
Miyahira v. American Home/GEICO, MVI-90-31+ (CFO December 17, 1990); and, *Raupp v. State Farm*, MVI-83-14 (CFO February 13, 1984).

Apportionment – "An insured's adverse pre-accident condition may result in greater damages and correspondingly greater payment obligations by the insurer, but the insurer is not independently responsible for preexisting conditions which are unrelated to the motor vehicle accident and is normally not obligated to restore the insured to a condition superior to his pre-accident status."
Cord v. State Farm, MVI-89-37 (CFO December 29, 1989).

ATTORNEY'S FEES/COSTS

Attorneys Fees/Costs – In a proceeding to determine the merit of a claim for attorney's fees and costs as a separate no-fault benefit "a claimant has the same burden of proof as is required in proving entitlement to any other no-fault benefit denied by a respondent."
Sildora v. AIG Hawaii, MVI-2001-1 (CFO June 20, 2001).

Attorneys Fees/Costs – "While a determination of attorney's fees and costs under varying circumstances necessarily involves a degree of discretion, it is also well recognized that the trier of fact is accorded considerable deference in evaluating the reasonableness of such amounts."
Sildora v. AIG Hawaii, MVI-2001-1 (CFO June 20, 2001).

Attorneys Fees/Costs – "The customary rate of reimbursement for time reasonably incurred by attorneys in the course of Hawaii administrative proceedings that involve no-fault or personal injury protection claims – in the absence of exceptional circumstances that would serve to increase or diminish that rate – has rather consistently been $125 per hour."
Sildora v. AIG Hawaii, MVI-2001-1 (CFO June 20, 2001).

Attorneys Fees/Costs – A provider's continued pursuit of a claim for the payment of services several months after the respondent had: 1) rescinded the denials, and 2) notified the provider that the claimant's no-fault benefits had been exhausted – especially when it was compounded by the provider's requesting fees for an attorney who was not counsel of record and the provider'sfailure to appear at the hearing – constituted the pursuit of a frivilous claim and warranted an award of reasonable attorney's fees/costs to the respondent.
Jou/Buloson v. AIG Hawaii, ATX-2000-21-P (CFO April 5, 2001).

Attorneys Fees/Costs – Where a claimant has prevailed on part (but not all) of the claims which he or she has asserted in a contested case hearing, the calculation of an award of attorney's fees/costs may take into consideration, *inter alia*, the degree to which the claimant actually prevailed.
Pedro v. AIG Hawaii, MVI-98-496-C (CFO March 28, 2001).

Attorneys Fees/Costs – Although prior decisions have historically interpreted HRS § 431:10C-211 as allowing the Insurance Commissioner discretion in determining whether an award of attorney's fees/costs should be made as well as the amount of any such award, more recent indications from appellate review are that where a claimant has prevailed he or she is entitled to such an award, and the element of discretion is limited to determining the reasonableness of the dollar amount to be awarded.
Graham v. AIG Hawaii, MVI-2000-34 (CFO February 1, 2001).

Attorneys Fees/Costs – "[W]hile the reasonableness of the amount of any award pursuant to HRS § 431:10C-211 is within the sound discretion of the Insurance Commissioner, a recent judicial interpretation of this subject (upon appellate review) would suggest that a prevailing claimant or provider is generally entitled to an award in some amount."
Ocon v. Oahu Transit, ATX-2000-87 (CFO September 18, 2000).

Attorneys Fees/Costs – Where a claimant is seeking attorney's fees and costs it is incumbent that he or she establish that the requested award would be reasonable under the particular circumstances surrounding the respondent's denial of no-fault benefits. "Resources spent on legal issues or ancillary matters which have no direct bearing on the outcome of the underlying issues are unlikely to warrant any award."
Chong-Echiverri v. AIG Hawaii, MVI-2000-10 (CFO July 28, 2000).

Attorneys Fees/Costs – "The provisions of HRS § 431:10C-211(a) allow the Commissioner to award reasonable attorney's fees and costs to a person who pursues a no-fault benefit claim against an insurer, unless such claim is determined to be unreasonable, fraudulent, excessive or frivolous. However, the same provisions do not authorize the award of pro se litigant fees such as requested by [the] Provider for the time and effort he had expended in pursuit of his claims."
Jou/Asahi et. al. v. GEICO, MVI-99-44-P (CFO July 5, 2000).

Attorney's Fees/Costs – Where the legal issue raised by an insurer's/ respondent's motion to dismiss have been previously and definitively decided in its favor (as reflected in existing caselaw) and the provider neither responds to the motion nor appears to contest it, the provider's underlying claim may be deemed frivolous – and thus constitute the basis for an award of reasonable attorney's fees and costs to the respondent.
Hyman/Caranto v. AIG Hawaii, MVI-97-115-P (CFO April 10, 2000); *Hyman/Caranto v. AIG Hawaii*, MVI-97-116-P (CFO April 10, 2000); and, *Hyman/Van Houten v. AIG Hawaii*, MVI-96-758-P (CFO April 7, 2000).

Attorney's Fees/Costs – "When requesting attorney's fees, the Claimant has the burden of establishing that the requested attorney's fees and costs are reasonable by presenting sufficient information and documents to justify the requested amounts."
Gorgonio v. Dai-Tokyo Royal, ATX-99-59+ (CFO March 3, 2000).

Attorney's Fees/Costs – "The existence of an attorney-client fee agreement and payment made by the client pursuant to such agreement is not dispositive of the matter of Claimant's request for the allowance to her of attorney's fees and costs expended to pursue her claim." The allowance of any such request must be reasonable in light of the factors set out in *Sebastian v. State Farm*, MVI-88-30A (CFO May 2, 1989).

Yoshimoto v. AIG Hawaii, MVI-99-185 (CFO November 26, 1999).

Attorney's Fees/Costs – In order for a respondent to be awarded attorney's fees or costs under the particular provisions of HRS § 431:10C-211 it must be shown that the claim being pursued by the claimant was "fraudulent or frivolous" in the sense of being manifestly and palpably without merit and indicative of bad faith on the part of the person making the claim.
Hough v. State Farm, MVI-94-484 (CFO August 28, 1998).

Attorney's Fees/Costs – A provider is - by statute - entitled to an award of attorney's fees and costs pursuant to HRS § 431:10C-211 as "a person making a claim" so long as the amount of the award is justified in the discretion of the Commissioner.
HEPA/Adams v. State Farm, MVI-96-1024 (CFO August 4, 1998).

Attorney's Fees/Costs – A claimant may be entitled to an award of attorney's fees or costs incurred in pursuing a matter which is substantially similar to a prior matter that was decided adversely to the claimant's interests where the prior matter is on appeal and where the pursuit is not deemed to be fraudulent, frivolous, excessive or unreasonable.
Sagisi v. AIG Hawaii, MVI-96-507-C/508-C (CFO August 19, 1997).

Attorney's Fees/Costs – There is no statutory authority to award attorney's fees to a provider who has represented himself (pro se) without assistance of legal counsel regardless of whether the provider prevails on the merits of his claim.
Luke/Eda v. State Farm, MVI-94-628-P (CFO June 20, 1997).

Attorneys Fees/Costs – "It is important to emphasize that although HRS § 431:10C-211 is entitled *Claimant's attorney's fees*, the language of the statute talks about a person making a claim, and the language of the statute does not actually use the word 'claimant' or otherwise limit the applicable class of persons....Providers may be entitled to discretionary awards of reasonable attorneys' fees and costs in accordance with the relevant statutory provisions of HRS § 431:10C-211 applicable to persons contesting a denial of no-fault benefits.
Hyman/Ream v. GEICO, MVI-95-239-P (CFO June 18, 1997).

Attorneys Fees/Costs – An award of attorney's fees or costs to a respondent (insurer) under HRS § 431:10C-211(d) requires a threshold determination that the claim being pursued (by a claimant or provider) was either fraudulent or frivolous.
Gumayagay v. State Farm, MVI-96-157-C (CFO June 18, 1997).

Attorney's Fees/Costs - "A lengthy and unbroken line of cases has sustained the discretionary authority of the Insurance Commissioner in considering requests for attorney's fees or costs by either party in contested no-fault insurance proceedings."

Schloderer v. Allstate, MVI-94-361 (CFO May 14, 1997).

Attorney's Fees/Costs - The issue of what, if any, reasonable attorney's fees/costs might be available to a claimant under the terms of a particular insurance policy is a contractual matter between the parties. It is distinguishable from the issue of what, if any, reasonable attorney's fees/costs might be awarded to a claimant as a result of the statutory provisions governing no-fault administrative hearings. The pursuit of such an award as a contractual matter should be within the judicial system.
Duhaylongsod v. State Farm, MVI-94-505-C+ (CFO April 3, 1997).

Attorney's Fees/Costs - A party is not entitled to a statutory award of attorney's fees which reflects an excessive hourly rate or an excessive amount of time. In such cases where (as a threshold consideration) an award is actually made, it should be reduced to reflect only amounts which are reasonably incurred in pursuing the matter even though - as a contractual matter - the insurance policy may not have limited attorney's fees to those allowed by statute.
Duhaylongsod v. State Farm, MVI-94-505-C+ (CFO April 3, 1997).

Attorney's Fees/Costs - "The award of a reasonable sum for attorney's fees [and reasonable costs pursuant to HRS § 431:10C-211(2)] is discretionary and is not automatic, mandatory or unscrutinized [citation omitted]. The reasonableness of the sum requested to be allowed requires an evaluation of the attorney's rate charged, the hours expended and purpose for which used, the relationship of the effort expended to the matter in dispute, the amount of the claim in dispute, etc.. It is incumbent upon the Claimant to establish the reasonableness of the award requested by presenting sufficient information and documents to justify the requested amounts, and a failure to do so will result in a denial or reduction of the amounts requested."
Lauth v. State Farm, MVI-94-356+ (CFO February 10, 1997).

Attorney's Fees/Costs - In determining whether a claimant's actions in pursuing a contested case hearing are frivolous (as one ground for awarding attorneys fees or costs to a respondent) a trier of fact evaluates whether the claim is "manifestly and palpably without merit, so as to indicate bad faith on [the pleader's] part such that argument to the court was not required." In addition to this guidance in *Kawaihae v. Hawaiian Insurance Companies*, 1 Haw. App. 355 (1980), the comments to Rule 3.1 of the Rules of Professional Conduct provide help in making such assessments.
Apilado v. State Farm, MVI-95-52-C (CFO November 4, 1996); and, *Bannister v. State Farm*, MVI-94-304 (CFO July 10, 1996).

Attorney's Fees/Costs - The reasonableness of a request for attorney's fees requires an evaluation of multiple factors such as the rate changed, the number of hours, the nature of the work, and the relationship of the effort expended to a resolution of the matter in dispute. Where a request contains amounts which, based

on the evidence presented, are determined to be unnecessary or excessive, such amounts should be excluded or reduced from any actual award that may be ordered. *Quillopo v. State Farm*, MVI-94-677-C (CFO September 26, 1996).

Attorney's Fees/Costs - "The decision as to whether an award of attorney's fees and/or costs should be made to either party, as well as any subsequent decision regarding actual dollar amounts are made on a case by case basis after reviewing the merits of any particular claim."
Larita v. State Farm, MVI-94-215+ (CFO September 26, 1996); *Dunn v. GEICO*, MVI-94-574-C (CFO July 12, 1996); *Ganal v. Travelers*, MVI-94-385 (CFO July 11, 1996); *Morales v. Allstate*, MVI-94-67 (CFO July 10, 1996); *Texeira v. Liberty Mutual*, MVI-94-569 (CFO May 15, 1996); *Cabral v. AIG Hawaii*, MVI-94-551 (CFO May 15, 1996); *Valdez v. GEICO*, MVI-94-340-C+ (CFO January 10, 1996); *Pecson v. GEICO*, MVI-94-254-C (CFO September 15, 1995); *Carvalho v. AIG Hawaii*, MVI-94-222 (CFO December 8, 1995); *Martinez v. AIG Hawaii*, MVI-94-250 (CFO September 15, 1995); *Tillmon v. AIG Hawaii*, MVI-94-312 (CFO September 11, 1995); *Shi v. AIG Hawaii*, MVI-94-236 (CFO July 31, 1995); *Ringer v. AIG Hawaii*, MVI-94-127-C (CFO June 14, 1995); *Yoshioka v. Transamerica*, MVI-94-23 (CFO April 21, 1995); *Teruya v. AIG Hawaii*, MVI-94-58 (CFO March 16, 1995); *Nguyen v. Dai-Tokyo*, MVI-94-86 (CFO March 16, 1995); and, *Sumter v. GEICO*, MVI-94-61-C (CFO February 2, 1995); and, *Rondolos v. AIG Hawaii*, MVI-92-197 (CFO August 30, 1993).

Attorney's Fees/Costs - "Where an award of reasonably attorney's fees and/or costs have been made without specifying a certain dollar amount, the effected parties have an obligation to negotiate an amount in good faith. If such negotiations fail, however, either party may make a timely request for further proceedings on this issue."
Dunn v. GEICO, MVI-94-574-C (CFO July 12, 1996); and, *Martinez v. AIG Hawaii*, MVI-94-250 (CFO September 15, 1995).

Attorney's Fees/Costs - "If further proceedings are required to determine the single issue of the dollar value of reasonable attorney's fees and/or costs, either or both of the parties may be subject to an assessment of administrative costs under HRS § 431:10C-212(d); an award of further attorney's fees and/or costs under HRS § 431:10C-211; or an imposition of sanctions under HRS § 431:10C-117."
Dunn v. GEICO, MVI-94-574-C (CFO July 12, 1996), *Martinez v. AIG Hawaii*, MVI-94-250 (CFO September 15, 1995).

Attorney's Fees/Costs - A claimant's continued pursuit of a hearing to contest an issue which - on the basis of existing fact rather than future speculation - is moot, and may constitute the pursuit of a frivolous claim which would entitle a respondent to an award of reasonable attorney's fees and costs.
Bannister v. State Farm, MVI-94-304 (CFO July 10, 1996).

Attorney's Fees/Costs - Where it has first been determined that adequate justification exists for an award of attorney's fees/costs to a prevailing claimant in an HRS § 431:10C-308.6 (peer review) proceeding, one reference for determining a reasonable dollar amount is to look at the provisions of HRS § 607-14 (25% of the civil judgment, exclusive of costs) as a guideline.
Chen v. State Farm, MVI-94-326-C (CFO March 12, 1996).

Attorney's Fees/Costs - Where a party is seeking an award of attorney's fees and/or costs it must establish that the expenditure of resources for which such an award is sought was reasonable in light of the legal and factual circumstances reflected in the denial of benefits, and resources spent on esoteric legal issues or ancillary matters which have no direct bearing on the outcome of the underlying issues are unlikely to warrant any award.
Guray v. State Farm, MVI-94-3-C (CFO October 26, 1995).

Attorney's Fees/Costs - "The various factors which may be applicable in measuring the reasonableness of attorney's fees in particular circumstances include those set out in *Sebastian v. State Farm*, MVI-88-30A (CFO May 22, 1989), *Merrill v. Hawaiian Ins.*, MVI-87-25 (CFO September 23, 1992), and the Code of Professional Responsibility (EC-218 and DR-2-106)."
Pecson v. GEICO, MVI-94-254-C (CFO September 15, 1995).

Attorney's Fees/Costs - The provisions of HRS § 431:10C-211(a), allowing an award of reasonable attorney's fees and costs in administrative proceedings to "[A] person making a claim for no-fault benefits" does not authorize the award of attorney's fees and costs to a provider.
Nutter/Garot v. State Farm, MVI-93-278-P (CFO September 11, 1995). [Note: overruled on this issue by *Hyman/Ream v. GEICO*, MVI-95-239-P (CFO June 18, 1997)].

Attorney's Fees/Costs - At the present time the generally approved hourly rate for attorney's fees awarded in contested no-fault insurance proceedings is $125.00 and higher amounts are unlikely to be approved in the absence of compelling evidence to support a higher rate.
Lozano v. AIG Hawaii, MVI-92-152 (CFO June 2, 1995); *Schuster v. AIG Hawaii*, MVI-94-24-C (CFO March 1, 1995) and *Tripp v. State Farm*, MVI-93-112 (CFO-R September 29, 1994).

Attorney's Fees/Costs - There is insufficient justification for an award of attorney's fees and costs to a claimant where an overview of the proceedings reflects little merit in either the substance of his or her case or in its presentation at the time of the hearing.
Yoshioka v. Transamerica, MVI-94-23 (CFO April 21, 1995).

Attorney's Fees/Costs - A provider is not entitled to an award of reasonable attorney's fees and costs because HRS § 431:10C-211 (which allows such an award

to claimants and respondents under certain criteria) was not amended to specifically allow for such an award at the time that the law was changed to allow providers their own right to request administrative hearings.
Toda/Lahr v. State Farm, MVI-93-223-P (CFO April 3, 1995). [Note: overruled on this issue by *Hyman/Ream v. GEICO*, MVI-95-239-P (CFO June 18, 1997)]

Attorney's Fees/Costs - "Where an award of reasonable attorney's fees and/or costs have been made without specifying a certain dollar amount, the effected parties have an obligation to negotiate an amount in good faith. If such negotiations fail, however, either party may make a timely request for further proceedings on this issue."
Brown v. AIG Hawaii, MVI-94-91-C (CFO March 28, 1995); and, *Nguyen v. Dai-Tokyo*, MVI-94-86 (CFO March 16, 1995).

Attorney's Fees/Costs - If further proceedings are required to determine the single issue of the dollar value of reasonable attorney's fees and/or costs, either or both of the parties may be subject to an assessment of administrative costs under HRS § 431:10C-212(d); an award of further attorney's fees and/or costs under HRS § 431:10C-211; or an imposition of sanctions under HRS § 431:10C-117.
Brown v. AIG Hawaii, MVI-94-91-C (CFO March 28, 1995); and, *Nguyen v. Dai-Tokyo*, MVI-94-86 (CFO March 16, 1995).

Attorney's Fees/Costs - In order for a claimant to be entitled to an award of reasonable attorney's fees and costs under the provisions of HRS § 431:10C-211(a), the claimant must make an evidentiary presentation as to the number of hours incurred, the nature of legal services provided, and any other relevant details. Typically, this kind of presentation can be made via an affidavit of counsel along with an itemized billing statement, and may be submitted after the close of evidence. In cases where the *only* issue is attorney's fees and costs, however, it is the only evidentiary matter to be considered at the hearing and this kind of presentation must be made as part of the hearing.
Tadaki v. AIG Hawaii, MVI-93-234 (CFO February 24, 1995).

Attorney's Fees/Costs - "Where legal obligations have been established as a result of a no-fault hearing, but a specific dollar award cannot be made because of insufficient evidence, the parties have an obligation to attempt to determine that amount in good faith without further administrative proceedings. Where a further hearing is allowed and/or required to make such a determination, the parties may be subject to an assessment of administrative costs pursuant to HRS § 431:10C-212(d); and award of attorney's fees and/or costs pursuant to HRS § 431:10C-211; or the imposition of sanctions pursuant to HRS § 431:10C-117."
Elarmo v. Island, MVI-93-260 (CFO January 24, 1995).

Attorney's Fees/Costs - It has been pointed out on numerous occasions that even in matters where, as a threshold consideration, the Commissioner has determined that an award of attorney's fees or costs is appropriate, only those fees

or costs which are reasonable may be awarded, and the party seeking them has the burden of proving their reasonableness as a matter of fact.
Pacubas v. AIG Hawaii, MVI-93-184 (CFO October 10, 1994).

Attorney's Fees/Costs - "[I]n order to determine the reasonableness of requested attorney's fees, the following factors will be considered significant: 1) the amount of the underlying claim for no-fault benefits; 2) the complexity and nature of the issues presented; 3) the efforts of the parties in trying to resolve the underlying issues; and 4) the fee customarily charged in the locality for similar legal services in light of the experience, reputation, and ability of the lawyer or lawyers performing the services."
Pacubas v. AIG Hawaii, MVI-93-184 (CFO October 10, 1994).

Attorney's Fees/Costs - "Any award of reasonable attorney's fees or costs to a claimant is a discretionary matter under the provisions of HRS § 431:10C-211(a)[.] ... It is important to note that the provisions of the statute require - as a mandatory threshold requirement - that the claimant establish that the claim being presented is not fraudulent, excessive or frivolous. It is also important to note that meeting this threshold is no guarantee of an award. This issue has been considered on previous occasions and the Insurance Commissioner has clearly stated that: "[A]ny award of attorney's fees and/or costs is clearly discretionary. The foremost goal of these administrative proceedings if the just application of Hawaii's no-fault statutes in accordance with the purpose stated in HRS 431:10C-102(a), and does not include automatic, mandatory or unscrutinized awards of attorney's fees or costs to either party."
Pacubas v. AIG Hawaii, MVI-93-184 (CFO October 10, 1994); *Valdez v. GEICO*, MVI-93-39+ (CFO February 15, 1994); *Rondolos v. AIG Hawaii*, MVI-92-197 (CFO August 30, 1993); *Oslund v. State Farm*, MVI-89-101 (CFO March 18, 1991); *Minoo v. Liberty Mutual*, MVI-88-16 (CFO May 26, 1989); and, *Henley v. State Farm*, MVI-89-91 (CFO July 18, 1990).

Attorney's Fees/Costs - Although the contents of an attorney-client fee contract provides one source of information in evaluating a party's request for an award of attorney's fees it is not itself dispositive of the issue of the reasonableness of the rate charged or the time expended by the attorney. Other evidence may establish that all or part of such a request is substantially unjustified.
Tripp v. State Farm, MVI-93-112 (CFO-R September 29, 1994).

Attorney's Fees/Costs - "Concerning the award of attorney's fees and costs to claimant, it has been emphasized previously that any award of attorney's fees and/or costs to the parties is a discretionary matter reserved to the Commissioner and is not automatic, mandatory or unscrutinized."
Redona v. State Farm, MVI-93-34 (CFO March 10, 1994).

Attorney's Fees/Costs - The amount charged by an expert witness to testify during the course of a hearing, where determined to be reasonable, is recognized as a legitimate expense which may be included in any award of costs to the claimant.
Shigemi v. AIG Hawaii, MVI-93-155 (CFO February 28, 1994).

Attorney's Fees/Costs - "[T]he following factors should be considered significant in determining the reasonableness of requested attorney's fees: 1) the amount of the underlying claim for no-fault benefits; 2) the complexity and nature of the issues presented; 3) the efforts of the parties in trying to resolve the underlying issues; and 4) the fee customarily charged in the locality for similar legal services, in light of the experience, reputation, and ability of the lawyer or lawyers performing the services. The commissioner also stated that the four factors are not the only factors which may be considered in reviewing requests for attorney's fees, although they constitute 'essential considerations in determining the reasonableness of the requests for attorney's fees and costs'."
Chotzen v. AIG Hawaii, MVI-92-61 (CFO December 17, 1993).

Attorney's Fees/Costs - The reasonableness of an attorney's request for fees must be viewed in light of the Code of Professional Responsibility [Rules of Professional Conduct], with particular attention to Disciplinary Rule 2-106 which provides in relevant part that: "A fee is clearly excessive when, after a review of the facts, a lawyer of ordinary prudence would be left with a definite and firm conviction that the fee is in excess of a reasonable fee ."
Chotzen v. AIG Hawaii, MVI-92-61 (CFO December 17, 1993).

Attorney's Fees/Costs - A claimant, in pursuing a request for his or her attorney's fees and/or costs incurred in pursuing no-fault benefits must meet the same standard (a preponderance of the evidence) as would be required to establish his or her entitlement to the underlying benefits.
Bernabe(s) v. AIG Hawaii, MVI-93-6 (CFO November 24, 1993).

Attorney's Fees/Costs - "While the settlement of a claim prior to a hearing is generally looked up with favor under the no-fault system of reparations, such settlements create considerable difficulties in later attempting to evaluate the merits - if any - of awarding reasonable attorney's fees or costs to either party.... A settlement autopsy ... to evaluate claims by either party for reasonable attorney's fees and costs is frequently inconclusive and consequently detrimental to whichever party bears the burden of proof. Parties are encouraged to resolve this issue when they enter into the pre-hearing resolution of other issues involving no-fault benefits."
Rondolos v. AIG Hawaii, MVI-92-197 (CFO August 30, 1993); and, *Henley v. State Farm*, MVI-89-91 (CFO July 18, 1990).

Attorney's Fees/Costs - The issue of attorney's fees and costs - whether to make such an award, and if so the amount - is discretionary and is based upon the particular facts in the matter under consideration. Nevertheless, when awarded,

attorney's fees have commonly been evaluated in recent matters at a rate of $125/hour.
Kamiya v. State Farm, MVI-92-213 (CFO June 21, 1993).

Attorney's Fees/Costs - Although attorney's fees granted by the Insurance Commissioner in recent cases have generally been calculated at the amount of $125.00 per hour, a somewhat higher (or presumably lower) hourly rate may be appropriate under certain particular factual circumstances.
Grugel v. USAA Casualty, MVI-92-175 (CFO June 18, 1993).

Attorney's Fees/Costs - "HRS § 431:10C-211(a) was intended to compensate insureds who are forced to take action against their insurer because of an alleged improper denial of benefits. This section does not authorize an award of reasonable attorney's fees and costs for work an attorney does on behalf of his client until a denial is issued by the insurer."
Martinez v. AIG Hawaii, MVI-92-160 (CFO March 31, 1993); and *Merrill v. Hawaiian Ins.*, MVI-87-25 (CFO September 23, 1992).

Attorney's Fees/Costs - "The permissive authority to approve attorney's fees and/or costs still requires a determination that the amounts be reasonable and that charges for unnecessary or unrelated legal services will not be awarded."
Martinez v. AIG Hawaii, MVI-92-160 (CFO March 31, 1993); and *Nakamoto v. State Farm*, MVI-89-93 (CFO July 8, 1991).

Attorney's Fees/Costs - "A determination of the reasonableness of a request for attorney's fees and/or costs rests upon a factual evaluation of the time and quality of the work performed in light of the applicable standards of practice and fees charged for similar work within the legal profession."
Martinez v. AIG Hawaii, MVI-92-160 (CFO March 31, 1993).

Attorney's Fees/Costs - "It is important to note that the provisions of the statute [HRS § 431:10C-211] require - as a mandatory threshold requirement - that the Claimant establish that the claim being presented is not fraudulent, excessive, nor frivolous. It is also important to note that meeting this threshold is no guaranty of an award. This issue has been considered on previous occasions and the Insurance Commissioner has clearly stated that: "[A]ny award of attorney's fees and/or costs is clearly discretionary. The foremost goal of these administrative proceedings is the just application of Hawaii's no-fault statutes in accordance with the purpose stated in HRS § 431:10C-102(a), and does not include automatic, mandatory or unscrutinized awards of attorney's fees or costs to either party." *Spangler v. Pacific Ins.*, MVI-91-131 (CFO-R October 30, 1992); and, *Oslund v. State Farm*, MVI-89-101 (CFO March 18, 1991).

Attorney's Fees/Costs - The jurisdiction of the Insurance Commissioner to award reasonable attorney's fees and/or costs under HRS 431:10C-211(a) generally does not include amounts incurred by the parties after the issuance of the

Commissioner's Final Order in a given matter. Where a Commissioner's Final Order has been sustained on appeal, any award of fees and costs incurred on appeal is an issue for determination by the court, although the Commissioner does have authority to enforce compliance with the terms of the Commissioner's Final Order.
Merrill v. Hawaiian Ins., MVI-87-25 (CFO September 23, 1992).

Attorney's Fees/Costs - In matters where, as a threshold consideration, the Commissioner has determined that an award of attorney's fees or costs is appropriate, only those fees or costs which are reasonable may be awarded, and the party seeking them has the burden of proving their reasonableness as a matter of fact. The various factors which may be applicable in measuring reasonableness in particular circumstances may include those set out in the Code of Professional Responsibility (EC-218 and DR 2-106) as well as elements set out in *Sebastian v. State Farm*, MVI-88-30A (CFO May 22, 1989).
Merrill v. Hawaiian Ins., MVI-87-25 (CFO September 23, 1992).

Attorney's Fees/Costs - There is specific statutory authority in HRS §431:10C-211 for the discretionary award of reasonable (and appropriate) costs incurred by either party, including an award of such items as expert witness fees.
Baker v. AIG Hawaii, MVI-90-101 (MVI-DR-91-11) (CFO June 25, 1992); *Wemple v. AIG Hawaii*, MVI-90-104 (CFO April 22, 1991); *Fujimoto v. AIG Hawaii*, MVI-89-97 (CFO June 22, 1990); and, *Calicdan v. AIG Hawaii*, MVI-89-81 (CFO March 23, 1990).

Attorney's Fees/Costs - "In addition to the specific provisions of HRS §431:10C-211, the weight of previous administrative caselaw supports a determination that the Insurance Commissioner has the authority to include expert witness fees among the costs which, if reasonably incurred, may be included in an award of attorney's fees and costs."
Baker v. AIG Hawaii, MVI-90-101 (MVI-DR-91-11) (CFO June 25, 1992).

Attorney's Fees/Costs - A review of the Insurance Commissioner's discretionary authority to award reasonable attorney's fees and costs in light of: 1) the statutory authority contained in HRS § 431:10C-211; 2) the legislative purpose of the no-fault law as set out in HRS § 431:10C-102(a); 3) the similarities and differences between civil litigation in the judicial branch and administrative proceedings in the executive branch, as well as 4) the weight of previous administrative case law, supports a determination that expert witness fees - if reasonably incurred - may be included in an award of attorney's fees and costs.
Baker v. AIG Hawaii, MVI-90-101 (MVI-DR-91-11) (CFO June 25, 1992).

Attorney's Fees/Costs - The provisions of HRS § 431:10C-211 provide a valid statutory basis for the award of particular fees and costs, including those reasonably incurred with respect to expert witnesses, incurred by a party in the course of resolving a no-fault dispute through an administrative hearing.
Baker v. AIG Hawaii, MVI-90-101 (MVI-DR-91-11) (CFO June 25, 1992).

Attorney's Fees/Costs - The guidance provided by statutes and cases within the judicial forum indicate that the inclusion of expert witness fees as part of an award of attorney's fees or costs resulting from a proceeding within the administrative forum should not be allowed.
Sur v. GEICO, MVI-90-53 (CFO March 5, 1991) [Note: overruled on this issue by *Baker v. AIG Hawaii*, MVI-90-101 (MVI-DR-91-11) (CFO June 25, 1992)].

Attorney's Fees/Costs - In order for a respondent to show entitlement to an award of attorney's fees or costs under the HRS § 431:10C-211 requirements for fraudulent or frivolous standards, it must be shown that the claimant was pursuing a claim "with a purpose or design to carry out a fraud, ... or done with the intent to deceive", or else that the claim was "manifestly and palpably without merit."
Tran v. Liberty Mutual/Hawaiian, MVI-90-74+ (CFO January 8, 1991).

Attorney's Fees/Costs - A determination of the reasonableness of a request for attorney's fees and/or costs rests upon a factual evaluation of the quality of work performed by the attorneys in light of the circumstances surrounding a particular matter as well as applicable standards of practice and fees charged for similar work within the legal profession.
Sebastian v. State Farm, MVI-88-30A (CFO May 22, 1989).

Attorney's Fees/Costs - "As a general guideline, the attorneys for the parties should prepare their cases as though their clients will be paying for their respective fees and costs, and the clients so informed.... In the final analysis, the request for a reasonable sum of attorney's fees made pursuant to HRS §§ 294-30(a) and 431:10C-211(a), is made by and on behalf of the claimant, and not by the claimant's attorney."
Sebastian v. State Farm, MVI-88-30A (CFO May 22, 1989).

Attorney's Fees/Costs - "In summary, in order to determine the reasonableness of requested attorney's fees, the following factors will be considered significant: 1) the amount of the underlying claim for no-fault benefits; 2) the complexity and nature of the issues presented; 3) the efforts of the parties in trying to resolve the underlying issues; and 4) the fee customarily charged in the locality for similar legal services in light of the experience, reputation, and ability of the lawyer or lawyers performing the services."
Sebastian v. State Farm, MVI-88-30A (CFO May 22, 1989).

Attorney's Fees/Costs - In the case of *Wong v. Hawaiian Ins. Companies*, 64 Haw. 189, 637 P.2d 1144 (1981), the Supreme Court considered the provisions of HRS § 294-30(a) [Section 4311:10C-211(a)] and held that the trial court has discretion to award attorney's fees and costs to a claimant and that: 1) the decision to award; as well as, 2) the decision as to the amount, would not be set aside unless there was an abuse of discretion.
Sebastian v. State Farm, MVI-88-30A (CFO May 22, 1989).

Attorney's Fees/Costs - The items which may be included in an award of attorney's fees and costs - so long as appropriately incurred and reasonably billed - may include the expense incurred in obtaining narrative reports from an expert witness as well as the cancellation fee of an expert witness because of the untimely cancellation of an appointment.
Hatchie v. State Farm, MVI-87-20 (CFO February 19, 1988).

Attorney's Fees/Costs - "[I]t is clear that in order for a claimant to be entitled to attorney's fees ... "an insurer must indicate some kind of denial of no-fault benefits, or otherwise refuse or fail to pay no-fault benefits to a claimant."
Strawbridge v. Hawaiian Ins., MVI-86-23 (CFO May 13, 1987).

Attorney's Fees/Costs - Any award of attorney's fees are to be treated separately from any claim for no-fault benefits and, if awarded to a claimant, must be paid directly by the insurer to the claimant's attorney.
Strawbridge v. Hawaiian Ins., MVI-86-23 (CFO May 13, 1987).

BASIS OF DENIAL

Basis of Denial – "[W]here the rationale for a no-fault denial is unclear, it will be interpreted in favor of the claimant in accordance with the principles of construction by which unclear documents are construed against the party who drafted them."
Naluai v. AIG Hawaii, MVI 2000-40+ (CFO December 4, 2001).

Basis of Denial – "The issue or issues to be determined in a hearing on an insurer's denial of no-fault benefits is initially determined from an examination of the denial form itself. It is incumbent upon a respondent to articulate in straightforward language a valid reason for issuing any denial of no-fault benefits."
Naluai v. AIG Hawaii, MVI 2000-40+ (CFO December 4, 2001).

Basis of Denial – "A claimant – especially one representing herself – should not have to search secondary documents in order to prepare for, or protect one's self from, the later assertion of other potential bases that might provide an alternative rationale for a respondent's denial."
Naluai v. AIG Hawaii, MVI 2000-40+ (CFO December 4, 2001).

Basis of Denial – Where a licensed massage therapist has provided therapeutic services to a claimant in accordance with a physician's prescription and has billed for them, the insurer may not deny payment for such services on the basis that they were not provided in a massage establishment which was then licensed by the State. The subject of enforcing the licensing requirements of the establishment itself is a separate regulatory matter for potential consideration in separate (disciplinary) proceedings.
Chun v. Progressive, ATX-2000-184 (CFO September 10, 2001).

Basis of Denial – A claimant is not required to guess or speculate about the basis for a respondent's denial of benefits. A respondent must clearly state its reason/basis for issuing the denial, and only the reason/basis so stated will be considered in determining the merit of the denial – unless otherwise stipulated to or tried by the parties during the course of the proceedings.
Chong v. AIG Hawaii, ATX-2001-20+ (CFO August 22, 2001).

Basis of Denial – A respondent's preemptive issuance of a denial in anticipation of a claim for no-fault benefits was procedurally improper "because it was a denial of prospective benefits that had not accrued and for which [the] Claimant had not submitted a claim."
Espiritu v. State Farm, MVI-94-56-C (CFO June 20, 2001).

Basis of Denial – A respondent's error in referring to HRS § 431:10C-315(2) rather than HRS § 431:10C-315(a)(2) in its statement of the basis for a denial

was *de minimus* and the claimant was neither misled nor prejudiced by the erroneous citation.
Santos v. AIG Hawaii, MVI-2000-57 (CFO April 20, 2001).

Basis of Denial – Where the sole basis for a respondent's denial was that certain health care treatment provided to the claimant was "not reasonable and appropriate", and the parties neither stipulated nor otherwise consented to consider "causation" as another basis for the denial, the only issue for determination was the reasonableness and propriety of the treatment.
Jou/Pulido v. AIG Hawaii, ATX-2000-103-P+ *(CFO March 27, 2001); and, Jou/Sekiya v. AIG Hawaii*, ATX-2000-102-P (CFO January 30, 2001).

***Basis of Denial* –** An insuer may condition its payment of no-fault benefits upon an insured's cooperation in attending an "independent medical examination" (IME) consistent with the provisions of HAR § 16-23-4(b) and, where an insured has negligently failed to attend a regularly scheduled IME, an insurer may require reasonable reimbursement from the insured for costs associated with that IME before agreeing to reschedule it. In order to be considered reasonable, however, the amount of reimbursement requested by the insurer should not exceed the payment limitations for such services as stated in HRS § 431:10C-308.5(b).
Perucho v. AIG Hawaii, ATX-2000-81+ (CFO February 1, 2001).

Basis of Denial – "[I]t is well recognized that insurance policies are subject to the general rules of contract construction [citation omitted] and while the rather general language in the "cooperation clause" suggests that it requires rather broad cooperation by insureds, it must still be tempered by considerations of *reasonableness*. Furthermore, since insurance policies are contracts of adhesion, their language is to be liberally construed in favor of the insured and against the insurer."
Vallejos v. AIG Hawaii, MVI-98-267+ (CFO August 31, 2000).

Basis of Denial – An insurer's "spontaneous" issuance of a denial of no-fault benefits which is generated in the absence of either a pending request for the payment of a claimant's no-fault benefits or a request by the claimant for prior authorization of certain treatment is procedurally improper. "[A] formal denial of no-fault benefits should only be issued in response to a claimant's or provider's request for the payment of no-fault benefits, or authorization to receive treatment."
Dolor v. USAA, MVI-2000-8 (CFO August 17, 2000).

Basis of Denial – "[A]n insured would have a difficult time successfully challenging a spontaneous denial of future treatment in situations where the insured was not experiencing accident-related symptoms as of the date of the denial. … [T]he claimant would have to prove by a preponderance of the evidence that it was more likely than not that the claimant would require some form of additional treatment or benefits within the applicable statute of limitations. This type of

speculative presentation places an undue burden on the insured vis a vis the insurer's desire to resolve and close claims as quickly as possible."
Dolor v. USAA, MVI-2000-8 (CFO August 17, 2000).

Basis of Denial – Under the provisions of HRS § 431:10C-304(3)(C) a respondent may delay a pay/deny decision for a reasonable time pending the receipt of additional information, but once the information is received (or it becomes clear that no further information will be received) the respondent must act upon whatever information is then available by either paying the claim or denying it.
Kuahane v. TIG Insurance, MVI-97-1656 (CFO August 4, 2000) [Note: affirmed on this issue, Civil No. 00-1-2742-09 (3-20-01)].

Basis of Denial – "It is well settled that an insurer cannot withhold payment of no-fault benefits pending the outcome of an IME. Prior caselaw … reflected the well-reasoned determination that a request for an IME does not constitute a request for additional information pursuant to HRS § 431:10C-304(3)(C). Therefore, an insurer's refusal to pay no-fault benefits pending an IME constitutes a prospective denial and is improper."
Kuahane v. TIG Insurance, MVI-97-1656 (CFO August 4, 2000)) [Note: affirmed on this issue, Civil No. 00-1-2742-09 (3-20-01)].

Basis of Denial – "A prospective denial of future benefits is contrary to the purpose of the Hawaii motor vehicle insurance law, set forth in HRS § 431:10C-102, as a system of reparations. [citation omitted] Prospective denials can have an unfair, chilling effect on individuals who wish to pursue further treatment and are improper. In the event that the Claimant does experience bona fide flare-ups and pain as a result of the motor vehicle accident, he should be entitled to reasonable and appropriate treatment, even if it is palliative care to help in the management of his pain."
Nemec v. AIG Hawaii, MVI-97-1018-C+ (CFO July 26, 2000) [Note: affirmed on factual grounds distinguishable from this issue, Civil No. 00-1-2636-08 (4-6-01)].

Basis of Denial – The provisions of HRS § 431:10C-304(3)(B) require that when an insurer elects to deny a claim "the insurer shall within thirty days notify the claimant in writing of the denial and the reasons for the denial." The caselaw has quite reasonably interpreted this requirement as meaning that the reasons for the denial must be articulated in straight language that is understandable to the reader, and that otherwise the denial would be legally inappropriate. "The Respondent's argument that the incorporation of a letter attached to the subject denial under the section identifying the particular benefits being denied can be considered as [a] separate basis for the denial of the contested benefits, is not persuasive."
Hyman/Pimental v. Liberty Mutual, MVI-97-205-P *et. seq*. (CFO July 10, 2000).

Basis of Denial – As stated in HRS § 431:10C-102, the purpose of the Hawaii motor vehicle insurance law is "a system of *reparations*" for accidental harm and loss ... [and] … "that the correct interpretation of the law governing the operation

of that system requires the consideration of claims for benefits which have been asserted for *previously incurred* losses that had been subsequently denied."
Sickel v. GEICO, MVI-96-595 (CFO May 24, 2000).

Basis of Denial – "The rights of insureds as reflected in [HRS] § 431:10C-303 and the obligations of insurers as reflected in HRS § 431:10C-304 require that their disputes focus on events as of the time of the denial, rather than on speculative events which may have occurred (or information which may have become available) after that time. … An insurer may neither base a denial on the predicted occurrence/outcome of some future event, nor subsequently validate such a denial on the actual occurrence/outcome of that event."
Sickel v. GEICO, MVI-96-595 (CFO May 24, 2000).

Basis of Denial – "[A]s stated in HRS § 431:10C-102, the purpose of the Hawaii motor vehicle insurance law is 'a system of *reparations'* (Emphasis added). It has also been uniformly understood … that the correct interpretation of the law governing the operation of that system requires the consideration of claims for benefits which have been asserted for *previously incurred* losses that had been subsequently denied. (Citations omitted) Although previous caselaw has also recognized limited exceptions to this interpretation under specific circumstances … the general prohibition on prospective denials has remained as the correct interpretation of both the letter of the law and the intent of the legislature. This is particularly true in the area of health care treatments."
Sickel v. GEICO, MVI-96-595 (CFO May 24, 2000).

Basis of Denial – "The rights of insureds as reflected in [HRS] § 431:10C-303 and the obligations of insurers as reflected in HRS § 431:10C-304 require that their disputes focus on events as of the time of the denial, rather than on speculative events which may have occurred (or information that may have become available) after that time. Experience has shown … that prospective denials can have an unfair, chilling effect on individuals who wish to pursue further treatment, and it is indeed unlikely that the issuance of an additional (later) denial would constitute an unfair burden on the resources of insurers. An insurer may neither base a denial on the predicted occurrence/outcome of some future event, nor subsequently validate such a denial on the actual occurrence/outcome of that event. (Citations omitted)."
Sickel v. GEICO, MVI-96-595 (CFO May 24, 2000).

Basis of Denial – A respondent may have been partially correct in relying on an IME which determined that a claimant was not entitled to particular no-fault benefits, and yet may have acted improperly by issuing a blanket denial of all benefits (including those that might be incurred in the future) without a reasonable basis for such action.
Chong v. Island Insurance, MVI-98-644 (CFO September 16, 1999*)*; *Howard v. USAA,* MVI-94-512 (CFO August 2, 1999); and, *Hotchkiss v. AIG Hawaii*, MVI-90-103 (CFO July 18, 1991).

Basis of Denial – A respondent's fallacious assumption that palliative care does not qualify as a legitimate no-fault benefit, is not a valid basis for issuing a denial.
Ma v. Liberty Mutual, MVI-96-1422-P (CFO February 26, 1999).

Basis of Denial - "[A] respondent's unlimited and/or future denial of certain no-fault benefits (based upon the peer review report of a treatment plan - yet beyond the scope of the treatment plan) is contrary to the statutory provisions set out in HRS § 431:10C-304(3), and thus at least that portion of the denial is improper and invalid on its face."
Vea v. Liberty Mutual, MVI-96-793-C+ (CFO September 11, 1998).

Basis of denial - A respondent's partial payment of no-fault benefits without issuing written notification of a denial for the unpaid balance of the claim(s) constitutes a violation of the requirements in HRS § 431:10C-304(3).
HEPA/Adams v. State Farm, MVI-96-1024 (CFO August 4, 1998).

Basis of denial - A denial of benefits may be constructed to effectuate the statutory intent of allowing claimants or providers to request an administrative hearing under circumstances where a respondent has failed to comply with the mandatory notification requirements that are set out in HRS § 431:10C-304(3).
HEPA/Adams v. State Farm, MVI-96-1024 (CFO August 4, 1998).

Basis of Denial - "[T]he procedurally improper activities of Respondent, where it paid only a part of the claims submitted for payment and thereafter knowingly and deliberately failed to issue a written notice of denial of the unpaid portion, obligated it to pay the balance of the outstanding claims submitted by Provider."
HEPA/Adams v. State Farm, MVI-96-1024 (CFO August 4, 1998).

Basis of Denial – "A request that a claimant undergo an IME is a procedure to obtain new information by having a claimant submit to an evaluation of a claimant's condition by the insurer's representative. Accordingly, … [the] Respondent's request that Claimant undergo an IME was not a request for additional information which, pursuant to HRS § 431:10C-304(3) would have tolled the running of the thirty day period within which Respondent was obligated to pay or deny … benefits[.]"
Honda v. State Farm, MVI-96-85-C (CFO March 19, 1998).

Basis of Denial – The peer review procedures enacted by the 1992 legislative session and effective as of January 1, 1993 are not applicable to the evaluation of claims arising out of motor vehicle accidents which occurred prior to January 1, 1993, and consequently may not be used as a basis for an insurer issuing a denial of no-fault benefits.
Yamane v. State Farm, MVI-94-298-C (CFO September 18, 1997).

Basis of Denial – Where a respondent's request for peer review was based upon a challenge to "continued treatment or service" pursuant to HRS § 431:10C-308.6(c) and not to a "treatment plan" pursuant to HRS § 431:10C-308.6(d) the treatment proposed in a specific treatment plan was not properly challenged and thus was approved by default.
Yamada v. State Farm, MVI-94-398-C (CFO July 15, 1997); and, *Tanksley/Melim v. State Farm*, MVI-95-414-P (CFO May 5, 1997).

Basis of Denial – A respondent need not present a claimant with pre-IME certification that the respondent's payment for the IME will not exceed the limitations on charges set out in HRS § 431:10C-308.5. The statute requires physicians, not insurers, to certify on the (post IME) billing that the charges are in accordance with its limitations, and is not a basis upon which a claimant can legitimately refuse to participate in an independent medical exam.
Durand v. GEICO, MVI-95-261 (CFO June 26, 1997).

Basis of Denial – Where a respondent's blanket denial of "any benefits" is unsupported by a preponderance of the evidence introduced at the hearing, and yet that same evidence: 1) fails to establish the extent of the claimant's injuries/treatment; and, 2) fails to establish what bills had been received by the respondent for the payment of treatments received by the claimant, the record is insufficient to allow for findings that would support the underlying claim.
Fays v. Hartford Insurance, MVI-96-440-C (CFO June 18, 1997).

Basis of Denial – "In light of [the] Respondent's procedurally improper denial it is unnecessry to conduct any further proceedings to address the substantive merit, if any, of the denial, and [the] Respondent is obligated to pay the contested no-fault benefits."
Ferreira v. Hawaiian Insurance, MVI-95-513-C (CFO June 18, 1997).

Basis of Denial – A request for a hearing by either a claimant or a provider (to contest a respondent's denial of no-fault benefits) must comply with all of the requirements specified in HRS § 431:10C-212(a) and the result of a failure to do so is that the requesting party is not entitled to a hearing.
Hyman/Butuyan v. State Farm, MVI-96-74-P (CFO April 3, 1997).

Basis of Denial – "An open ended denial of future benefits is contrary to the statutory provisions set out in HRS § 431:10C-304(3) and is, on its face, procedurally invalid. Where additional bills have been received by an insurer after its issuance of a denial, the law (except in limited circumstances involving HRS § 431:10C-308.6 denials of treatment plan requests) requires that they be responded to by one of the three options set out in HRS § 431:10C-304(3). The law does not allow for a previously issued denial of benefits to serve as a basis for the subsequent denial of additional bills for treatment incurred in the future."
Ho v. Hawaiian Insurance, MVI-94-391 (CFO February 18, 1997).

Basis of Denial – "Although claimants, respondents, and providers may voluntarily choose to rely on previous denials of no-fault benefits (and/or their adjudication through the administrative hearing process) as a guide for predicting what benefits might be allowable in the future, past denials do not constitute mandatory determinations of potential future claims."
Ho v. Hawaiian Insurance, MVI-94-391 (CFO February 15, 1997).

Basis of Denial – "The issue or issues to be determined where a claimant has requested a hearing to challenge [contest] a respondent's denial of no-fault benefits is principally determined from an examination of the denial form itself."
Ho v. Hawaiian Insurance, MVI-94-391 (CFO February 15, 1997).

Basis of Denial – "An administrative hearing is a look backward in time to assess the situation as it existed when a denial of no-fault benefits was made.... Its primary purpose is not to evaluate subsequent conduct by either party for the purpose of predicting what, if any, no-fault benefits would be appropriate in the future."
Ho v. Hawaiian Insurance, MVI-94-391 (CFO February 14, 1997); *Perreira-Pico v. GEICO*, MVI-94-27 (CFO April 12, 1995); and, *Yung v. AIG Hawaii*, MVI-91-134 (CFO July 28, 1992).

Basis of Denial – A respondent's unlimited denial of certain no-fault benefits, which was construed in conjunction with a peer review report, was intended to deny future no-fault benefits in excess of those proposed by the treatment plan, and thus at least that portion of the denial was improper and invalid on its face.
Federico v. Allstate, MVI-94-157-C (CFO January 15, 1997).

Basis of Denial – "While the initial analysis of the propriety of a no-fault denial is based on an evaluation of the content of the denial form itself, the content of other pleadings, acknowledgements made at the pre-hearing conference, or the conduct of the proceeding itself may be considered in analyzing the basis of a denial if the language in the form itself does not articulate a clear basis."
Entendencia v. Dollar, MVI-94-498 (CFO January 15, 1997); and, *Arashiro v. GEICO*, MVI-92-219 (CFO September 17, 1993).

Basis of Denial – "A respondent may not withhold/deny benefits under HRS § 431:10C-304(3)(C) pending the outcome of a future independent medical examination, or any other unilaterally imposed and clearly impermissible basis. The language of the statute simply does not permit an insurer to impose such conditions, as distinguished from making a reasonable request for existing documents, as a basis for withholding/denying no-fault insurance benefits."
Lucas v. AIG Hawaii, MVI-94-165 (CFO October 30, 1996) [Note: affirmed by summary dispositional order - S.C. No. 21464 (12-28-98)]; *Pacubas v. AIG Hawaii*, MVI-93-184 (CFO October 10, 1994); and, *Calatrava v. AIG Hawaii*, MVI-93-76+ (CFO March 4, 1994).

Basis of Denial – A provider's treatment plan request which does not comply with the regulatory provisions of HAR § 16-23-95 may be rejected by the insurer without resort to the statutory provisions of HRS § 431:10C-308.6.
Antolin v. State Farm, MVI-94-538-C (CFO September 23, 1996).

Basis of Denial – "The denial of a treatment plan request pursuant to the provisions of HRS § 431:10C-308.6 is limited to the content of the plan itself and the denial of any benefits that are not included in the plan or extend beyond the timeframe covered by the plan, is improper and misleading."
Dunn v. GEICO, MVI-94-574-C (CFO July 12, 1996).

Basis of Denial – The issuance of a denial of no-fault benefits based upon a peer review report stating - that a claimant's condition could not be attributed to his motor vehicle accident was invalid on its face, as causation is not an issue for determination by peer review and thus not a proper basis for the subsequent issuance of a denial pursuant to a peer review report.
Randall v. USAA, MVI-94-625-C (CFO July 10, 1996).

Basis of Denial – An insurer's refusal to pay no-fault insurance benefits pending an IME constitutes a prospective denial and has consistently been ruled to be a violation of HRS § 431:10C-304(3)(c) since it does not qualify as a "required document" which could be requested in the case where an insurer needs "additional information or loss documentation."
Khan-Miyasaki v. State Farm, MVI-94-276 (CFO March 12, 1996).

Basis of Denial – The only ground for an insurer to issue a denial of benefits pursuant to a peer review organization determination is that the treatment in question is not appropriate or reasonable. HAR § 16-23-118(e). Other grounds such as causation are simply not subject to the peer review process outlined in HRS § 431:10C-308.6.
Hilario v. State Farm, MVI-93-193 (CFO March 12, 1996).

Basis of Denial – "Only challenges based on whether treatment is appropriate or reasonable shall be filed with the commissioner for submission to a peer review organization. Denials or partial denials of claims based on other grounds, such as coverage questions, shall not be subject to peer review. Section 16-23-118."
Hilario v. State Farm, MVI-93-193 (CFO March 12, 1996).

Basis of Denial – "The issue or issues to be determined where a claimant has requested a hearing to challenge a respondent's denial of no-fault benefits is principally determined from an examination of the denial form itself. Other issues which might provide a basis for the denial are not considered in determining its merits unless they are stipulated to by the parties, or tried by the consent of the parties during the course of the proceedings."

Valdez v. GEICO, MVI-94-340-C+ (CFO January 10, 1996); *Elarmo v. Island*, MVI-93-260 (CFO January 24, 1995); *Aoki v. AIG Hawaii*, MVI-93-281-C (CFO October 27, 1994); *Valdez v. GEICO*, MVI-93-39+ (CFO February 15, 1994); *Bernabe(s) v. AIG Hawaii*, MVI-93-6 (CFO November 24, 1993); *Baugh v. AIG Hawaii*, MVI-92-146 (CFO May 19, 1993); *Tadeo v. AIG Hawaii*, MVI-92-118 (CFO March 8, 1993); and, *Fujimoto v. AIG Hawaii*, MVI-89-97 (CFO June 22, 1990).

Basis of Denial – Where the rationale for a no-fault denial is unclear, it will be interpreted in favor of the claimant in accordance with the principles of construction by which unclear documents are construed against the party who drafted them.
Valdez v. GEICO, MVI-94-340-C+ (CFO January 10, 1996); *Sumter v. GEICO*, MVI-94-61-C (CFO February 2, 1995); and, *Rivera v. USAA Casualty*, MVI-92-66 (CFO July 2, 1993).

Basis of Denial – It should be noted that issues other than the appropriateness and reasonableness of health care treatment and services for injuries - such as the cause of an injury claimed to have been the result of an accident - are not subject to the PRO evaluation process envisioned by HRS § 431:10C-308.6 and HAR § 16-23-118(e).
Ching v. AIG Hawaii, MVI-94-89-C (CFO January 5, 1996).

Basis of Denial – "Any determination of the merits of a denial based on a peer review recommendation under HRS § 431:10C-308.6 has the same procedural and substantive requirements - including same standard of review - as all other administrative proceedings initiated under HRS § 431:10C-212."
Pecson v. GEICO, MVI-94-254-C (CFO September 15, 1995).

Basis of Denial – Where a respondent has limited its challenge to a specific treatment plan or to specific bills for treatment that has been rendered it may not thereafter issue a denial which includes prospective benefits beyond the scope of either the existing plan or the existing bills.
Eder v. State Farm, MVI-94-135-C (CFO September 15, 1995); and, *Butuyan v. State Farm*, MVI-93-257-C (CFO January 9, 1995) [Note: overruled by *Swords v. Commercial Union*, MVI-95-126 (CFO September 18, 1997) – affirmed on this issue, Civil No. 97-4064-10 (11-4-98) - (pending further appeal)].

Basis of Denial – "A respondent may be partially correct in determining that a claimant is not entitled to particular no-fault benefits, and yet may have acted improperly by issuing a blanket denial of any benefits without a reasonable basis for such action." While such conduct may warrant the imposition of sanctions under the penalty provisions contained in HRS § 431:10C-117(b) and (c), it is generally not a sufficient reason for invalidating the entire denial.
Brown v. AIG Hawaii, MVI-94-91-C (CFO March 28, 1995); and, *Sumter v. GEICO*, MVI-94-61-C (CFO February 2, 1995).

Basis of Denial – Where a respondent has limited its denial of a claimant's benefits to "treatment" it may not use that denial as a basis for withholding payments on a providers bill for "diagnostic" services which have not otherwise been denied.
Sua v. State Farm, MVI-94-39 (CFO March 16, 1995).

Basis of Denial – "A no-fault denial form should state, on its face, a valid reason - by legal reference or by statement of fact - for its issuance, without simply referring to additional documents which require further interpretation in order to establish that reason."
Naluai v. AIG Hawaii, MVI 2000-40+ (CFO December 4, 2001), and *Elarmo v. Island Ins.*, MVI-93-260 (CFO January 24, 1995).

Basis of Denial – "The provisions of HRS Chapter 431 do not preclude a claimant from being eligible for no-fault benefits simply because the same incident upon which his or her claim is based may also establish eligibility for worker's compensation benefits under HRS Chapter 386. ... Similarly, while the payment of worker's compensation benefits, or the compromise of a worker's compensation claim pursuant to HRS § 386-78, will normally impact on the source and scope of no-fault payments, neither event, in itself, extinguishes a respondent's obligation to pay no-fault benefits pursuant to HRS § 431:10C-304."
Elarmo v. Island, MVI-93-260 (CFO January 24, 1995).

Basis of Denial – "A threshold determination must be made in evaluating a no-fault denial as to whether, as a procedural matter, it actually states a valid reason for the respondent's actions. It is incumbent upon a respondent to articulate - in straight forward language - its rationale for issuing the denial, and where a respondent fails to do so in the denial itself , the Hearings Officer may look to the pleadings, the pre-hearing conference, or the conduct of the hearing itself to make this determination."
Aoki v. AIG Hawaii, MVI-93-281-C (CFO October 27, 1994); *Rivera v. USAA Casualty*, MVI-92-66 (CFO July 2, 1993).

Basis of Denial – When a respondent challenges a claimant's health care treatment by utilizing the peer review process, it may not subsequently issue a valid denial of such treatment for a reason (even if supported by the PRO evaluation) other than a determination that the treatment was not appropriate or reasonable. A correct reading of HRS § 431:10C-308.6 (in conjunction with the less authoritative and somewhat conflicting provisions of HAR § 16-23-118) precludes use of PROs as a basis for determining other issues.
Aoki v. AIG Hawaii, MVI-93-281-C (CFO October 26, 1994); and, *Germano v. State Farm*, MVI-94-18-C+ (CFO June 1, 1995).

Basis of Denial – A respondent may not issue a valid denial of no-fault benefits, pursuant to the peer review process envisioned by HRS § 431:10C-308.6,

and supplemented by HAR § 16-23-118, on a basis other than an assertion that the treatment at issue is not "appropriate and reasonable."
Aoki v. AIG Hawaii, MVI-93-281-C (CFO October 26, 1994).

Basis of Denial – Where the language used by a respondent in articulating the basis for issuing a denial of no-fault benefits shows that the denial is invalid on its face, a full hearing is not warranted to search beyond its face to see if the denial was nevertheless based upon meritorious intentions.
Aoki v. AIG Hawaii, MVI-93-281-C (CFO October 26, 1994).

Basis of Denial – Where a respondent has specifically based its denial of a claimant's benefits on the portion of a peer review evaluation which has gratuitously commented on "lack of causation" the result is an invalid denial - even if other portions of the peer review evaluation (which were neither articulated nor referred to in the denial) correctly commented on "appropriateness or reasonableness" of the challenged treatment.
Aoki v. AIG Hawaii, MVI-93-281-C (CFO October 26, 1994).

Basis of Denial – Where a respondent has challenged a claimant's health care treatment by utilizing the peer review process outlined in HRS § 431:10C-308.6, it is not permitted to thereafter issue a denial of no-fault benefits which is based on the peer review report for any reason other than its assertion that the treatment was inappropriate or unreasonable, even if some other reason (such as lack of causation) is supported by the content of the report.
Aoki v. AIG Hawaii, MVI-93-281-C (CFO October 26, 1994).

Basis of Denial – "A timely request for a narrative report from a treating health care provider or a request for copies of existing health care records may well constitute a proper course of action under HRS § 431:10C-304(3)(C) where reasonable doubt exists about the merit of alleged no-fault benefits. Furthermore, such a request, once issued, may be a valid basis to withhold payment on subsequent bills of the same nature until a determination can reasonably be made to either pay or deny the benefits."
Pacubas v. AIG Hawaii, MVI-93-184 (CFO October 10, 1994); and, *Alpuro v. AIG Hawaii*, MVI-92-154 (CFO June 15, 1993).

Basis of Denial – "The opinion of a health care provider regarding the status of a Claimants condition is only as good as the underlying information upon which it is based and the qualifications of the examiner to interpret that information in the form of an opinion." *Calatrava v. AIG Hawaii*, MVI-93-76+ (CFO March 4, 1994).

Basis of Denial – "It is incumbent upon a respondent to articulate in straight forward language, a valid reason for issuing any denial of no-fault benefits. ... Only those issues noticed in the denial itself or otherwise tried by the consent of the parties are considered in determining the merit of a no-fault denial."
Valdez v. GEICO, MVI-93-39+ (CFO February 15, 1994).

Basis of Denial – After a final order has been issued an insurer may not lawfully assert, as a basis to withhold payment of previously challenged benefits, a basis which was not previously asserted in the denial and found to be appropriate in the final order.
Bernabe(s) v. AIG Hawaii, MVI-93-6 (CFO November 24, 1993).

Basis of Denial – The provisions of HRS Chapter 431 do not preclude a Claimant from being eligible for no-fault benefits simply because the same incident upon which his or her claim is based may also establish eligibility for workers compensation benefits under HRS Chapter 386 and may ultimately result in some allocation of the source(s) of payments under the provisions of HRS § 431:10C-305.
Arashiro v. GEICO, MVI-92-219 (CFO September 17, 1993).

Basis of Denial – "It should be noted that HRS § 431:10C-305 is entitled "Source of payment" and focuses on the origin of payments to an eligible recipient under certain designated conditions. Since it deals with allocation of payment responsibilities, rather than eligibility for benefits, it is technically an inappropriate basis upon which to assert alleged ineligibility for such benefits."
Arashiro v. GEICO, MVI-92-219 (CFO September 17, 1993).

Basis of Denial – "Although the report resulting from an IME could assist the insurer in determining the validity of a claim, ... a request for an IME does not constitute a request for additional information pursuant to HRS § 431:10C-304(3)(C) and therefore, it was improper for [the] respondent to pend payment of outstanding bills until it obtained the results of an IME."
Boyle v. State Farm, MVI-92-103 (CFO September 14, 1993).

Basis of Denial – "[A]n invalid denial of no-fault benefits does not necessarily preclude a Respondent from successfully issuing a subsequent denial on the same (or other) basis in light of changed circumstances."
Baugh v. AIG Hawaii, MVI-92-146 (CFO May 19, 1993); *Tadeo v. AIG Hawaii*, MVI-92-118 (CFO March 8, 1993); and *Yung v. AIG Hawaii*, MVI-91-134 (CFO July 28, 1992).

Basis of Denial – An administrative evaluation of the merits of a no-fault denial focuses on events as of the time of the denial, rather than on events or information which may have occurred or become available after that time. An insurer must provide a valid existing reason for issuing a denial of benefits, and may neither base a denial on the predicted occurrence/outcome of some future event, nor subsequently validate such a denial on the actual occurrence/outcome of that event.
Martinez v. AIG Hawaii, MVI-92-160 (CFO March 31, 1993); *Spangler v. Pacific Ins.*, MVI-91-131 (CFO September 16, 1992); and, *Baker v. AIG Hawaii*, MVI-90-101 (CFO May 20, 1991).

Basis of Denial – "The issue or issues to be determined in a hearing on an insurer's denial of no-fault benefits is initially determined from an examination of the denial itself. It is incumbent upon a respondent to articulate in straightforward language a valid reason for issuing any denial of no-fault benefits."
Martinez v. AIG Hawaii, MVI-92-160 (CFO March 31, 1993); and, *Siu v. AIG Hawaii*, MVI-92-4 (CFO August 28, 1992).

Basis of Denial – "[T]he provisions of HRS § 431:10C-304(3) allow an insurer to reasonably require a health care provider to submit justification or additional documentation pertaining to treatment provided to an no-fault claimant, before the insurer decides to pay or deny no-fault benefits."
Key v. AIG Hawaii, MVI-91-58 (CFO December 18, 1992).

Basis of Denial – While an insurer may require an insured to submit to an independent medical examination as a condition for receiving no-fault benefits, any and all health care professionals designated by the insurer to perform such an examination must be duly licensed to practice their profession. Where one or more of the health care professionals offered to the insured failed to be properly licensed, the refusal of the claimant to submit to such an examination was not a valid basis for a denial of no-fault benefits.
Wade v. AIG Hawaii, MVI-92-50 (CFO October 8, 1992).

Basis of Denial – The failure of a claimant to comply with a respondent's reasonable request for an IME, as provided for in the applicable insurance policy provisions and consistent with HAR §§ 16-23-4 and 16-23-60, is generally a valid basis for a respondent to issue a denial of no-fault benefits.
Jose v. AIG Hawaii, MVI-92-44 (CFO September 23, 1992).

Basis of Denial – The issuance of a valid denial of benefits by a respondent on the basis of a claimant's failure to comply with a requested IME is procedural in nature and is not determinative of the underlying merit of any substantive claims which the claimant may have for particular no-fault benefits.
Jose v. AIG Hawaii, MVI-92-44 (CFO September 23, 1992); and *Yung v. AIG Hawaii*, MVI-91-134 (CFO July 28, 1992); and, *Cabudol, Jr. v. GEICO*, MVI-91-10 (CFO December 15, 1991).

Basis of Denial – "Although subsequent [post-denial but pre-hearing] corrective action by a respondent to bring a flawed denial of benefits up to the standards set out in HRS § 431:10C-304 will not necessarily shield the respondent from the imposition of sanctions, it may well preclude a claimant from successfully challenging the denial on a procedural basis in the absence of some other showing of prejudice."
Kennedy v. AIG Hawaii, MVI-92-28 (CFO September 9, 1992).

Basis of Denial – "An initial determination which must be made in evaluating a no-fault denial is: What is the legal basis for the respondent's denial of no-fault

benefits to the claimant? When a respondent fails to articulate such a basis in the denial itself, the hearings officer will look to the pleadings, the pre-hearing conference, or the conduct of the hearing to make this determination."
Hinzo v. AIG Hawaii, MVI-91-128 (CFO September 3, 1992); and, *Branch v. AIG Hawaii*, MVI-91-9 (CFO November 8, 1991).

Basis of Denial – "A valid denial of no-fault benefits does not necessarily preclude a claimant from successfully asserting a right to the same (or other) benefits at a subsequent time in light of changes circumstances. Similarly, an invalid denial of no-fault benefits does not necessarily preclude a respondent from successfully issuing a subsequent denial on the same (or other) basis in light of changed circumstances."
Yung v. AIG Hawaii, MVI-91-134 (CFO July 28, 1992).

Basis of Denial – "Although overall fact patterns may raise doubts about issues which have not been asserted as the basis of a respondent's actions, only those issues noticed in the denial itself or otherwise tried by the consent of the parties are considered in determining the merit of a no-fault denial."
Branch v. AIG Hawaii, MVI-91-9 (CFO November 8, 1991).

Basis of Denial – A respondent may be partially correct in determining that a claimant is not entitled to particular no-fault benefits, and yet may have acted improperly by issuing a blanket denial of any benefits without a reasonable basis for such action.
Hotchkiss v. AIG Hawaii, MVI-90-103 (CFO July 18, 1991).

Basis of Denial – A blanket denial of "any" benefits is clearly improper when the independent medical exam (which provided the basis for the denial) established only that passive modalities were improper given the stage of the claimant's recovery.
Hotchkiss v. AIG Hawaii, MVI-90-103 (CFO July 18, 1991).

Basis of Denial – It is worth noting whether there has been a significant passage of time between the date of a claimant's independent medical examination and the date of any denial of no-fault benefits based upon that examination. A denial of benefits based upon an evaluation which had been conducted many months earlier may be inappropriate, especially in the absence of any relevant information with respect to the claimant's actual condition at the time of the denial.
Rodrigues v. Maryland Casualty, MVI-90-123 (CFO June 3, 1991).

Basis of Denial – An insurer should specify both the type or types of benefits being denied as well as specifying the basis for the denial in the notice to a claimant. "A denial of no-fault benefits is generally a retrospective evaluation of the actual merit (or lack thereof) of benefits previously incurred rather than a prospective determination of the presumed merit (or lack thereof) of benefits which might be incurred in the future."

Davis v. National Union, MVI-89-107 (CFO November 15, 1990).

Basis of Denial – A denial of no-fault benefits should be specific in its terms and it is precipitous to deny all benefits when only certain benefits are really at issue. *Cortez v. American International*, MVI-88-87 (CFO September 27, 1990).

Basis of Denial – There is no requirement for "pre-approval" of services which qualify as no-fault benefits in the application of Hawaii's no-fault insurance law. Nevertheless, while a claimant is not required to obtain a respondent's approval prior to obtaining health care services, a claimant still has the burden of proof to establish that the cost of services which he or she has incurred do qualify for no-fault reimbursement.
Tanigawa v. First Ins., MVI-89-109 (CFO August 16, 1990).

Basis of Denial – A respondent's denial of wage loss benefits to a claimant based upon the results of an independent medical exam which predicts that a claimant will probably be able to resume employment in the near future (and therefore implicitly acknowledges that the claimant is not currently able to resume employment) was precipitous and based on an erroneous premise.
Paaoao v. Liberty Mutual, MVI-89-90 (CFO June 12, 1990).

BURDEN OF PROOF

BURDEN OF PROOF – "A respondent does not have an initial obligation to show that it has issued a procedurally lawful denial, and a claimant has the same burden of proof to establish the procedural invalidity (of the whole or any portion) of a respondent's denial of benefits that the claimant would otherwise have to establish the substantive merit of his or her own claim."
Dugaduga v. Allstate, MVI-2001-14 (CFO December 19, 2001).

Burden of Proof – A showing of a possibility that a claimant's condition resulted from a motor vehicle accident does not constitute sufficient evidence to satisfy the standard of proof required to establish causation.
Lewis v. Oahu Transit, ATX-2000-137+ (CFO August 9, 2001).

Burden of Proof – The opinions of health care providers are only as good as, *inter alia*, the factual bases underlying such opinions as explained (or not explained) by the provider, and where there is little or no supporting evidence for the opinion there is little or no reason to accept it as a valid conclusion.
Thomas v. AIG Hawaii, ATX-2000-164 (CFO July 5, 2001).

Burden of Proof – In a proceeding to determine the merit of a claim for attorney's fees and costs as a separate no-fault benefit "a claimant has the same burden of proof as is required in proving entitlement to any other no-fault benefit denied by a respondent."
Sildora v. AIG Hawaii, MVI-2001-1 (CFO June 20, 2001).

Burden of Proof – Under circumstances where, after the passage of many months without seeking health care services, a claimant obtains an opinion from a chiropracter which disagrees with the opinion of the claimant's initial treating physician (that the injuries were previously resolved), but the claimant does not testify at the hearing to offer a direct explanation for the gap in treatment or otherwise present evidence to justify the claimed benefits, it is unlikely that causation can be established between current injuries (if any) and the accident.
Ta v. State Farm, MVI-98-492 (CFO May 31, 2001).

Burden of Proof – A provider seeking reimbursement from an insurer for the amount of a disputed charge in an administrative proceeding initiated under the provisions of HAR § 16-23-120 has the same burden of proof as is required by a party seeking entitlement to any other no-fault benefit that has been denied by a respondent.
Jou/Leano v. GEICO, ATX-2000-208-P+ (CFO May 14, 2001).

Burden of Proof – "The fact that [a claimant] may have improved and may have recovered after receiving treatment … did not ipso facto establish that the

treatment prescribed and received by [the claimant] was reasonable and appropriate." A provider's (or claimant's) burden of proof imposes an obligation to affirmatively establish his or her entitlement to the contested personal injury protection benefits.
Jou/Pulido v. AIG Hawaii, ATX-2000-103-P+ (CFO March 27, 2001).

Burden of Proof – The factual assertions of a party must be founded upon evidence received during the hearing, and where a party has argued a factual position in the absence of evidence to support that position the Hearings Officer is unable to consider it as a basis for making recommendations.
Daso/Sapp v. Progressive Ins., MVI-99-117-P (CFO June 23, 2000).

Burden of Proof – Although a peer review evaluator may request more information from a provider to assist in his or her review of the provider's treatment plan request, there is no obligation to do so, as the provider should normally have included sufficient documentation to justify the plan within the existing records furnished to the peer review evaluator.
Daso/Sapp v. Progressive Ins., MVI-99-117-P (CFO June 23, 2000).

Burden of Proof – Where it has been factually determined that a claimant went to a hospital emergency room for health care treatment as a matter of personal convenience, rather than because of a need for emergency treatment or services as defined in HAR § 16-23-94, the treatment or services rendered do not fall within the exception to the fee schedule requirements set out in HAR § 16-23-93 for "emergency" care.
HEPA/Petty v. Hawaiian Insurance, ATX-99-78-P (CFO January 27, 2000).

Burden of Proof – "[A] "community standard", and not what the provider chooses to charge [for health care services], is the baseline for determining what shall be considered an appropriate and reasonable charge pursuant to HAR § 16-23-94."
HEPA/Matsuoka v. Hawaiian Insurance, ATX-99-79-P (CFO January 25, 2000).

Burden of Proof – In determining whether an "emergency" existed which would have warranted application of the fee schedule exception (for emergency treatment or services) as stated in HAR § 16-23-93, the focus is on the reasonably understood condition of the claimant under the immediacy of the circumstances, as perceived by the claimant or others. This determination involves a factual analysis in light of the information available at the time such treatment or services were received, rather than upon the results of some subsequent review of events which, retrospectively, might or might not reach the same conclusion.
HEPA/Matsuoka v. Hawaiian Insurance, ATX-99-80-P (CFO January 25, 2000).

Burden of Proof – The opinion of a health care provider is only as good as, *inter alia*, the factual basis underlying that opinion, and where there is little or no factual basis for the opinion there is little or no reason to validate it.

Hyman/Peralta v. State Farm, MVI-96-963-P+ (CFO December 30, 1999).

Burden of Proof – Although treatment proposed or rendered occurred some two and a half years after the claimant's motor vehicle accident, if the evidence establishes that it aided in the claimant's recovery and/or alleviated pain which had arisen out of that accident the treatment constituted a valid no fault benefit.
Hyman/Peralta v. State Farm, MVI-96-963-P+ (CFO December 30, 1999).

Burden of Proof – "[W]hen an insurer's conduct in issuing a denial is determined to be procedurally improper behavior because the insurer had failed to comply with applicable statutory and/or regulatory provisions, the insurer is obligated to pay for the contested no-fault benefits and no further proceedings to address the substantive merits, if any, of the denial is required."
Ramos v. Liberty Mutual, MVI-99-34-C (CFO September 9, 1999).

Burden of Proof – "Although there was a possibility that the symptoms in the Claimant's left shoulder were the result of injuries that she sustained in the subject accident, the existence of such [a] possibility did not satisfy the standard of proof required in these administrative proceedings."
Todd v. State Farm, MVI-96-1302+ (CFO July 26, 1999).

Burden of Proof – A claimant is required to assist in his or her recovery by pursuing a reasonable course of conduct for the restoration of his or her health. *Yang v. AIG Hawaii*, MVI-97-530-C (CFO July 15, 1999); *Hyman/Dayoan v. State Farm*, MVI-96-1387-P (CFO July 15, 1999); and, *Semana v. State Farm*, MVI-94-339-C (CFO February 26, 1998).

Burden of Proof – A party pursuing a claim for benefits has an affirmative burden of proof to establish entitlement to the contested benefits, and may not rely on simply casting doubts or suspicions upon the conduct or evidence presented by a responding party.
Currie v. AIG Hawaii, MVI-95-650-C (CFO July 15, 1999); and, *Yang v. AIG Hawaii*, MVI-97-530-C (CFO July 15, 1999).

Burden of Proof – In order to show entitlement to contested health care benefits, such as passive physical therapy, a claimant must establish that he or she would improve (or at least be reasonably better served) by the contested care than by other modalities, such as an active home exercise program.
Hyman/Dayoan v. State Farm, MVI-96-1387-P (CFO July 15, 1999).

Burden of Proof – A claimant is obligated to present a prima facie case with sufficient evidence to address each element of proof necessary to show that a respondent's denial of no-fault benefits was improper, and the failure to do so warrants the (procedural) granting of a motion to dismiss the claimants request for a hearing.
Scavitto v. State Farm, MVI-95-943 (CFO July 15, 1999).

Burden of Proof – A claimant must present credible evidence, as a threshold procedural matter, to show that some actual service/billing has been denied by the insurer, or face the prospect of having his or her request for a hearing being summarily dismissed as moot.
El-Zir v. AIG Hawaii, MVI-95-713-C (CFO July 14, 1999).

Burden of Proof – The possibility that the injuries for which a claimant is seeking no-fault benefits are related to a qualifying accident does not satisfy the standard of proof to establish causation, and the probability of such a connection decreases significantly where there has been a substantial passage of time between the accident and the subsequent treatment and/or inconsistencies between the claimant's statements and his or her medical records.
Kuhiki v. State Farm, MVI-95-616 (CFO October 26, 1998).

Burden of Proof – The analysis of a mechanical engineer (concerning the force of impact involved in a motor vehicle accident) - as well as the results of an independent medical examination which placed great reliance on the mechanical engineer's analysis - while of some interest, was not persuasive in determining whether the claimant's injuries were accident related.
Aila v. AIG Hawaii, MVI-94-390 (CFO October 21, 1998).

Burden of Proof – "The submission of a speculative treatment plan - such as the one prepared for the Claimants in this matter [p.r.n. or 'as needed' care] - does not allow for a definitive assessment of its content by either a respondent or a peer reviewer, and as such does not conform to the applicable provisions of the Hawaii motor vehicle insurance law nor the administrative rules and cases adopted in support of that law."
Vea v. Liberty Mutual, MVI-96-793-C+ (CFO September 11, 1998).

Burden of Proof – "[I]t is worth reemphasizing that a treatment plan proposing p.r.n. (as needed) treatments is inherently suspicious and unlikely to meet the statutory requirements for such documents. While the preparation of treatment plan requests remains an option of the provider, the exercise of this option under HRS § 431:10C-308.6 and HAR § 16-23-95 presupposes knowledge by the provider that the patient/claimant has a specific need for regularly scheduled services for the treatment of specific injuries. It also requires that the timing of visits, the treating modalities, and the intended goals be articulated with reasonable precision."
Vea v. Liberty Mutual, MVI-96-793-C+ (CFO September 11, 1998).

Burden of Proof – The failure of a claimant to testify at an administrative hearing in which he or she is contesting a denial of no-fault benefits may well have adverse consequences, especially where there is not sufficient alternative evidence to demonstrate that the claimant continued to suffer from injuries sustained in the motor vehicle accident or that the claimant's health care treatments were appropriate and reasonable.

Jou v. GEICO, MVI-96-766-P (CFO September 10, 1998).

Burden of Proof – A respondent's procedurally improper denial precludes the need to conduct further proceedings for addressing the substantive merit, if any, of the denial and obligates the respondent to pay the claimant's contested no-fault benefits.
Ferreira v. Hawaiian Insurance, MVI-95-513-C (CFO June 18, 1997).

Burden of Proof – Although it may be apparent that the symptoms experienced by a claimant several years after a motor vehicle accident might have been caused in that accident, establishing such a possibility is not by itself sufficient to meet the claimant's burden of proof by a preponderance of the evidence.
Puna v. State Farm, MVI-94-159 (CFO February 19, 1997).

Burden of Proof – "A respondent does not have an initial obligation to show that it has issued a procedurally lawful denial, and a claimant has the same burden of proof to establish the procedural invalidity (of the whole or any portion) of a respondent's denial of benefits that the claimant would otherwise have to establish the substantive merit of his or her own claim. On the other hand, where a claimant has met his or her burden of proof to establish that part of a respondent's denial is procedurally invalid, the claimant need not proceed to substantively prove the impropriety of that portion of the denial."
Arrington v. AIG Hawaii, MVI-94-710-C (CFO January 15, 1997).

Burden of Proof – "While it is often possible that a claimant's discomfort may be related to (i.e. caused by) a motor vehicle accident, the existence of such a possibility does not meet the standard of proof required in no-fault insurance proceedings. In order to prevail, it is not enough for a claimant to simply raise suspicion about the legitimacy of a respondent's denial in lieu of meeting the affirmative obligation to establish entitlement to the contested benefits."
Entendencia v. Dollar, MVI-94-498 (CFO January 15, 1997).

Burden of Proof – "In an administrative hearing of this nature, a claimant has the burden to prove the merits of his or her claim by a preponderance of the evidence pursuant to HRS § 91-10(5) and HAR § 16-201-21(d)."
Arrington v. AIG Hawaii, MVI-94-710-C (CFO January 15, 1997); *Entendencia v. Dollar,* MVI-94-498 (CFO January 15, 1997); *Dunn v. GEICO*, MVI-94-574-C (CFO July 12, 1996); *Ganal v. Travelers*, MVI-94-385 (CFO July 11, 1996); *Morales v. Allstate*, MVI-94-67 (CFO July 10, 1996); *Texeira v. Liberty Mutual*, MVI-94-569 (CFO May 15, 1996); *Cabral v. AIG Hawaii*, MVI-94-551 (CFO May 15, 1996); *McBeth v. Allstate*, MVI-94-439 (CFO March 12, 1996); *Valdez v. GEICO*, MVI-94-340-C+ (CFO January 10, 1996); *Carvalho v. AIG Hawaii*, MVI-94-222 (CFO December 8, 1995); *Martinez v. AIG Hawaii*, MVI-94-250 (CFO September 15, 1995); *Shi v. AIG Hawaii*, MVI-94-236 (CFO July 31, 1995); *Ringer v. AIG Hawaii*, MVI-94-127-C (CFO June 14, 1995); *Alameida v. Allstate*, MVI-94-161 (CFO April

21, 1995); *Yoshioka v. Transamerica*, MVI-94-23 (CFO April 21, 1995; and, *Nguyen v. Dai-Tokyo*, MVI-94-86 (CFO March 16, 1995).

Burden of Proof – A provider has the same burden of proof as a claimant in contesting a respondent's denial of no-fault benefits, and thus must show by a preponderance of the evidence that the denial was improper.
CHART v. State Farm, MVI-94-436-P (CFO September 23, 1996).

Burden of Proof – A provider's attack on the credibility of a peer review report, without the presentation of substantive evidence establishing that the treatment rendered by the provider was appropriate is, in itself, insufficient to meet the provider's burden of proof to show that the respondent's denial was improper. *CHART v. State Farm*, MVI-94-436-P (CFO September 23, 1996).

Burden of Proof – "In order to prevail, it is not enough for a claimant to simply raise suspicions about the legitimacy of a respondent's denial in lieu of meeting the affirmative obligations to establish entitlement to the contested benefits." *Ganal v. Travelers*, MVI-94-385 (CFO July 11, 1996); *Valdez v. GEICO*, MVI-94-340-C+ (CFO January 10, 1996); *Carvalho v. AIG Hawaii*, MVI-94-222 (CFO December 8, 1995); *Martinez v. AIG Hawaii*, MVI-94-250 (CFO September 15, 1995); *Ymer v. Alexsis*, MVI-93-157 (CFO November 9, 1994); *Phelan v. AIG Hawaii*, MVI-92-71 (CFO November 3, 1993); and, *Aceret/Castro v. AIG Hawaii*, MVI-92-208+ (CFO May 14, 1993).

Burden of Proof – "In order to prevail it is not enough for a claimant to establish that an "IME" was unable to conclude that he or she was pain free, or even that the claimant might have been experiencing accident-related pain. Although it is often possible that a claimant may be experiencing accident-related discomfort, a suspicion or conjecture to that effect does not satisfy the standard of proof required to show that the denial was improper."
Morales v. Allstate, MVI-94-67 (CFO July 10, 1996); *Quach v. Colonial Penn*, MVI-92-30 (CFO September 15, 1992); and, *Kennedy v. AIG Hawaii*, MVI-92-28 (CFO September 9, 1992).

Burden of Proof – Although a Claimant is not required, per se, to substantiate his or her subjective symptomatology by objective medical evidence, it is not enough for a Claimant to simply raise suspicions about the legitimacy of a Respondent's denial in lieu of meeting his or her affirmative obligation of showing entitlement to the contested benefits.
Morales v. Allstate, MVI-94-67 (CFO July 10, 1996).

Burden of Proof – While a treating physician's opinion regarding the cause of symptoms experienced by a claimant is usually deserving of greater evidentiary weight that the opinion of a non-treating physician, it is neither conclusive nor binding on the trier of fact.
Mababa v. State Farm, MVI-94-22 (CFO May 15, 1996).

Burden of Proof – A party may not, via its written exceptions to the recommended decision, introduce new "evidence" which was not submitted during the course of the hearing. An attempt to do so is improper, untimely, and will not be countenanced.
Nguyen v. State Farm, MVI-94-4-C (CFO September 25, 1995).

Burden of Proof – "Any determination of the merits of a denial based on a peer review recommendation under HRS § 431:10C-308.6 has the same procedural and substantive requirements - including same standard of review - as all other administrative proceedings initiated under HRS § 431:10C-212."
Pecson v. GEICO, MVI-94-254-C (CFO September 15, 1995).

Burden of Proof – "Where the conduct of a respondent in issuing a denial has been determined to be procedurally improper (by failing to comply with mandatory statutory requirements) the respondent is obligated to pay the claimant's contested no-fault benefits, and it is unnecessary to conduct any further proceedings to address the substantive merit, if any, of the denial itself."
Pecson v. GEICO, MVI-94-254-C (CFO September 15, 1995).

Burden of Proof – "The failure of a respondent to challenge a treatment plan within five workings days as required by HRS § 431:10C-308.6(d) constituted approval of the proposed treatment plan, and there is no legitimate basis for any further administrative proceedings with respect to the substantive basis of the subsequent denial."
Speers/Skeen v. AIG Hawaii, MVI-94-52-P (CFO June 22, 1995).

Burden of Proof – "A party may not submit additional evidence, or arguments based upon it, after the close of the evidentiary record, and the attempt to submit such information it clearly improper."
Speers/Skeen v. AIG Hawaii, MVI-94-52-P (CFO June 22, 1995); *Valdez v. GEICO*, MVI-93-39+ (CFO February 15, 1994).

Burden of Proof – A demonstration of reasonable conduct by a respondent in issuing a denial of no-fault benefits will normally be sufficient to preclude the impositions of sanctions even if the denial is later judged to be improper. It is insufficient, however, to enable a respondent to prevail on the merits where a claimant has established that he or she is entitled to the contested benefits.
Ringer v. AIG Hawaii, MVI-94-127-C (CFO June 14, 1995).

Burden of Proof – "The difficulty of making medical assessments - even where there has been a physical examination (IME) of a claimant - with respect to validating and/or treating pain (a subjective symptom of a claimant's injury) has been recognized in previous cases. Further consideration of this topic raises serious questions about the adequacy of using the peer review process as a means of

evaluating health care treatments which are at least partially palliative in nature." *Ringer v. AIG Hawaii*, MVI-94-127-C (CFO June 14, 1995).

Burden of Proof – A medical (chiropractic) determination made by a health care provider as reflected in a peer review report which states that a claimant should have reached "maximum medical improvement" does not reflect the correct standard for determining a claimant's eligibility for no-fault benefits.
Ringer v. AIG Hawaii, MVI-94-127-C (CFO June 14, 1995).

Burden of Proof – Where a claimant is contesting the substantive merit of a peer review report he or she has an affirmative burden of proof to establish the merit of the claim, and simply showing that the peer review's conclusions might be flawed is insufficient to meet this burden.
Brion v. State Farm, MVI-94-182-C (CFO April 4, 1995).

Burden of Proof – In an administrative no-fault hearing, a claimant has the burden of proof to establish the merits of his or her claim by a preponderance of the evidence pursuant to HRS § 91-10(5) and HAR § 16-201-21(d).
Brown v. AIG Hawaii, MVI-94-91-C (CFO March 28, 1995); *Nguyen v. Dai-Tokyo*, MVI-94-86 (CFO March 16, 1995); *Sumter v. GEICO*, MVI-94-61-C (CFO February 2, 1995); *Elarmo v. Island*, MVI-93-260 (CFO January 24, 1995); *Ymer v. Alexsis*, MVI-93-157 (CFO November 9, 1994); *Yuen v. Alexsis*, MVI-93-205 (CFO August 10, 1994); and, *Madden v. GEICO*, MVI-93-131 (CFO May 13, 1994).

Burden of Proof – "While a respondent's reasonable conduct in issuing a denial of no-fault benefits is sufficient to preclude the imposition of sanctions, it is not sufficient to conclude that a respondent should prevail on the merits where a claimant has ultimately established that he or she is entitled to the contested benefits."
Nguyen v. Dai-Tokyo, MVI-94-86 (CFO March 16, 1995).

Burden of Proof – A claimant's psychological trauma which resulted from a motor vehicle accident and included nightmares, uncontrollable crying, depression, and sleep disturbance, constituted a "sickness" or "disease" within the meaning of HRS § 431:10C-103(1) even in the absence of any actual physical injury.
Sua v. State Farm, MVI-94-39 (CFO March 16, 1995).

Burden of Proof – "A claimant's pain is no less real simply because it is medically considered to be a subjective symptom, rather than an objective sign, of injury or disease. The testimony of a claimant - or other credible evidence - that he or she is experiencing such pain is a valid basis for a factual finding that it does exist."
Dalere v. GEICO, MVI-93-128 (CFO March 15, 1994); *Naito v. USAA Casualty*, MVI-92-174 (CFO August 30, 1993); *Rivera v. USAA Casualty*, MVI-92-66 (CFO July 2, 1993); and, *Branch v. AIG Hawaii*, MVI-91-9 (CFO November 8, 1991).

Burden of Proof – In order to prevail, a claimant has the burden of producing credible evidence to establish, pursuant to HRS § 91-10(5), that by a preponderance of the evidence the respondent's denial of no-fault benefits should be rejected. *Yamashita v. State Farm*, MVI-93-40 (CFO March 10, 1994).

Burden of Proof – Although, as a general proposition, a claimant's failure to seek and receive treatment for an extended period of time weighs heavily toward a conclusion that his or her injuries had resolved and that subsequent treatment is unrelated to the prior accident, such a gap in treatment may be satisfactorily explained by specific factual circumstances in a particular case.
Freitas-Mortensen v. Allstate, MVI-93-32 (CFO December 3, 1993).

Burden of Proof – A claimant, in pursuing a request for his or her attorney's fees/or costs incurred in pursuing no-fault benefits must meet the same standard (a preponderance of the evidence) as would be required to establish his or her entitlement to the underlying benefits.
Bernabe(s) v. AIG Hawaii, MVI-93-6 (CFO November 24, 1993).

Burden of Proof – A respondent has an obligation to show that it has issued a procedurally lawful denial of no-fault benefits before a claimant has an obligation to show that he or she is substantively entitled to the contested benefits. *Bernabe(s) v. AIG Hawaii*, MVI-93-6 (CFO November 24, 1993) [overruled by *Arrington v. AIG Hawaii*, MVI-94-710-C (CFO January 15, 1997)].

Burden of Proof – "While it is often possible that a Claimant's discomfort may be related to (i.e. caused by) a motor vehicle accident, the existence of such a possibility does not meet the standard of proof required in no-fault insurance proceedings."
Arashiro v. GEICO, MVI-92-219 (CFO September 17, 1993).

Burden of Proof – "A claimant, in pursuing his or her claim for no-fault benefits, must prove by a preponderance of the evidence that the action of the respondent in issuing a denial of benefits was improper. In order to prevail, it is not enough for a claimant to simply raise suspicions about the legitimacy of a respondent's denial in lieu of meeting the affirmative obligation to establish entitlement to the contested benefits."
Miller v. AIG Hawaii, MVI-92-184 (CFO September 1, 1993); and *Aceret/Castro v. AIG Hawaii*, MVI-92-208+ (May 14, 1993).

Burden of Proof – "A claimant is not required, per se, to substantiate his or her claim by objective medical evidence. While the absence of such evidence may well be detrimental to particular claims for a particular claimant, it is only one of many factors which may be considered a part of the overall objective legal evidence in determining whether the claimant has met the burden of proof."
Naito v. USAA Casualty, MVI-92-174 (CFO August 30, 1993).

Burden of Proof – "There is no requirement per se that a Claimant substantiate his or her claim, in whole or in part, on objective medical evidence. While the absence of such evidence in a hypothetical case may be detrimental to particular claims for a particular claimant, it is but one of many factors to be considered as part of the objective legal evidence in determining whether a party has met its burden of proof."
Rivera v. USAA Casualty, MVI-92-66 (CFO July 2, 1993).

Burden of Proof – "[A] Claimant's attempt to submit additional evidence after the close of the evidentiary record, is clearly improper and any such information submitted as part of the post-hearing pleadings cannot be considered."
Ho/Tran v. Royal Ins., MVI-91-66+ (CFO July 1, 1993); and, *Valdez v. State Farm*, MVI-92-31 (CFO January 19, 1993).

Burden of Proof – Where a respondent attempts to subsequently argue an issue (such as the licensure status of a health care provider) which was not a basis for the respondent's denial, the argument will not be considered in determining the propriety of the denial.
Gates v. GEICO, MVI-92-95 (CFO April 21, 1993).

Burden of Proof – A medical determination made by a health care provider during the course of an independent medical exam that a claimant "can safely engage in ordinary activities of daily living without fear of harming her back in some irreparable manner" does not meet the standard for determining a claimant's eligibility for continued health care services.
Tadeo v. AIG Hawaii, MVI-92-118 (CFO March 8, 1993); and, *Wemple v. AIG Hawaii*, MVI-90-104 (CFO April 22, 1991).

Burden of Proof – While an assertion by a claimant that a particular type of health care provides pain management does constitute objective evidence for consideration, it is by no means solely determinative of the outcome in most cases. This is especially true where such assertions are not well supported by other lay or expert testimony and are contradicted by credible medical evidence presented by a respondent.
Bernabe(s) v. AIG Hawaii, MVI-92-74 (CFO January 14, 1993).

Burden of Proof – "[M]atters involving the psychological aspects of rehabilitation result in a magnification of the role of the doctor - patient relationship in obtaining beneficial results in the patient. The patients trust and confidence in the doctor would be among the cornerstone of the treatment program." Accordingly, neither the suggestion of additional modalities which might enhance a claimant's recovery, nor an opinion that the claimant could "adequately function" in the absence of the existing treatment, is sufficient to support a determination that the claimant is ineligible for continuing no-fault benefits.
Gugudan v. AIG Hawaii, MVI-92-23 (CFO November 6, 1992).

Burden of Proof – The credible testimony of a claimant regarding subjective complaints or symptoms of injuries sustained in a motor vehicle accident constitutes objective evidence when presented during the course of a proceeding and may be sufficient to establish his or her entitlement to no-fault benefits even in the absence of other objective findings.
Shigemi-Horner v. AIG Hawaii, MVI-92-39 (CFO October 8, 1992).

Burden of Proof – "In order to prevail it is not enough for a claimant to establish that an "IME" was unable to conclude that he or she was pain free, or even that the claimant might have been experiencing accident-related pain. Although it is often possible that a claimant may be experiencing accident-related discomfort, a suspicion or conjecture to that effect does not satisfy the standard of proof required to show that the denial was improper."
Quach v. Colonial Penn, MVI-92-30 (CFO September 15, 1992); and, *Kennedy v. AIG Hawaii*, MVI-92-28 (CFO September 9, 1992).

Burden of Proof – In order to prevail in a claim for coverage, a claimant has the burden of proving by a preponderance of the evidence that the action of the respondent in issuing its denial of benefits was improper.
Quach v. Colonial Penn, MVI-92-30 (CFO September 15, 1992); *Kennedy v. AIG Hawaii*, MVI-92-28 (CFO September 9, 1992); *McIntosh v. GEICO*, MVI-90-138 (CFO June 3, 1991); *Rodrigues v. Maryland Casualty*, MVI-90-123 (CFO June 3, 1991); and *Wemple v. AIG Hawaii*, MVI-90-104 (CFO April 22, 1991); and *Lovejoy v. National Union*, MVI-90-48 (CFO December 17, 1990).

Burden of Proof – "A claimant has the burden of proof to establish his or her entitlement to no-fault benefits by a preponderance of the evidence, and the existence of a mere possibility of some relationship between a motor vehicle accident, a claimant's injuries, and subsequent health care treatment does not satisfy this burden."
Hinzo v. AIG Hawaii, MVI-91-128 (CFO September 3, 1992).

Burden of Proof – If an insurer denies payment of no-fault benefits because the charges or amounts billed are not reasonable, the claimant has the burden of establishing the reasonableness of the disputed charges or amounts billed. *Kim/Yoon v. State Farm*, MVI-91-28 (CFO March 27, 1992).

Burden of Proof – A claimant seeking retroactive coverage for an accident which occurred after his policy expired but after payment of an attempted renewal must factually establish both detrimental and reasonable reliance on representations of the insurer that such coverage existed in order to benefit from the doctrine of equitable estoppel.
Lee v. GEICO, MVI-90-132 (CFO July 18, 1991).

Burden of Proof – "The subjective testimony of a claimant as to either the existence or extent of pain does not always lend itself to objective medical

confirmation. Nevertheless, such testimony is part of the criteria upon which a legal determination must be made as to whether a party has met its evidentiary burden of proof."
Rodrigues v. Maryland Casualty, MVI-90-123 (CFO June 3, 1991).

Burden of Proof – Although it is possible that a claimant was experiencing discomfort at the time of the denial, and although it is possible that this discomfort was related to injuries sustained in a motor vehicle accident, the existence of such a possibility does not itself satisfy the standard of proof required in this type of proceeding.
Smith v. Colonial Penn, MVI-90-102 (CFO May 10, 1991); *Daos v. National Union*, MVI-90-1 (CFO September 13, 1990); and, *Mostoles v. State Farm*, MVI-88-20 (CFO January 10, 1989).

Burden of Proof – "Although the no-fault system of reparations does not require a finding of fault, neither does it lend itself to a *res ipsa loquitur* analysis in most cases. In order to establish causation, there must generally be more than a sequential chronology of events." The resolution of questions concerning causation rests primarily on a determination of factual questions which must be convincingly answered by a claimant.
Oslund v. State Farm, MVI-89-101 (CFO March 18, 1991).

Burden of Proof – In order for a respondent to show entitlement to an award of attorney's fees or costs under the HRS § 431:10C-211 requirements for fraudulent or frivolous standards, it must be shown that the claimant was pursuing a claim "with a purpose or design to carry out a fraud, ... or done with the intent to deceive", or else that the claim was "manifestly and palpably without merit."
Tran v. Liberty Mutual/Hawaiian, MVI-90-74+ (CFO January 8, 1991).

Burden of Proof – While an objective standard should be applied in assessing the merit of claims regarding pain management, the subjective testimony of a claimant may constitute part of the evidence weighed by the trier of fact in applying an objective standard.
Fujimoto v. AIG Hawaii, MVI-89-97 (CFO June 22, 1990); and *Yeh v. Royal Ins.*, MVI-89-54 (CFO May 10, 1990).

Burden of Proof – "In administrative proceedings conducted under HRS Chapter 91 and § 431:10C-212, the claimant has the burden of proving by a preponderance of the evidence that the insurer improperly denied payment of no-fault benefits as of the date of the denial, based upon the reasons specified or identified in the denial of claim form."
Ostrander v. National Union, MVI-89-80 (CFO February 2, 1990); and *Okabe v. American International*, MVI-89-47 (CFO February 2, 1990).

Burden of Proof – Vague generalities that a claimant's discomfort may have been partially related to her sleeping accommodations together with the suggestion

that such arrangements might be improved by the replacement of an allegedly poor mattress through the purchase of a standard, non-therapeutic bed is insufficient to establish the claimant's burden of proof in her attempt to qualify for benefits under HRS § 294-2(10)(A) [HRS § 431:10C-103(10)(A)].
Tada v. Liberty Mutual, MVI-89-40 (CFO October 3, 1989); *Baron v. State Farm*, MVI-88-39 (CFO June 9, 1989); and, *Howard v. State Farm*, MVI-88-12 (CFO December 4, 1988).

Burden of Proof – Although unique factual circumstances involving the personal and business relationships among the triad of claimant, chiropractor, and massage therapist raised suspicions of abuse in obtaining benefits, the creation of "a substantial doubt" does not equate with the establishment of "a preponderance of the evidence" as the standard of proof required in administrative proceedings. *Warren v. Transamerica*, MVI-88-32 (CFO March 6, 1989).

Burden of Proof – It is not essential that a party present a specialist or expert witness from the same discipline as an opposing specialist or expert witness in order to controvert the testimony offered by the opposing party in an administrative no-fault hearing.
Stephens v. State Farm, MVI-86-26 (CFO July 28, 1987).

CAUSATION

Causation – "The fact that [a claimant] may have improved and may have recovered after receiving treatment … did not ipso facto establish that the treatment prescribed and received by [the claimant] was reasonable and appropriate." A provider's (or claimant's) burden of proof imposes an obligation to affirmatively establish his or her entitlement to the contested personal injury protection benefits.
Jou/Pulido v. AIG Hawaii, ATX-2000-103-P+ (CFO March 27, 2001).

Causation – A claimant's assumption that severe cuts to his fingers were caused by some object that he touched while alighting from a bus, without presenting evidence to substantiate such an assumption, was insufficient to show that the injuries were the result of a motor vehicle accident.
Rafael v. Oahu Transit, ATX-99-221 (CFO November 30, 2000).

Causation – "[E]ven if the Claimant did have some *latent* depression in the timeframe immediately preexisting the accident whioch subsequently became *patent* depression as a result of the accident (and/or aggravated other accident related injuries) there would be no change in the Respondent's obligation to provide appropriate benefits. (citations omitted) It is well recognized that respondents take their claimants as they find them, and thus the 'eggshell plaintiff' is entitled to be reimbursed for his or her legitimate no-fault insurance benefits."
Hart v. AIG Hawaii, MVI-96-1325+ (CFO September 18, 2000).

Causation – Although a respondent might have properly denied certain specific benefits, its denial of all no-fault benefits was shown to be improper where the preponderance of the evidence established that (even after 15 years) the claimant still had physical and/or psycho-physiological symptomology that was attributable to a covered motor vehicle accident.
Chong v. Island Insurance, MVI-98-644 (CFO September 16, 1999).

Causation - In order to establish that a psychological injury meets the statutory definition of accidental harm set out in HRS § 431:10C-103(1) a claimant may have to show that it constitutes a psychiatric disorder as set out in DSM-III-R.
Hyman/Butuyan v. State Farm, MVI-96-517-P (CFO August 11, 1999);
Hyman/Chandara v. State Farm, MVI-95-249-P+ (CFO July 14, 1999); and
Hyman/Melchor v. State Farm, MVI-95-315-P (CFO September 4, 1998).

Causation – In order to establish that a claimant's distress constituted a "psychiatric disorder", it must be shown that the claimant's condition met the diagnostic criteria established by the [American Psychiatric Association Classification] DSM-IV, and when this is not shown the claimant has failed to prove that he or she is suffering from the level of "accidental harm" sufficient to qualify for no-fault benefits.

Hyman/Butuyan v. State Farm, MVI-96-517-P (CFO August 11, 1999); *Hyman/ Kawano v. State Farm*, MVI-96-296-P+ (CFO February 26, 1999); *Hyman/Butuyan v. State Farm*, MVI-96-520-P (CFO February 18, 1998); and, *Hyman/Tran v. State Farm*, MVI-96-69-P+ (CFO February 8, 1998).

Causation – In considering an HRS § 431:10C-308.6 (peer review) denial of no-fault benefits (as well as the merit of the underlying treatment plan request), one does not consider the issue of causation but rather focuses on whether the plan's health care services were appropriate or reasonable for the claimant's condition.
Ma v. Liberty Mutual, MVI-96-1422-P (CFO February 26, 1999).

Causation – The possibility that the injuries for which a claimant is seeking no-fault benefits are related to a qualifying accident does not satisfy the standard of proof to establish causation, and the probability of such a connection decreases significantly where there has been a substantial passage of time between the accident and the subsequent treatment and/or inconsistencies between statements made by the claimant and his or her medical records.
Kuhiki v. State Farm, MVI-95-616 (CFO October 26, 1998).

Causation – The analysis of a mechanical engineer (concerning the force of impact involved in a motor vehicle accident) - as well as the results of an independent medical examination which placed great reliance on the mechanical engineer's analysis - while of some interest, was not persuasive in determining whether the claimant's injuries were accident related.
Aila v. AIG Hawaii, MVI-94-390 (CFO October 21, 1998).

Causation – Although a claimant may be able to show that the requirements for establishing a wage loss claim have been met, it is still essential - as a threshold issue - for the claimant to show that his or her injuries were the result of the motor vehicle accident underlying the claim.
Madison v. State Farm, MVI-96-47 (CFO September 14, 1998).

Causation – "In [citations omitted] the Insurance Commissioner determined that there was no causal connection between the claimants' conditions at the time that no-fault benefits were denied and any injuries which may have arisen out of their motor vehicle accidents where there was a lengthy delay in seeking treatment and inconsistency between claimants' statements and their medical records."
Connors v. State Farm, MVI-96-522 (CFO September 4, 1998).

Causation – Although a claimant may be experiencing some degree of anxiety related to a motor vehicle accident, the anxiety must reach the level of a psychiatric disorder under the diagnostic criteria established by the [American Psychiatric Association – Diagnostic and Statistical Manual of Mental Disorders] DSM-III-R Classification in order to qualify for no-fault health care benefits to treat the anxiety.
Hyman/Alana v. Allstate, MVI-95-630-P+ (CFO February 26, 1998).

Causation – The issuance of a denial of no-fault benefits based upon a peer review report stating - that a claimant's condition could not be attributed to his motor vehicle accident was invalid on its face, as causation is not an issue for determination by peer review and thus not a proper basis for the subsequent issuance of a denial pursuant to a peer review report.
Randall v. USAA, MVI-94-625-C (CFO July 10, 1996).

Causation – The only ground for an insurer to issue a denial of benefits pursuant to a peer review organization determination is that the treatment in question is not appropriate or reasonable. HAR § 16-23-118(e). Other grounds such as causation are simply not subject to the peer review process outlined in HRS § 431:10C-308.6.
Hilario v. State Farm, MVI-93-193 (CFO March 12, 1996).

Causation – "Only challenges based on whether treatment is appropriate or reasonable shall be filed with the commissioner for submission to a peer review organization. Denials or partial denials of claims based on other grounds, such as coverage questions, shall not be subject to peer review. Section 16-23-118."
Hilario v. State Farm, MVI-93-193 (CFO March 12, 1996).

Causation – "While, as a general proposition, it may be that more severe accidents are likely to produce more serious injuries, this is not always correct; a true analysis of forces cannot be accurately reconstructed in every case, and much depends on the positioning of the injured party as well as his or her preexisting conditions."
Pecson v. GEICO, MVI-94-254-C (CFO September 15, 1995).

Causation – The issue of causation/apportionment may present an especially difficult question where a claimant has been involved in multiple accidents or incidents and has received health care treatment or evaluation from multiple health care providers.
Martinez v. AIG Hawaii, MVI-94-250 (CFO September 15, 1995).

Causation – "In order to establish causation, there must generally be a showing of more than a mere sequential chronology of events even if there is no subsequent trauma. Significant gaps in treatment (especially when they occur well after the date of the accident) in conjunction with an active lifestyle make the establishment of causation particularly difficult."
Martinez v. AIG Hawaii, MVI-94-250 (CFO September 15, 1995); *Dalere v. GEICO*, MVI-93-128 (CFO March 15, 1994); *Hinzo v. AIG Hawaii*, MVI-91-128 (CFO September 3, 1992); and, *McIntosh v. GEICO*, MVI-90-138 (CFO June 3, 1991).

Causation – "While it is often possible that a claimant's discomfort may be related to (i.e. caused by) a motor vehicle accident, the existence of such a possibility does not meet the standard of proof required in no-fault insurance

proceedings. In order to prevail, it is not enough for a claimant to simply raise suspicion about the legitimacy of a respondent's denial in lieu of meeting the affirmative obligation to establish entitlement to the contested benefits."
Shi v. AIG Hawaii, MVI-94-236 (CFO July 31, 1995).

Causation – Although the no-fault system of reparation does not require a finding of fault, neither does it lend itself to a res ipsa loquitur analysis in most cases. A proper resolution of the issue of causation rests primarily on a determination of factual questions which must be satisfactorily answered by the claimant.
Yuen v. Alexsis, MVI-93-205 (CFO August 10, 1994); and, *Oslund v. State Farm*, MVI-89-101 (CFO March 18, 1991).

Causation – "The ability of a claimant to establish causation between a motor vehicle accident and his or her subsequent condition is dependent upon a factually satisfactory explanation, and delays in the manifestation or reporting of such injuries, as well as narrative inconsistencies in explaining such delays, make it vary difficult to present a convincing explanation."
Yuen v. Alexsis, MVI-93-205 (CFO August 10, 1994); and, *Phelan v. AIG Hawaii*, MVI-92-71 (CFO November 3, 1993).

Causation – "While it is often possible that a claimant's discomfort may be related to (ie. caused by) a motor vehicle accident, the existence of such a possibility does not meet the standard of proof required in no-fault insurance proceedings."
Yuen v. Alexsis, MVI-93-205 (CFO August 10, 1994); and, *Arashiro v. GEICO*, MVI-92-219 (CFO September 17, 1993).

Causation – A claimant's pre-accident good health and absence of symptomatology followed by the post-accident onset (within a reasonable period and without subsequent trauma) of symptoms conforming to hyperflexion/hyperextension injuries commonly accruing in head-on motor vehicle accidents established that "more likely than not" the symptoms were the result of injuries caused by the accident.
Anastacio v. AIG Hawaii, MVI-93-52 (CFO May 16, 1994).

Causation – "Questions of causation are factual in nature ... and each claimant is entitled to a separate determination of the merits of his or her claim based on the unique factual circumstances surrounding it."
Dalere v. GEICO, MVI-93-128 (CFO March 15, 1994).

Causation - "Where a claimant establishes reoccurring discomfort which did not exist before the motor vehicle accident and which cannot reasonable be attributed to post-accident trauma or other events, he or she has made good progress in establishing causation. Where the claimant then goes on to provide a satisfactorily explanation for any significant gap in treatment, it becomes increasingly likely that the requisite degree of proof has been met on this issue."
Dalere v. GEICO, MVI-93-128 (CFO March 15, 1994).

Causation – A claimant may be able to establish that he or she is entitled to reimbursement for health care benefits where causation is in questions after a significant gap in treatment if the factual evidence provides a satisfactorily convincing explanation as to why there was no treatment during the gap.
Kamiya v. State Farm, MVI-92-213 (CFO June 21, 1993); and, *Bass v. GEICO*, MVI-91-92 (CFO August 26, 1992).

Causation – The opinion of a health care provider about the cause of a claimant's condition is only as good as the underlying information upon which it is based and the qualifications of the health care provider to interpret that information in the form of an opinion.
Hinzo v. AIG Hawaii, MVI-91-128 (CFO September 3, 1992).

Causation – "Although it is often possible that a causal relationship exists between a claimant's motor vehicle accident and the injuries for which he or she was receiving treatment at the time benefits were denied, a possibility does not satisfy the administrative standard of proof which is a preponderance of the evidence."
Uyematsu v. AIG Hawaii, MVI-91-49 (CFO February 14, 1992).

Causation – "It is generally necessary for a claimant to convincingly show more than a sequential chronology of events (even in the absence of subsequent trauma) in order to establish and/or maintain causation between an accident and his or her discomfort later in life."
Uyematsu v. AIG Hawaii, MVI-91-49 (CFO February 14, 1992).

Causation – "A claimant must meet the causational threshold set out in HRS § 294-3(a) [HRS § 431:10C-303] in order to establish entitlement to health care or other no-fault benefits. In other words: "Even before reaching the questions of whether the expenses are appropriate, reasonable and necessarily incurred, a determination must first be made that the injuries leading to the expenses arose out of the motor vehicle accident."
McIntosh v. GEICO, MVI-90-138 (CFO June 3, 1991); and, *Felipe v. State Farm*, MVI-87-9 (CFO September 4, 1987).

Causation – Although it is frequently possible that a causal relationship may exist between a claimant's motor vehicle accident and certain injuries for which treatment was being received at the time that no-fault benefits were denied, a possibility does not satisfy the standard of proof required to show that the denial was improper.
McIntosh v. GEICO, MVI-90-138 (CFO June 3, 1991); and, *Mostoles v. State Farm*, MVI-88-20 (CFO January 10, 1989).

Causation – "Significant reductions in treatment (especially when they occur well after the date of the accident) in conjunction with an active lifestyle make the establishment of causation particularly difficult."

Baker v. AIG Hawaii, MVI-90-101 (CFO May 20, 1991).

Causation – "Although it is indeed possible that there is a causal relationship between the claimant's motor vehicle accident and the injuries for which he was receiving treatment at or about the time when the respondent issued its denial of benefits, a possibility does not satisfy the standard of proof required in this type of proceeding."
Baker v. AIG Hawaii, MVI-90-101 (CFO May 20, 1991).

Causation – Although a claimant may have sustained injuries in a particular motor vehicle accident his or her subsequent activities as well as sporadic treatment by various health care providers may make a determination of causation particularly difficult.
Smith v. Colonial Penn, MVI-90-102 (CFO May 10, 1991).

Causation – "An extensive, unexplained delay or interruption in treatment strongly suggests that later treatment may not be related to an earlier accident." . . . In any particular matter, however, a claimant may be able to provide a reasonable explanation for the lack of such treatment under the particular circumstances of his or her situation.
Wemple v. AIG Hawaii, MVI-90-104 (CFO April 22, 1991).

Causation –The issue of causation/apportionment may present an especially difficult question where a claimant has been involved in multiple accidents and has participated in treatment programs or evaluation sessions with numerous health care providers over extended periods of time, especially where no single health care professional has followed the claimant throughout the entire treatment period.
Miyahira v. American Home/GEICO, MVI-90-31+ (CFO December 17, 1990).

Causation – "Although the no-fault system of reparations is not based upon fault, it is based upon causation and follows the elementary principal that a party pay compensation only for those injuries for which it is responsible."
Botelho v. Commercial Union, MVI-89-55 (CFO September 13, 1990).

Causation – All no-fault benefits are paid secondarily and net of any workers' compensation benefits that a person is entitled to receive because of harm sustained in a motor vehicle accident. If, however, a claimant's injuries are not established to have been caused by an accident which also qualifies as a motor vehicle accident under the no-fault statutes, any payment of workers' compensation benefits is not in lieu of (primary of) no-fault benefits and does not constitute payments which would otherwise extend the statute of limitations.
Botelho v. Commercial Union, MVI-89-55 (CFO September 13, 1990).

Causation – The public policy considerations of the legislature with respect to no-fault insurance benefits do not extend the concept of "causal connection" so far as to include injuries sustained by a third party who was not involved in the motor

vehicle accident. This is true within the Hawaii no-fault system of reparations even if the person did sustain subsequent damages as a result of learning that a family member had been killed in the motor vehicle accident. "While the determination of an individual claimant's qualifications require an evaluation of the factual circumstances which are unique to that matter, every individual must establish a sufficient legal 'nexus' of spatial and temporal causation as a threshold requirement." *Dodson v. GEICO*, MVI-87-50 (CFO October 11, 1989).

Causation – The ability of a claimant to establish a causative relationship between the motor vehicle accident and subsequent health care services is dependent upon a factually convincing explanation, and delays in the manifestation of injuries, delays in obtaining health care, and narrative inconsistencies in explaining such delays can make a convincing explanation very difficult to obtain. *Omalza v. State Farm*, MVI-88-27 (CFO July 26, 1989); *Mostoles v. State Farm*, MVI-88-20 (CFO January 10, 1989); *Felipe v. State Farm*, MVI-87-9 (CFO September 4, 1987); and, *Kaisan v. American Home*, MVI-88-24 (CFO October 26, 1988).

CERTIFICATION OF BILLINGS

Certification of Billings – "[I]t appears that a provider's failure to comply with the requirements of HAR § 16-23-116 would provide a procedural basis for an insurer to reject an uncertified billing and/or to file a motion to dismiss a provider's subsequent request for a hearing to contest such a rejection."
Jou/Leano v. GEICO, ATX-2000-208-P+ (CFO May 14, 2001).

CONDITIONAL BENEFITS

Conditional Benefits – A claimant has a responsibility to engage in good faith efforts to assist in his own recovery by pursuing a reasonable course of conduct for restoring his pre-accident health, and a failure to do so may be sufficient for a respondent to use as a basis for issuing a denial of benefits.
Jou/Pulido v. AIG Hawaii, ATX-2000-103-P+**Error! Bookmark not defined.** (CFO March 27, 2001).

Conditional Benefits – Although a claimant has considerable choice in selecting his or her own course of health care treatment, a claimant may also have an obligation to pursue alternative health care treatments to avoid further injury and/or assist in further identifying the cause of any chronic conditions.
Yamashita v. State Farm, MVI-93-40 (CFO March 10, 1994).

Conditional Benefits – Where it is established that a claimant's participation in an active physical therapy program - in conjunction with palliative chiropractic treatment - would likely result in an enhanced recovery, the payment of no-fault benefits for such chiropractic treatment may be conditioned upon participation in the physical therapy program.
Ea v. State Farm, MVI-93-20 (CFO September 23, 1993).

Conditional Benefits – "Although the choice of a claimant is a factor in determining whether a certain type of health care is appropriate, it is not the only factor, and a claimant has an obligation to pursue a reasonable course of conduct for the restoration of his or her full health."
Miller v. AIG Hawaii, MVI-92-184 (CFO September 1, 1993); and, *Aceret/Castro v. AIG Hawaii*, MVI-92-208+ (CFO May 14, 1993).

Conditional Benefits – "While a claimants choice of treatment for either curative or palliative purposes is an important consideration in evaluating the suitability or cost of no-fault benefits, it is not necessarily conclusive and claimants do not have carte blanche ability to unilaterally select their methods of treatment .... Furthermore, although a claimant is entitled to select a reasonable method of treatment, the method may - under certain factual circumstances - be considered reasonable only when conditioned upon participation in additional treatments which may enhance recovery in conjunction with pain relief."
Valentino v. AIG Hawaii, MVI-92-157 (CFO July 2, 1993).

Conditional Benefits – A claimant has a responsibility to act reasonably in mitigating damages and, under certain circumstances, a claimant's qualification to receive certain no-fault benefits may be conditional upon other appropriate conduct.
Lovejoy v. National Union, MVI-90-48 (CFO December 17, 1990); and, *Jordan v. State Farm*, MVI-88-18 (CFO September 22, 1988).

Conditional Benefits – Although a claimant is entitled to select a reasonable method of treatment, the method may - under certain factual circumstances - be considered reasonable only when conditioned upon participation in additional treatments which may enhance recovery in conjunction with pain relief.
Teramae v. National Union, MVI-90-24 (CFO August 30, 1990); and, *Warren v. Transamerica*, MVI-88-32 (CFO March 6, 1989).

Conditional Benefits – In addition to a claimant's obligation to avoid further injury by receiving only such health care services as are appropriate, a claimant also has an obligation to pursue a reasonable course of conduct for the restoration of his or her full health. Accordingly, the reimbursement of certain palliative health care costs may be conditional upon the claimant's participation in health care services which have the potential for actually improving the underlying condition as well as reducing present discomfort.
Calicdan v. AIG Hawaii, MVI-89-81 (CFO March 23, 1990).

Conditional Benefits – "The basis for ordering pre-conditions to health benefits in certain no-fault matters is that such benefits would not otherwise meet the reasonable, necessary and appropriate requirements."
Howard v. State Farm, MVI-88-12 (CFO December 4, 1988).

Conditional Benefits – Where the preponderance of the evidence establishes that a claimant would benefit significantly from a properly structured program of physical therapy (active modalities) her participation in such a program was a reasonable condition upon which reimbursement for chiropractic or massage treatments (passive modalities) could reasonably be based.
Jordan v. State Farm, MVI-88-18 (CFO September 22, 1988).

CONSTRUCTIVE DENIAL

Constructive Denial – A denial of benefits may be constructed to effectuate the statutory intent of allowing claimants or providers to request an administrative hearing pursuant to HRS § 431:10C-212 under circumstances where a respondent has failed to comply with mandatory notification requirements set out in HRS § 431:10C-304(3).
HEPA/Adams v. State Farm, MVI-96-1024 (CFO August 4, 1998).

Constructive Denial – "The construction of a denial was an equitable device to overcome an insurer's wrongful conduct and [to] implement the intent of the statutory provisions to provide a fair, orderly, and expeditious procedure to address claims for payment of no-fault benefits. Insurers may avoid the application of a constructive denial by simply complying with the provisions of HRS § 431:10C-304(3)."
HEPA/Adams v. State Farm, MVI-96-1024 (CFO August 4, 1998).

Constructive Denial – A Respondent may not withhold/deny benefits under HRS § 431:10C-304(3)(C) pending the outcome of a future independent medical examination, or any other unilaterally imposed and clearly impermissible basis. The language of the statute simply does not permit an insurer to impose such conditions, as distinguished from making a reasonable request for existing documents, as a basis for withholding/denying no-fault insurance benefits.
Lucas v. AIG Hawaii, MVI-94-165 (CFO October 30, 1996). [Note: affirmed by summary dispositional order - S.C. No. 21464 (12-28-98)].

Constructive Denial – "Where an insurer has failed to comply with the provisions of HRS § 431:10C-304(3) by stopping payment of no-fault benefits without issuing any actual denial, or otherwise complying with the requirements of the statute, such conduct will be considered as a constructive denial which is, on its face, a violation of the law."
Lucas v. AIG Hawaii, MVI-94-165 (CFO October 30, 1996) [Note: affirmed by summary dispositional order - S.C. No. 21464 (12-28-98)]; *Alpuro v. AIG Hawaii*, MVI-92-154 (CFO June 15, 1993); and, *Santos v. Allstate*, MVI-87-40 (CFO July 6, 1989).

Constructive Denial – A respondent's partial payment of no-fault benefits for which the amount of the changes was being disputed in accordance with the provisions of HAR § 16-23-120 was effectively a partial denial which required compliance with the provisions of HRS § 431:10C-304(3)(B) and a respondent's failure to comply with these statutory provisions constituted an unlawfully constructive denial. An insurer's refusal to pay a claim on the basis that the change is not reasonable, regardless of whether it is submitted by the provider or the claimant, must be accompanied by appropriate written notification.

HEPA/Matthews v. State Farm, MVI-93-160-P+ (CFO December 12, 1995).

Constructive Denial – "Where a challenge has not been issued pursuant to HRS § 431:10C-3-8.6, and an insurer has stopped payment of no-fault benefits without issuing an actual denial pursuant to HRS § 431:10C-304(3) or otherwise complying with the requirements of that statute, the result is considered to be a constructive denial which is, on its face, a violation of the law."
Pacubas v. AIG Hawaii, MVI-93-184 (CFO October 10, 1994).

Constructive Denial – A respondent's notification to a claimant's health care provider that future payments of no-fault benefits would be dependent on the outcome of a future independent medical exam (in the absence of issuing an actual denial notification in accordance with HRS § 431:10(C)-304(3)(B)) constitutes a de facto or constructive denial.
Calatrava v. AIG Hawaii, MVI-93-76+ (CFO March 4, 1994).

Constructive Denial – Under circumstances where an insurer declines to pay ***any part*** of the no-fault benefits requested by its insured such conduct constitutes a "denial" which must be handled in compliance with HRS § 431:10C-304(3)(B). That statute clearly requires the insurer to notify the claimant within thirty days of any denial (whether it addresses the whole or only part of the claim) and state the basis for the denial.
Felisi v. AIG Hawaii, MVI-90-128 (CFO December 2, 1991).

COVERAGE

Coverage – "[The] argument that an injured third party is not bound by the provisions contained in the insured's policy is not well founded. While a claimant's entitlement to personal injury protection coverage is set out by law, the extent of such entitlement may be qualified in accordance with the content of the applicable insurance policy."
Daproza-Fung v. Liberty Mutual, ATX-2001-40+ (CFO October 3, 2001).

Coverage – The extent of coverage offered by a particular insurance policy is determined by the language of that policy on the date of its issuance or, if renewed, on the date of the most recent renewal. Neither statutes nor rules enacted after that date effect policy coverages unless the legislature has expressed its intention that such laws have retroactive effect. Furthermore, informal opinions of the Insurance Commissioner are just that, and while they are often helpful they have neither the force nor the efffect of law.
Ajifu v. AIG Hawaii, ATX-2000-212 (CFO September 25, 2001).

Coverage – An interpretation of the language of the Hawaii motor vehicle insurance law which limits coverage to claims involving motor vehicles - exclusive of motorcycles, motor scooters, and mopeds - is not inconsistent with the intent of the legislature in establishing the system of reparations reflected in the current law.
Musick v. Insurance Division, MVI-95-280-J (CFO February 13, 1997).

Coverage – A pedestrian or bicyclist who has no insurance of his or her own, and who is struck by an uninsured motorist, does not qualify for no-fault insurance benefits and is not eligible for an assignment of his or her claims through the Hawaii joint underwriting plan.
Musick v. Insurance Division, MVI-95-280-J (CFO February 13, 1997).

Coverage – The provisions of HRS § 431:10C-304(1) do not extend coverage for no-fault benefits to persons in their capacity as users of motorcycles or motor scooters, and the good faith belief of a claimant that he was operating a moped which was, in fact, a motor scooter is insufficient to extend such coverage and/or impose payment obligations on a respondent.
Kaminski v. State Farm, MVI-94-403 (CFO March 12, 1996).

Coverage – The procedural requirements governing a claimant's request for administrative review where his or her policy of insurance has been canceled are contained in HAR § 16-23-16, and the failure to make such a request within ten days of receiving notice of cancellation deprives this forum of jurisdiction to hear the matter.
McBeth v. Allstate, MVI-94-439 (CFO March 12, 1996).

Coverage – "Only challenges based on whether treatment is appropriate or reasonable shall be filed with the commissioner for submission to a peer review organization. Denials or partial denials of claims based on other grounds, such as coverage questions, shall not be subject to peer review. Section 16-23-118."
Hilario v. State Farm, MVI-93-193 (CFO March 12, 1996).

Coverage – The statutory provisions of HRS § 431:10C-304(3)(C) do not restrict an insurer from including, as a provision of the insurance policy (and subsequent enforcing) a requirement that the insured submit to reasonably required examinations under oath.
Tillmon v. AIG Hawaii, MVI-94-312 (CFO September 11, 1995).

Coverage – Since fault is not an element of proof in this type of proceeding, a claimant's negligent conduct in causing a motor vehicle accident does not preclude the claimant from coverage for no-fault insurance benefits based on injuries sustianed in the accident.
Luna v. Alamo/GAB, MVI-91-109 (CFO September 29, 1994).

Coverage – The Hawaii motor vehicle insurance law does not cover motorcycle drivers/passengers (nor other persons) unless they are involved in an incident which qualifies as a "motor vehicle accident," and the provisions of HRS § 431:10C-305(d)(3) do not create any eligibility which is not otherwise stated in the law.
Kaneaiakala v. AIG Hawaii, MVI-93-175 (CFO June 28, 1994).

Coverage – An insurer may cancel the entire policy where an insured has paid the premium for the original coverage but has failed, after proper notice and subsequent reminders, to pay the additional premium for an added vehicle. Therefore, the insurer was not obligated to pay any no-fault benefits arising out of an accident which occurred after the policy had been canceled.
Picana v. First Insurance, MVI-91-122 (CFO August 19, 1992).

Coverage – "[T]he most reasonable interpretation of the language in HRS § 431:10C-103(13)(B) is that the 'business exception' applies to employees of a business which includes - as a major part of its activities - repairing, servicing, or otherwise maintaining vehicles, even if that is not its primary business activity."
Tahi v. MTL, Inc., MVI-91-86 (CFO August 19, 1992).

Coverage – The actions of a claimant, by requesting further no-fault payments from a respondent under a spouse's policy, after having already received benefits under her own policy, were in direct conflict with the provisions of HRS § 431:10C-305(b)(1)(B) which prohibits a person from obtaining no-fault benefits for a single motor vehicle accident from more than one insurer.
Tanigawa v. First Ins., MVI-91-78 (CFO April 15, 1992).

Coverage – A claimant who was not physically involved in, nor in the immediate proximity of, a spouse's motor vehicle accident, is not entitled to no-fault benefits for health care services relating to subsequent emotional distress.
Santiago v. Industrial/AIG Hawaii, MVI-90-125 (CFO November 18, 1991); and, *Dodson v. GEICO*, MVI-87-50 (CFO October 11, 1989).

Coverage – A self-insured respondent is not obligated to provide no-fault benefits on a motor vehicle which it has sold to a claimant after delivery of the vehicle and endorsement of the certificate of ownership despite the fact that a new certificate of ownership and/or registration was not issued prior to the time of an accident.
Suka v. Budget, MVI-91-15 (CFO October 7, 1991).

Coverage – The purchaser of a motor vehicle is obligated to provide his or her own coverage after the vehicle is "sold" and possession has transferred to the purchaser, despite lack of title documentation or non-compliance with the motor vehicle registration statute.
Suka v. Budget, MVI-91-15 (CFO October 7, 1991).

Coverage – A claimant seeking retroactive coverage for an accident which occurred after his policy expired but after payment of an attempted renewal must factually establish both detrimental and reasonable reliance on representations of the insurer that such coverage existed in order to benefit from the doctrine of equitable estoppel.
Lee v. GEICO, MVI-90-132 (CFO July 18, 1991).

Coverage – Where a claimant cannot show that reliance on statements made by a respondent was reasonable and detrimental, a misunderstanding by the parties regarding "retroactive coverage" was not sufficient to engage the principle of equitable estoppel - which requires that "one invoking equitable estoppel must show that he or she has detrimentally relied on the representation or conduct of the person sought to be estopped, and that such reliance was reasonable."
Lee v. GEICO, MVI-90-132 (CFO July 18, 1991).

Coverage – An insured is not entitled to a double recovery by collecting payments from a second insurer (as a result of a second mva) for wage loss benefits which he or she is still receiving from a first insurer (as a result of a first mva).
Tran v. Liberty Mutual/Hawaiian, MVI-90-74+ (CFO January 8, 1991).

Coverage – A claimant whose regular course of business is employment in the repair, service, or maintenance of motor vehicles may nevertheless qualify for no-fault benefits for injuries which occur outside of the scope of such activities or outside of the premises where he is employed.
Kimura v. Pacific Ins., MVI-89-77 (CFO June 14, 1990).

Coverage – The factual circumstances in a particular matter may support a claim for no-fault benefits by a claimant under a policy maintained by his father on a motor vehicle which was not involved in the claimant's accident at a time when the claimant was residing as a member of his father's household and was driving a motor vehicle which, unknown to the claimant, had previously been deleted from his father's policy and was thus uninsured. In evaluating such a matter, however, the actual provisions of the insurance policy may preclude such coverage as would otherwise exist.
Henry v. AIG Hawaii, MVI-89-74 (CFO February 26, 1990).

Coverage – The definition of "criminal conduct" provided in HRS § 294-2(3) [HRS § 431:10C-103(2)] is not limited to the conviction of a claimant for the commission of a crime. The statute is written in the disjunctive and any one of the three criteria may be sufficient to show that the exclusion of no-fault benefits based upon "criminal conduct" was appropriate.
Dias v. John Mullen, MVI-88-22 (CFO November 21, 1988).

Coverage – The ownership of a motor vehicle can be established in ways other than possessing legal title or effecting a valid registration, and the facts of a particular case may establish that ownership lies with someone other than the party possessing such documentation.
Sugimoto v. Transamerica, MVI-87-16 (CFO April 28, 1988).

Coverage – "[A] claimant's request for payments for property damage, as well as payments for pain and suffering were not within the preview of no-fault benefits payable by a respondent under HRS Chapter 294 [HRS Chapter 431]."
Strawbridge v. Hawaiian Ins., MVI-86-23 (CFO May 13, 1987).

DEATH BENEFITS

Death Benefits – "The amount of "survivor's loss" payable to any particular claimant as a separate category of no-fault benefits is a contractual matter determined by the terms of his or her insurance policy."
Cabral v. AIG Hawaii, MVI-94-551 (CFO May 15, 1996).

DISPUTES REGARDING CHARGES

Disputes Regarding Charges – A provider seeking reimbursement from an insurer for the amount of a disputed charge in an administrative proceeding initiated under the provisions of HAR § 16-23-120 has the same burden of proof as is required by a party seeking entitlement to any other no-fault benefit that has been denied by a respondent.
Jou/Leano v. GEICO, ATX-2000-208-P+ (CFO May 14, 2001).

Disputes Regarding Charges – "[I]t … appears that a provider's failure to comply with the requirements of HAR § 16-23-120 would … provide a procedural basis for an insurer to file a motion to dismiss a provider's request for a hearing."
Jou/Leano v. GEICO, ATX-2000-208-P+ (CFO May 14, 2001).

Disputes Regarding Charges – The substantive merit, if any, of an insurer's "downcoding" of a provider's billings presents questions of fact as to the degree of consistency between the individual billing codes used and the criteria set out in the relevant American Medical Association E/M Guidelines covering the year when the services were rendered.
Jou/Leano v. GEICO, ATX-2000-208-P+ (CFO May 14, 2001).

Disputes Regarding Charges – The the introduction of credible evidence may support a provider's assertion that massage and myofacial release were two separate procedures which could be billed separately although performed on the same day.
Jou/Miranda v. HIG, MVI 98-1175-P (CFO December 5, 2001).

FINDINGS/CONCLUSIONS

Findings/Conclusions – "While a determination of attorney's fees and costs under varying circumstances necessarily involves a degree of discretion, it is also well recognized that the trier of fact is accorded considerable deference in evaluating the reasonableness of such amounts."
Sildora v. AIG Hawaii, MVI-2001-1 (CFO June 20, 2001).

Findings/Conclusions –"The prior decisions of the Insurance Commissioner - unless reversed on appeal - constitute a significant portion of the body of law governing no-fault insurance proceedings, and a party who chooses to ignore or disregard such precedent does so at his or her peril."
Ho v. Hawaiian Insurance, MVI-94-391 (CFO February 14, 1997); *Valdez v. GEICO*, MVI-94-340-C+ (CFO January 10, 1996); and, *Siu v. AIG Hawaii*, MVI-92-4 (CFO August 28, 1992).

Findings/Conclusions – "The purpose of findings of fact is to reflect the preponderance of the credible evidence and not to simply restate the totality of the evidence which has been offered during the course of a hearing. It is also worth noting that large amounts of speculative, controverted, and unsupported evidence are not the equivalent of lesser amounts of credible evidence, and do not provide a suitable basis for establishing factual determinations."
Texeira v. Liberty Mutual, MVI-94-569 (CFO May 15, 1996); *Yoshioka v. Transamerica*, MVI-94-23 (CFO April 21, 1995; and, *Nguyen v. Dai-Tokyo*, MVI-94-86 (CFO March 16, 1995).

Findings/Conclusions – "Factual determinations made by a trier of fact who has actually conducted the full evidentiary hearing are presumptively correct unless subsequently shown to be unsupported by substantial evidence in any later review of the matter."
Martinez v. AIG Hawaii, MVI-94-250 (CFO September 15, 1995).

Findings/Conclusions – "Factual or discretionary determinations by a Hearings Officer will generally be set aside only if the Commissioner is left with the firm conviction that a mistake has been made."
Martinez v. AIG Hawaii, MVI-94-250 (CFO September 15, 1995).

Findings/Conclusions – "Where legal obligations have been established as a result of a no-fault hearing, but a specific dollar award cannot be made because of insufficient evidence, the parties have an obligation to attempt to determine that amount in good faith without further administrative proceedings. Where a further hearing is allowed and/or required to make such a determination, the parties may be subject to an assessment of administrative costs pursuant to HRS § 431:10C-

212(d); an award of attorney's fees and/or costs pursuant to HRS § 431:10C-211; or the imposition of sanctions pursuant to HRS § 431:10C-117."
Elarmo v. Island, MVI-93-260 (CFO January 24, 1995).

Findings/Conclusions – "A determination made by a trier of fact upon conducting a hearing is given considerable weight in any subsequent review of the record. Such determination will generally be set aside only if the Commissioner is firmly convinced that a mistake has been made."
Redona v. State Farm, MVI-93-34 (CFO March 10, 1994); and, *Tiletile v. GEICO*, MVI-90-69 (CFO May 13, 1991).

Findings/Conclusions – "The testimony of claimants and witnesses often takes a subjective form as they relate their perception of events, but this does not preclude such testimony as being part of the whole record upon which a hearings officer would make objective determinations in weighing the preponderance of the evidence."
Branch v. AIG Hawaii, MVI-91-9 (CFO November 8, 1991).

Findings/Conclusions – "In terms of evaluating the credibility of witnesses and determining the weight which should be accorded to specific exhibits, unsworn conclusory statements from parties or other persons that may have interests in the outcome of the proceedings, without sufficient foundation, background, or corroboration, must yield to the credible testimony of an expert witness subject to cross-examination."
Ostrander v. National Union, MVI-89-80 (CFO February 2, 1990).

Findings/Conclusions – The factual determinations made by hearings officers are not lightly set aside, especially when they are based upon substantial evidence.
Cord v. State Farm, MVI-89-37 (CFO December 29, 1989).

Findings/Conclusions – "[A] determination made by the trier of fact as a result of actually conducting a hearing is given considerable weight in any subsequent review of the record. Factual or discretionary determinations by a hearings officer will generally be set aside only if the Commissioner is left with the firm conviction that a mistake has been made."
Minoo v. Liberty Mutual, MVI-88-16 (CFO May 26, 1989); and, *Howard v. State Farm*, MVI-88-12 (CFO December 4, 1988).

Findings/Conclusions – The credibility of a witness is determined by the Hearings Officer, who has conducted the proceedings and has discretion to weigh the relative merits of his or her testimony in light of the testimony of other witnesses or other evidence. Unless an assessment of the credibility of a witness is not supported by the evidence, the Commissioner will defer to the Hearings Officer's determination.
Stephens v. State Farm, MVI-86-26 (CFO July 28, 1987).

HEALTH CARE

Health Care – Where a licensed massage therapist has provided therapeutic services to a claimant in accordance with a physician's prescription and has billed for them, the insurer may not deny payment for such services on the basis that they were not provided in a massage establishment which was then licensed by the State. The subject of enforcing the licensing requirements of the establishment itself is a separate regulatory matter for potential consideration in separate (disciplinary) proceedings.
Chun v. Progressive, ATX-2000-184 (CFO September 10, 2001).

Health Care – Where it has been factually determined that a claimant went to a hospital emergency room for health care treatment as a matter of personal convenience, rather than because of a need for emergency treatment or services as defined in HAR § 16-23-94, the treatment or services rendered do not fall within the exception to the fee schedule requirements set out in HAR § 16-23-93 for "emergency" care.
HEPA/Petty v. Hawaiian Insurance, ATX-99-78-P (CFO January 27, 2000).

Health Care – "[A] "community standard", and not what the provider chooses to charge [for health care services], is the baseline for determining what shall be considered an appropriate and reasonable charge pursuant to HAR § 16-23-94."
HEPA/Matsuoka v. Hawaiian Insurance, ATX-99-79-P (CFO January 25, 2000).

Health Care – In determining whether an "emergency" existed which would have warranted application of the fee schedule exception (for emergency treatment or services) as stated in HAR § 16-23-93, the focus is on the reasonably understood condition of the claimant under the immediacy of the circumstances, as perceived by the claimant or others. This determination involves a factual analysis in light of the information available at the time such treatment or services were received, rather than upon the results of some subsequent review of events which, retrospectively, might or might not reach the same conclusion.
HEPA/Matsuoka v. Hawaiian Insurance, ATX-99-80-P (CFO January 25, 2000).

Health Care – A respondent's fallacious assumption that a claimant's palliative care does not qualify as a legitimate no-fault benefit, is not a valid basis for issuing a denial.
Ma v. Liberty Mutual, MVI-96-1422-P (CFO February 26, 1999).

Health Care – In reviewing the reasonableness of a no-fault claim for psychotherapy provided to a Claimant by an unlicensed practitioner, the most appropriate code for reference within the Workers' Compensation Medical Fee Schedule is 90869. This is true even though it sets the rate of compensation for mental health professionals who provide mental health services under the employ

and supervision of a psychiatrist since it applies to unlicensed mental health professionals. The utilization of either code 90800 or 90805 for guidance under such circumstances is misplaced.
Valdez v. GEICO, MVI-94-340-C+ (CFO January 10, 1996).

Health Care – It should be readily apparent that psychotherapy must be billed at the correct codes/rates for such services (even if they were to be provided by a licensed practitioner who could bill at a higher rate where psychiatric or psychological services were actually provided).
Valdez v. GEICO, MVI-94-340-C+ (CFO January 10, 1996).

Health Care – The workers' compensation program does not permit an unlicensed health care provider to be compensated. Therefore, it must be presumed that the unit values contained in the Workers' Compensation Medical Fee Schedule are considered reasonable compensation for a *licensed health care provider.*
Valdez v. GEICO, MVI-94-340-C+ (CFO January 10, 1996).

Health Care – A provider may charge for treatments performed on two separate areas of a claimant's spine during a single office visit in accordance with the applicable provisions of the Worker's Compensation Medical Fee Schedule adopted for no-fault insurance matters pursuant to HAR § 16-23-115. Since, for such purposes, the schedule does not consider the spine as a single, unitary area, but instead considers it to be comprised of cervical, thoracic, lumbosacral and sacrioliac regions, a provider may use procedure code 97260 for one area and procedure code 97261 for the additional area. The schedule, however, does limit the total charges for separate manipulations in a single office visit to one application under each of these procedural codes.
Nguyen v. State Farm, MVI-94-4-C (CFO September 25, 1995).

Health Care – "The standard for evaluating health care expenditures as set out in HRS § 431:10C-103(10)(A) requires that they reflect "appropriate and reasonable expenses necessarily incurred". The Insurance Commissioner has consistently upheld a claimant's right to palliative care which is reasonable, appropriate, an necessarily incurred, either alone or in conjunction with curative care. The adoption of HAR § 16-23-105 as replacement for HAR § 12-13-39 did not preclude palliative no-fault benefits, and HAR § 16-23-93 states that palliative treatments remain subject to the same requirements as any other (curative) type of treatment."
Pecson v. GEICO, MVI-94-254-C (CFO September 15, 1995).

Health Care – The provisions of the Medical Fee Schedule which state that Codes 97260 & 97261 "may not be used more than once, whether singularly or in combination for a single office visit" do not limit consideration of the spine as a single, unitary area. A provider may request payment for separate manipulations of distinct areas of a claimant's spine, although only two separate manipulations are

allowed as the maximum charge under the fee schedule. The first would be under Procedure Code 97260 and the second would be under Procedure Code 97261.
Nutter/Garot v. State Farm, MVI-93-278-P (CFO September 11, 1995).

Health Care – The provisions of the Medical Fee Schedule which state that Codes 97260 & 97261 "may not be used more than once, whether singularly or in combination for a single office visit" do not limit consideration of the spine as a single, unitary area. A provider may request payment for separate manipulations of distinct areas of a claimant's spine, although only two separate manipulations are allowed as the maximum charge under the fee schedule. The first would be under Procedure Code 97260 and the second would be under Procedure Code 97261.
Nutter/Garot v. State Farm, MVI-93-278-P (CFO September 11, 1995).

Health Care – While a claimant does not have an unrestricted license to select a particular method of treatment, he or she is generally entitled to make such a decision so long as it is within the parameters of appropriateness, reasonableness, and necessity - and may do so for either a curative or a pain management purpose.
Ige v. AIG Hawaii, MVI-93-42 (CFO February 18, 1994).

Health Care – Where it is clear that a claimant would obtain curative benefits from participating in additional health care treatments, it is reasonable to condition the receipt of benefits for pain management (such as passive modalities) upon the claimant engaging in additional treatment (such as physical therapy) to enhance her overall condition.
Ige v. AIG Hawaii, MVI-93-42 (CFO February 18, 1994).

Health Care – "[T]he kind of treatment which a Claimant ultimately chooses, must be left largely to the claimant's discretion, so long as the treatment is appropriate, reasonable, and necessarily incurred. The fact that one health care professional may believe that a particular form of treatment would provide maximal therapeutic benefit as opposed to other forms of treatment, is not the correct standard to apply. It is sufficient that the treatment which a claimant decides upon is appropriate, reasonable, and necessarily incurred."
Tungpalan v. AIG Hawaii, MVI-92-68 (CFO January 27, 1994).

Health Care – Prior to 1992 the Insurance Commissioner utilized the workers compensation medical fee schedules (adopted by the Department of Labor and Industrial Relations) as a guideline to determine if the cost of health care benefits received by claimants under the no-fault insurance laws were reasonable. In 1992, however, the legislature mandated the use of these schedules in determining the reasonable cost of such benefits when they are received from a licensed health care provider.
Mueller v. GEICO, MVI-92-59 (CFO January 12, 1994).

Health Care – A health care provider who fails to maintain a currently valid license at the time that he or she engages in a licensed activity, is prevented (under

HRS § 436B-26) from receiving compensation for the cost of such work or services. On the other hand, there is no restriction in the no-fault law which would prevent an unlicensed person from receiving compensation for having provided health care services of a nature which does not require licensure by the provider. Under such circumstances, the reasonable value of such services may be determined, in part, by referring to analogous types of categories within the workers compensation fee schedules as guidelines to be used in conjunction which such other relevant evidence as may be presented during the course of the hearing.
Mueller v. GEICO, MVI-92-59 (CFO January 12, 1994).

Health Care – "Neither the no-fault statutes nor the applicable rules require a claimant to get a referral from a licensed mental health professional prior to seeking treatment from an unlicensed mental health professional[.]"
Mueller v. GEICO, MVI-92-59 (CFO January 12, 1994).

Health Care – It has been well established in prior cases that chiropractic treatments which satisfy the definitional criteria of HRS § 431:10(C)-103(10)(A)(i) are proper when provided for either a curative or pain management purpose and constitute compensable no-fault benefits.
Neilsen v. USAA, MVI-93-38 (CFO December 13, 1993).

Health Care – The kind of health care treatment which an insured chooses to provide relief from injuries sustained in a motor vehicle accident must be left largely to the insured's discretion, so long as the treatment is appropriate, reasonable, and unnecessarily incurred.
Menez v. State Farm, MVI-92-200 (CFO November 15, 1993); and, *Gonong v. State Farm*, MVI-92-187 (CFO November 15, 1993).

Health Care – " A plain reading of the statutory language that sets forth the definition of "accidental harm" reveals that the legislative intent was to cover several categories of harm or consequence that a person might incur as a result of involvement in a motor vehicle accident[.] ... Nothing in the language of the statute directs that no-fault benefits for death, sickness, or disease are to be limited to only such mental sickness or disease that might flow from a physical harm incurred by the claimant. ... Additionally, to say that the term "accidental harm" includes only ***bodily*** (physical) sickness and ***bodily*** (physical) disease would be inconsistent with the provision of the statute authorizing payment of no-fault benefits for psychiatric therapy and rehabilitation[.]"
Kekuewa v. Alexsis, MVI-93-13 (CFO September 10, 1993).

Health Care – "Payments for psychotherapeutic treatments are recognized as a valid no-fault benefit when the treatments are considered to be appropriate, reasonable, and necessarily incurred."
Kekuewa v. Alexsis, MVI-93-13 (CFO September 10, 1993).

Health Care – "The statute, HRS § 431:10C-103(10)(A)(ii), has no requirement that payments of no-fault benefits are to be limited to those situations in which the harm, in this instance mental distress, that requires treatment has its genesis in some physical injury sustained by the claimant."
Kekuewa v. Alexsis, MVI-93-13 (CFO September 10, 1993).

Health Care – "While the referral of a Claimant for consultative health care evaluations need not necessarily be made by a health care professional, the referral must be a valid one based upon the health care interests of the Claimant rather than for some other purpose."
Aina/Ferreira/Ganir v. AIG Hawaii, MVI-92-163 (CFO September 1, 1993).

Health Care – "As a threshold matter, the eligibility of the underlying health care services as no-fault benefits must be established before one can determine whether related expenses (such as travel and accommodations) qualify as no-fault benefits. The simple, unexplained act of a respondent in paying for underlying health care services does not equate to a legal determination that there was an obligation to do so because the services met the standard of 'appropriate and reasonable expenses necessarily incurred.'"
Aina/Ferreira/Ganir v. AIG Hawaii, MVI-92-163 (CFO September 1, 1993).

Health Care – "Reasonable travel costs and other expenses related to health care services may be compensable as no-fault benefits, but the reasonableness of such costs - even where they are incurred for obtaining otherwise unchallenged health care treatment - is determined in light of the factual circumstances surrounding each case."
Aina/Ferreira/Ganir v. AIG Hawaii, MVI-92-163 (CFO September 1, 1993).

Health Care – "While a claimants choice of treatment for either curative or palliative purposes is an important consideration in evaluating the suitability or cost of no-fault benefits, it is not necessarily conclusive and claimants do not have carte blanche ability to unilaterally select their methods of treatment .... Furthermore, although a claimant is entitled to select a reasonable method of treatment, the method may - under certain factual circumstances - be considered reasonable only when conditioned upon participation in additional treatments which may enhance recovery in conjunction with pain relief."
Valentino v. AIG Hawaii, MVI-92-157 (CFO July 2, 1993).

Health Care – "[T]he kind of treatment which a claimant ultimately chooses, must be largely left to the claimants discretion so long as the treatment is appropriate, reasonable, and necessarily incurred. The fact that one health care professional may believe that a particular form of treatment would provide maximum therapeutic benefit as opposed to other forms of treatment, is not the correct standard to apply. It is sufficient that the treatment which a claimant decides upon is appropriate, reasonable and necessarily incurred."

Testa v. AIG Hawaii, MVI-92-75 (CFO February 16, 1993); *Mondress v. USAA Casualty*, MVI-92-63 (CFO February 16, 1993); and, *Suganuma v. AIG Hawaii*, MVI-92-102 (CFO February 16, 1993).

Health Care – The provisions of HRS § 431:10C-103(10)(a) apply to the acquisition of equipment or supplies which may be required for physical and/or occupational therapy and rehabilitation in the same manner as the apply to the provision of health care treatment or services. In any particular case, it is a question of fact whether the purchase of exercise equipment meets the appropriate, reasonable, and necessarily incurred requirements set out in that statute, and a claimant has the same burden of proof to show that he or she is entitled to such equipment or supplies.
Tsue v. AIG Hawaii, MVI-92-81 (CFO February 16, 1993).

Health Care – While an assertion by a claimant that a particular type of health care provides pain management does constitute objective evidence for consideration by the Hearings Officer, it is by no means solely determinative of the outcome in most cases. This is especially true where such assertions are not well supported by other lay or expert testimony and are contradicted by credible medical evidence presented by a respondent.
Bernabe(s) v. AIG Hawaii, MVI-92-74 (CFO January 14, 1993).

Health Care – "It is established precedent that chiropractic treatments which meet the definitional requirements of the statute [HRS § 431:10C-103(10)(A)] are proper when provided for either a curative or a pain management purpose."
Agor v. AIG Hawaii, MVI-92-84 (CFO January 11, 1993).

Health Care – "By its nature, matters involving the psychological aspects of rehabilitation result in a magnification of the role of the doctor - patient relationship in obtaining beneficial results in the patient. The patients trust and confidence in the doctor would be among the cornerstone of the treatment program." Accordingly, neither the suggestion of additional modalities which might enhance a claimant's recovery, nor an opinion that the claimant could "adequately function" in the absence of the existing treatment is sufficient to support a determination that the claimant is ineligible for continuing no-fault benefits.
Gugudan v. AIG Hawaii, MVI-92-23 (CFO November 6, 1992).

Health Care – The provisions of HRS § 436B-26 are clear in stating that a person who fails to maintain a valid license at the time he or she engages in an activity which requires licensure shall be prevented from recovering the cost of services or supplies which were provided in the purported capacity of a licensee. An insurer is not required to pay bills for no-fault services furnished by an unlicensed provider.
Abrams-Fuller v. GEICO, MVI-91-127 (CFO September 23, 1992).

Health Care – In determining whether diagnostic tests should be covered under no-fault benefits, the reasonableness, necessity, and appropriateness of the particular test must be examined - together with concerns regarding the relative benefits of the tests being significantly outweighed by the costs. "[T]he health care provider should be cognizant of the monetary limitations of the patient's no-fault policy and whenever possible, discuss with the patient, the cost of the diagnostic test and any viable alternative test which may be less expensive."
Walter v. AIG Hawaii, MVI-90-134 (CFO June 12, 1992).

Health Care – A claimant's no-fault benefits with respect to health care include the cost of obtaining "second opinions" from other health care providers so long as they are suitable in nature and reasonable in cost. Any subsequent coincidental use of such "second opinions" for purposes of litigation does not disqualify them as no-fault benefits. They are not analogous to the costs of an IME conducted on behalf of a respondent as a business expense.
Epps v. CNA/Crawford, MVI-90-61 (CFO February 14, 1991).

Health Care – Under certain factual circumstances particular costs associated with a claimant's membership and/or activities in a health club may qualify as legitimate no-fault benefits, particularly where the claimant pays the initiation cost and where the activity is a specifically designated exercise program which the claimant attends during non-working hours.
Kardynalczyk v. Transamerica, MVI-89-34 (CFO October 17, 1990).

Health Care – The no-fault system of reparations, as envisioned by the legislature and as further defined in HRS § 294-2(10)(b) [HRS 431:10C-103(10)(A)(iii)] includes vocational rehabilitation services to the extent that they are both reasonable (in cost) and necessary (in purpose).
Tanigawa v. First Ins., MVI-89-109 (CFO August 16, 1990).

Health Care – "It is worth noting that the choice of a claimant, although a factor in determining the type of health care to be provided, is not the only factor which must be considered."
Calicdan v. AIG Hawaii, MVI-89-81 (CFO March 23, 1990).

Health Care – In order to qualify for prosthetic services, products, and/or accommodations under HRS § 294-2(10)(A) [HRS 431:10C-103(10)] a claimant must convincingly demonstrate their suitability under the phrase "appropriate and reasonable expenses necessarily incurred".
Tada v. Liberty Mutual, MVI-89-40 (CFO October 3, 1989); *Baron v. State Farm*, MVI-88-39 (CFO June 9, 1989); and, *Howard v. State Farm*, MVI-88-12 (CFO December 4, 1988).

Health Care – Vague generalities that a claimant's discomfort may have been partially related to her sleeping accommodations coupled with the suggestion that her discomfort might be reduced by the replacement of an allegedly poor mattress

through the purchase of a standard, non-therapeutic bed is not sufficient to qualify the claimant for prosthetic benefits under HRS § 294-2(10)(A) [HRS § 431:10C-103(10)(A)(i)].
Tada v. Liberty Mutual, MVI-89-40 (CFO October 3, 1989).

Health Care – Under certain particular circumstances it may become necessary for a respondent to actually restore a claimant to a condition superior to that which he or she enjoyed prior to the motor vehicle accident. "The respondent must take the claimant as it has insured her, and if - in order to correct an accident-related injury - it becomes professionally necessary to correct a preexisting, non-accident related condition, so be it."
Huynh v. State Farm, MVI-88-9 (CFO June 26, 1989).

Health Care – A claimant who is seeking reimbursement for prosthetic devices must convince the trier of fact, by a preponderance of the evidence, that the facts of his or her case meet the legal criteria in HRS § 294-2(10)(A) [HRS § 431:10C-103(10)(A)(i)] in order to qualify for such no-fault benefits.
Baron v. State Farm, MVI-88-39 (CFO June 9, 1989).

Health Care – "[T]here is no absolute proscription on giving reasonable discounts to cash providers, to professional associates, or to friends and family members. The policy and rationale behind allowing such discounts is clearly set forth in *Shimabukuro v. Liberty Mutual*, MVI-82-22 (Insurance Commissioner, December 22, 1982) as well as *Recinello v. National Union*, MVI-83-19 (Insurance Commissioner, May 12, 1984). These cases illustrated the limitations inherent in such discounts, however, and underlined the qualification that they must be applied in an equitable and non-discriminatory manner."
Thomas v. State Farm, MVI-88-51 (CFO April 11, 1989).

Health Care – Compensable no-fault health care benefits are defined in HRS § 294-2(10)(a) [HRS § 431:10C-103(10)(A)(i)] as "all appropriate and reasonable expenses necessarily incurred." The first and third requirements (appropriateness and necessity) are generally considered as one criteria (suitability of care). The second requirement (reasonableness) refers to the dollar amount of the charges billed for health care services.
Daoang v. State Farm, MVI-88-38 (CFO December 4, 1988).

Health Care – "A number of recent cases ... have restated and re-emphasized that there is no validity to an argument that insurers should be liable only to the point where a claimant's condition is made stable. Benefits for comfort and pain management are covered by the Hawaii no-fault system of reparations even after a claimant has reached a stable medical condition."
Daoang v. State Farm, MVI-88-38 (CFO December 4, 1988).

HJUP ELIGIBILITY

HJUP Eligibility – "Although the benefits claimed by Claimant derived from his eligibility under the HJUP, pursuant to the provisions of HRS § 431:10C-406(d) [The provisionsof all other parts of this article apply to the joint underwriting plan, whether direct reference is made or not, unless in conflict with the provisions of this part.] the provisions of HAR § 16-23-4 were applicable to this matter.
Mahelona v. AIG Hawaii, MVI-2000-48 (CFO February 14, 2001).

HJUP Eligibility – "The purpose of [the] HJUP is to provide no-fault benefits to victims of motor vehicle accidents for whom no policy is applicable." Thus, under the provisions of HRS § 431:10C-408, where a claimant (who is not otherwise disqualified) has testified that he or she was injured in a motor vehicle accident for which there is no identifiable insurance policy, and where there is no introduction of any evidence to the contrary, that person is eligible to apply for no-fault benefits under the HJUP in accordance with the usual entitlement requirements for them.
Mahelona v. AIG Hawaii, MVI-98-1232 (CFO April 20, 2000).

HJUP Eligibility – A pedestrian or bicyclist who has no insurance of his or her own, and who is struck by an uninsured motorist, does not qualify for no-fault insurance benefits and is not eligible for an assignment of his or her claims through the Hawaii joint underwriting plan.
Musick v. Insurance Division, MVI-95-280-J (CFO February 13, 1997).

HJUP Eligibility – Under the provision of HRS § 294-23(a) [HRS § 431:10C-408] a person is not entitled to obtain benefits through the Hawaii Joint Underwriting Plan if the person has or can receive no-fault benefits through an applicable no-fault insurance policy. The argument that a claimant should be entitled to HJUP coverage because her previously received no-fault benefits were "inadequate and insufficient to pay her damages" is without legal merit.
Jacobson v. Liberty Mutual, MVI-88-64 (CFO January 9, 1989).

HJUP Eligibility – The historical background, statutory construction, and inherent relevancy of HRS § 294-23 [HRS § 431:10C-408] is well presented in the case of *Newmann v. Ramil*, 6 Haw. App. 377, 722 P.2d 1048 (1986) wherein the court concluded that the statute only referred to claims for no-fault benefits and not to claims based on mandatory public liability policies for accidental harm or property damage.
Jacobson v. Liberty Mutual, MVI-88-64 (CFO January 9, 1989).

HJUP Eligibility – The requirements for alternative eligibility under the provisions of HRS § 294-23(c) [HRS § 431:10C-408] in lieu of eligibility under HRS § 294-23(a) (as a person "who becomes eligible to file a claim or an action against the mandatory public liability or property damage policies") are not limited to those

contained in HRS § 294-6. A person seeking eligibility for participation in the HJUP must show that he or she satisfies the provisions of HRS § 294-23(a) as a prerequisite to consideration under HRS § 294-23(c).
Jacobson v. Liberty Mutual, MVI-88-64 (CFO January 9, 1989).

HJUP Eligibility – A claimant must satisfy a two-pronged requirement to establish eligibility for no-fault benefits through the Hawaii Joint Underwriting Plan by being eligible under HRS § 294-23(a) [HRS § 431:10C-408] for no-fault benefits as well as by being eligible under HRS § 294-23(c) to file a claim or action against the mandatory public liability policy after having met the threshold requirement of HRS § 294-23(a). Furthermore, alternative eligibility under HRS § 294-23(c) is dependent upon a favorable determination by the joint underwriting plan bureau.
Jacobson v. Liberty Mutual, MVI-88-64 (CFO January 9, 1989).

INDEPENDENT MEDICAL EXAM

Independent Medical Exam – While the report generated by an independent medical examination of a claimant may present a thorough and thoughtful snapshot of his or her condition at the time the examination took place, its subsequent value may be seriously hampered by a lengthly passage of time between the examination and the later issuance of a denial of benefits.
Ajifu v. AIG Hawaii, ATX-2001-52+ (CFO November 1, 2001).

Independent Medical Exam – A claimant's failure to respond to an insurer's reasonable request that he or she to submit to a physical exam (by a physician selected by the insurer) equates to a claimant's failure to comply with such a request, is as detrimental as a failure to appear for the exam itself, and discharges the respondent (insurer) from any obligation it might otherwise have had to provide no-fault benefits to the claimant.
Dick v. AIG Hawaii, MVI-98-1319 (CFO July 25, 2001).

Independent Medical Exam – "[A] claimant's participation in a medical examination as requested by his or her insurer is a multi-step process which is initiated by the request (notice) and includes the subsequent selection of a physician, the scheduling of the examination, the appearance of the insured [claimant], and the preparation of a report. Each step requires commitments and involves the expenditure of resources, and each step is dependent upon compliance with those preceding it. Furthermore, this multi-step process is a time sensitive one in which the then-existing condition of the insured must be evaluated without undue delay."
Dick v. AIG Hawaii, MVI-98-1319 (CFO July 25, 2001).

Independent Medical Exam – When an insurer – in accordance with the provisions of HAR § 16-23-4 – has issued a policy which includes a requirement for the insured to submit to an independent medical examination, the insured must comply with any such reasonable request and the insurer may base a denial on his or her refusal to do so. Furthermore, an insured's act of offering or providing the insurer with the results of some other examination does not fulfill his or her obligation in this regard.
Mahelona v. AIG Hawaii, MVI-2000-48 (CFO February 14, 2001).

Independent Medical Exam – The value of an "independent medical examination" depends on a number of variables, including the particular focus of the examination as well as its timeliness, and if its focus does not extend to part of a particular topic at issue or it was not conducted at a time close to the date of an event or condition at issue the value of an otherwise useful examination may be significantly diminished.
Graham v. AIG Hawaii, MVI-2000-34 (CFO February 1, 2001).

Independent Medical Exam – An insuer may condition its payment of no-fault benefits upon an insured's cooperation in attending an "independent medical examination" (IME) consistent with the provisions of HAR § 16-23-4(b) and, where an insured has negligently failed to attend a regularly scheduled IME, an insurer may require reasonable reimbursement from the insured for costs associated with that IME before agreeing to reschedule it. In order to be considered reasonable, however, the amount of reimbursement requested by the insurer should not exceed the payment limitations for such services as stated in HRS § 431:10C-308.5(b).
Perucho v. AIG Hawaii, ATX-2000-81+ (CFO February 1, 2001).

Independent Medical Exam – "A denial of benefits based upon an evaluation which was conducted many [eleven] months earlier, is inherently suspect and may be inappropriate without [an] examination of any relevant information with respect to the Claimant's actual condition at the time of the denial."
Sanchez v. Allstate, MVI-99-193 (CFO November 29, 1999).

Independent Medical Exam – "The fact that … [an IME evaluator] received payment in excess of that allowed for IME's [sic] conducted by a licensed Hawaii provider in the amount set under the worker's' compensation schedules did not render his report void. Such compensation, however, may be considered in determining the weight to be given a report rendered by a physician paid in excess of the amount set by the worker's' compensation schedule.
Takemoto v. State Farm, MVI-95-690 (CFO July 15, 1999).

Independent Medical Exam – When a claimant's injuries are "soft tissue" in nature and are treated for palliative as well as curative purposes, it is particularly difficult to use a one-time "independent" evaluation (especially when limited to a records only review) to assess either the causation of the injuries or the propriety of their care.
Yeung v. AIG Hawaii, MVI-95-233 (CFO October 24, 1997).

Independent Medical Exam – "Hawaii Administrative Rules ("HAR") § 16-23-4 provides that a no-fault policy may provide that an injured person shall submit to a medical examination by physicians selected by or acceptable to the insurer when, and as often as, the insurer may reasonably require. It has been previously determined that the failure of a claimant to comply with a respondent's reasonable request for an IME, as provided for in the applicable insurance policy provisions and consistent with HAR §§ 16-23-4 and 16-23-60, is a valid basis for a respondent to issue a denial of no-fault benefits."
Durand v. GEICO, MVI-95-261 (CFO June 26, 1997).

Independent Medical Exam – A respondent need not present a claimant with pre-IME certification that the respondent's payment for the IME will not exceed the limitations on charges set out in HRS § 431:10C-308.5. The statute requires physicians, not insurers, to certify on the (post IME) billing that the charges are in

accordance with its limitations, and is not a basis upon which a claimant can legitimately refuse to participate in an independent medical exam.
Durand v. GEICO, MVI-95-261 (CFO June 26, 1997).

Independent Medical Exam – "[T]he provisions of HRS § 431:10C-308.5(b) relating to charges for the conduct of independent medical examinations ("IME") will, where circumstances dictate, be enforced by excluding consideration of proffered evidence that is based upon an IME rendered in violation of such statutory requirement."
Durand v. GEICO, MVI-95-261 (CFO June 26, 1997).

Independent Medical Exam – Although the provisions of HAR §§ 16-23-4 and 16-23-60 require a respondent to present a claimant with a list of three physicians from which the claimant may make a selection for conducting an IME, they do not preclude a claimant from waiving his or her right to make such a selection where the waiver is accompanied by notice to the respondent that the claimant would participate in the IME by whichever physician the respondent choose. Under these circumstances the claimant's refusal to choose a particular physician is not the equivalent of refusing to submit to the exam itself.
Khan-Miyasaki v. State Farm, MVI-94-276 (CFO March 12, 1996).

Independent Medical Exam – The peer review process offers insurers an alternative to an IME as a basis for evaluating whether treatment for an accident related injury is appropriate and reasonable. It provides an assessment by a medical (or other) peer similar to what might be rendered by an IME, is rebuttable, and is not entitled to any greater validity than other evidence that may be received on the question of whether an insurer's denial of no-fault benefits was proper.
Ching v. AIG Hawaii, MVI-94-89-C (CFO January 5, 1996).

Independent Medical Exam – "The difficulty of making medical assessments - even where there has been a physical examination (IME) of a claimant - with respect to validating and/or treating pain (a subjective symptom of a claimant's injury) has been recognized in previous cases. Further consideration of this topic raises serious questions about the adequacy of using the peer review process as a means of evaluating health care treatments which are at least partially palliative in nature."
Ringer v. AIG Hawaii, MVI-94-127-C (CFO June 14, 1995).

Independent Medical Exam – "Although a claimant's evaluation at an Independent Medical Exam may establish that the claimant is not suffering from discomfort or disability at a particular time, such an evaluation is usually only one of many evidentiary factors to be considered in determining the merit, it any, of a denial of no-fault benefits."
Perreira-Pico v. GEICO, MVI-94-27 (CFO April 21, 1995); *Dalere v. GEICO*, MVI-93-128 (CFO March 15, 1994); *Kihano v. GEICO*, MVI-92-106 (CFO January 11, 1994); *Naito v. USAA Casualty*, MVI-92-174 (CFO August 30, 1993); *Baugh v. AIG Hawaii*,

MVI-92-146 (CFO May 19, 1993); and, *Naranjo v. AIG Hawaii*, MVI-90-11 (CFO September 27, 1990).

Independent Medical Exam – A respondent's denial of wage loss benefits to a claimant based upon the results of an independent medical exam which predicts that a claimant will probably be able to resume employment in the near future (and therefore implicitly acknowledges that the claimant is not currently able to resume employment) was precipitous and based on an erroneous premise.
Perreira-Pico v. GEICO, MVI-94-27 (CFO April 21, 1995), *Paaoao v. Liberty Mutual*, MVI-89-90 (CFO June 12, 1990).

Independent Medical Exam – The Commissioner has previously held that a request for an IME does not constitute a request for further information under the provisions of HRS § 431:10C-304(3)(C) and that an insurer cannot withhold payment of no-fault benefits pending the outcome of an IME.
Kersting v. AIG Hawaii, MVI-93-181 (CFO December 1, 1994).

Independent Medical Exam – "Conduct by a respondent which violates the provisions of HRS § 431:10C-308.5(b) relating to the allowable costs for IMEs, and therefore subjects the respondent to the potential imposition of sanctions pursuant to HRS § 431:10C-117(b) or (c), does not automatically invalidate an otherwise proper IME. It may, of course, affect the weight of such evidence but does not preclude its admissibility per se."
Pacubas v. AIG Hawaii, MVI-93-184 (CFO October 10, 1994).

Independent Medical Exam – Where the opinion expressed in an independent medical exam is based upon an incomplete review of existing health care records, is indefinite and/or conflicting in its analysis, and attempts to assess what the status was of a claimant well prior to the date of the examination, it generally tends to raise as many questions as it answers. This is even more true where the examiner does not testify at the hearing and where little, if any, material information is introduced on the examiner's own background and qualifications, since such opinions are only as good as the information upon which they are based and the qualifications of the examiner to interpret that information.
Calatrava v. AIG Hawaii, MVI-93-76+ (CFO March 4, 1994).

Independent Medical Exam – An evaluation of a claimant's condition as of a particular date which is based upon an independent medical exam is particularly difficult where the independent medical exam attempts to assess the status of the claimant several weeks, or even months, before the date when the examination was actually conducted.
Calatrava v. AIG Hawaii, MVI-93-76+ (CFO March 4, 1994).

Independent Medical Exam – "The failure of a Claimant to comply with a Respondent's request for an independent medical examination, as provided for in the applicable insurance policy provisions, and consistent with HAR § 16-23-4 and

16-23-60, is generally a valid basis for a Respondent to issue a denial of no-fault benefits."
Rondolos v. AIG Hawaii, MVI-92-197 (CFO August 30, 1993); and, *Jose v. AIG Hawaii*, MVI-92-44 (CFO September 23, 1992).

Independent Medical Exam – "Information, including medical opinions, resulting from an independent medical exam conducted after a denial of benefits has already been issued, cannot be used as the basis (reason) upon which the denial was previously issued. Such information is frequently not even relevant for consideration in a hearing on the merits of the prior denial."
Ho/Tran v. Royal Ins., MVI-91-66+ (CFO July 1, 1993).

Independent Medical Exam – "It is worth noting whether there has been a significant passage of time between the date of a claimant's independent medical exam and the date of any denial of no-fault benefits based upon that examination. A denial of benefits based upon an evaluation which had been conducted many months earlier may be inappropriate, especially in the absence of any relevant information with respect to the claimant's actual condition at the time of the denial."
Baugh v. AIG Hawaii, MVI-92-146 (CFO May 19, 1993); and, *Rodrigues v. Maryland Casualty*, MVI-90-123 (CFO June 3, 1991).

Independent Medical Exam – An independent medical examination performed by a doctor not licensed to practice in Hawaii (and not in actual consultation with another doctor who is licensed to practice in Hawaii) constitutes an unlawful practice (in violation of HRS § 453-2) and has no efficacy in administrative proceedings to contest the propriety of a denial of no-fault benefits based upon the results of such an exam.
Jose v. State Farm, MVI-93-14 (CFO May 14, 1993) [reversed and remanded, Civil No. 93-2433-06, December 20, 1993].

Independent Medical Exam – "A medical determination made by a health care provider during the course of an independent medical exam that a claimant "can safely engage in ordinary activities of daily living without fear of harming her back in some irreparable manner" does not meet the standard for determining a claimant's eligibility for continued health care services."
Tadeo v. AIG Hawaii, MVI-92-118 (CFO March 8, 1993); and, *Wemple v. AIG Hawaii*, MVI-90-104 (CFO April 22, 1991).

Independent Medical Exam – While an insurer may require an insured to submit to an independent medical examination as a condition for receiving no-fault benefits, any and all health care professionals designated by the insurer to perform such an examination must be duly licensed to practice their profession. Where one or more of the health care professionals offered to the insured failed to be properly licensed, the refusal of the claimant to submit to such an examination was not a valid basis for a denial of no-fault benefits.
Wade v. AIG Hawaii, MVI-92-50 (CFO October 8, 1992).

Independent Medical Exam – The failure of a claimant to comply with a respondent's reasonable request for an IME, as provided for in the applicable insurance policy provisions and consistent with HAR §§ 16-23-4 and 16-23-60, is generally a valid basis for a respondent to issue a denial of no-fault benefits.
Jose v. AIG Hawaii, MVI-92-44 (CFO September 23, 1992); and, *Lissauer v. AIG Hawaii*, MVI-90-66 (CFO May 6, 1991).

Independent Medical Exam – "In order to prevail it is not enough for a claimant to establish that an "IME" was unable to conclude that he or she was pain free, or even that the claimant might have been experiencing accident-related pain. Although it is often possible that a claimant may be experiencing accident-related discomfort, a suspicion or conjecture to that effect does not satisfy the standard of proof required to show that the denial was improper."
Kennedy v. AIG Hawaii, MVI-92-28 (CFO September 9, 1992).

Independent Medical Exam – The unreasonable failure of a claimant to comply with an insurer's reasonable request that the claimant submit to an independent medical examination is a valid basis upon which the insurer may issue a denial of no-fault benefits.
Cabudol, Jr. v. GEICO, MVI-91-10 (CFO December 15, 1991), *Lissauer v. AIG Hawaii*, MVI-90-66 (CFO May 6, 1991).

Independent Medical Exam – A blanket denial of "any" benefits is clearly improper when the independent medical exam (which provided the basis for the denial) established only that passive modalities were improper given the stage of the claimant's recovery.
Hotchkiss v. AIG Hawaii, MVI-90-103 (CFO July 18, 1991).

Independent Medical Exam – A respondent's imposition of charges on a claimant's no-fault account for any costs relating to the scheduling, cancellation, or conduct of an independent medical evaluation may be a basis for imposing penalties under HRS § 431:10C-117.
Lissauer v. AIG Hawaii, MVI-90-66 (CFO May 6, 1991).

Independent Medical Exam – A respondent's payment of a health care billing which was submitted as the cost of performing an "independent medical evaluation" is a business expense of the insurance carrier which is voluntarily incurred at its option and for its benefit. The cost of an "independent medical examination" is neither a no-fault benefit (nor is it "somewhat akin" to the payment of no-fault benefits by public assistance) and does not toll the statute of limitations.
Ruperti v. State Farm, MVI-88-81 (CFO September 6, 1989).

JURISDICTION

Jurisdiction – The provisions of HRS § 431:10C-315 which set time limits on the filing of a "suit" are equally applicable to the filing of an administrative request for a hearing to contest a denial of no-fault benefits, and where its provisions are not met there is a threshold, procedural absence of jurisdiction to proceed with a hearing.
Santos v. AIG Hawaii, MVI-2000-57 (CFO April 20, 2001).

Jurisdiction – Although HRS § 431:10C-212 initially provides an insured with three options for pursuing claim(s) for no-fault benefits, they may not be used either simultaneously or consecutively in attempting to obtain relief on the same claim(s). The actions of an insured in electing to litigate a claim within the judicial forum precludes that claim from also being pursued within the administrative forum regardless of the claimant's dissatisfaction with the outcome of the court action.
Hill v. Oahu Transit, MVI-97-1658 (CFO September 6, 2000).

Jurisdiction – A provider may not intervene as a party to a contested case proceeding between a claimant and a respondent under circumstances where the provider did not request an administrative hearing within sixty days of the date of the respondent's denial in accordance with the provisions of HRS § 431:10C-212.
Ha v. AIG Hawaii, MVI-95-318-C (CFO August 25, 2000).

Jurisdiction – A respondent's denial of excess medical benefits available through the seat belt endorsement is not a denial of no-fault benefits and thus does not fall within the insurance commissioner's jurisdiction to review denials of no-fault benefits as set out in HRS § 431:10C-212.
Peretz v. USAA, MVI-94-606 (CFO September 23, 1996).

Jurisdiction – The procedural requirements governing a claimant's request for administrative review where his or her policy of insurance has been canceled are contained in HAR § 16-23-16, and the failure to make such a request within ten days of receiving notice of cancellation deprives this forum of jurisdiction to hear the matter.
McBeth v. Allstate, MVI-94-439 (CFO March 12, 1996).

Jurisdiction – Although the Insurance Commissioner has jurisdiction under HRS § 431:10C-212(b) to review any denial of no-fault benefits, he or she may, on the basis of *forum non conveniens*, decline to hear a private contractual matter which happens to involve a denial of benefits but does not involve a regulatory matter under the Hawaii motor vehicle insurance law.
Tillmon v. AIG Hawaii, MVI-94-312 (CFO September 11, 1995).

Jurisdiction – "Where a provider's client/patient (the insured) has not participated as a party (claimant) in the administrative proceedings, the provider may still have to litigate the issue of the insured's obligation in a judicial proceeding. This would seem to be particularly true if the outcome of the administrative hearing was based upon a procedural issue without any substantive determination of the merit of the peer review's recommendations regarding the provider's services. Accordingly, under certain circumstances an administrative hearing may be a *forum non-conveniens* for this type of hearing."
Speers/Skeen v. AIG Hawaii, MVI-94-52-P (CFO June 22, 1995).

Jurisdiction – During the course of contested case proceedings Hearings Officers, similar to trial judges, are entitled to wide latitude in the questioning of witnesses as long as the inquiry is relevant, material, not unduly repetitious and reflects a fair and impartial posture. It is also well within an adjudicator's discretion to call witnesses when necessary to supplement the evidence produced by the parties.
Sua v. State Farm, MVI-94-39 (CFO March 16, 1995).

Jurisdiction – "A claimant may not later contest the propriety of a denial of no-fault benefits where he or she has failed to make a timely request for a hearing pursuant to HRS § 431:10C-212(a)".
Pacubas v. AIG Hawaii, MVI-93-184 (CFO October 10, 1994).

Jurisdiction – The review of a claimant's allegation that a respondent's course of conduct in processing a demand for benefits constitutes an unfair claims settlement practice (in violation of HRS §§ 431:10C-304(2) and (3), as well as 431:13-102 and 431:13-103) which would subject the respondent to the assessment of penalties is beyond the scope of a no-fault hearing conducted pursuant to HRS § 431:10C-212 if that is the sole purpose of such a review and no-fault benefits are not actually at issue.
Tripp v. State Farm, MVI-93-112 (CFO January 31, 1994).

Jurisdiction – A contested case hearing is generally inappropriate where the respondent has paid the claimant the full amount of no-fault benefits available under the relevant policy. A claimant's request for a determination of what future no-fault benefits might become available under various scenarios (if the respondent were to be reimbursed as a result of some disposition of the claimant's pending worker's compensation proceeding) presents a moot question. It is not the purpose of these proceedings to speculate on future legal obligations in the absence of any contested issue with respect to present legal obligations.
Maharaj v. Pacific Ins., MVI-92-93 (CFO December 16, 1992).

Jurisdiction – In the absence of any compelling justification for non-compliance with the provisions of HRS § 431:10C-212(a) the Hearings Office does not have jurisdiction in matters where a request for a hearing has not been filed within 60 days from the date on which no-fault benefits were denied.
Zych v. GEICO, MVI-91-43 (CFO February 12, 1992).

Jurisdiction – A claimant is procedurally barred from pursuing an administrative hearing to substantively determine whether he or she is entitled to no-fault benefits where there has been a failure on the part of the claimant to comply with the two-year limitation set out in HRS §431:10C-315. Compliance with the statute of limitations is a threshold requirement which goes to jurisdiction, and cannot be stipulated to by the parties.
Pires v. First Insurance, MVI-91-38 (CFO January 16, 1992).

Jurisdiction – A party's appeal from the Insurance Commissioner's Final Order in a no-fault proceeding transfers jurisdiction to the court and precludes any further administrative action, including determinations regarding attorney's fees and/or costs, unless and until the matter is remanded for such further proceedings.
Merrill v. Hawaiian Ins., MVI-87-25 (CFO December 20, 1989).

LEGISLATIVE PURPOSE

Legislative Purpose – "While the provisions of the Hawaii Motor Vehicle Insurance Law focus largely on the rights of insureds and the responsibilities of insurers, the system of reparations envisioned by this law is not a one way street. In addition to any contractual obligations which may exist based upon the insurance policy, both parties have an obligation to act in good faith to resolve no-fault disputes prior to pursuing formal administrative remedies."
Dugaduga v. Allstate, MVI-2001-14 (CFO December 19, 2001); and, *Rondolos v. AIG Hawaii*, MVI-92-197 (CFO August 30, 1993).

Legislative Purpose – "The purpose of the Hawaii motor vehicle insurance code includes the equitable and expeditious resolution of no-fault disputes over the payment of reparations for accidental harm and loss arising from motor vehicle accidents. … Such a system presupposes the timely submission of claims as a prerequisite for the timely processing of claims, and lengthy delays in the submission of claims may delay or even preclude payment of them. At a minimum, a claimant must offer a reasonable explanation for late submissions – and extensive, unwarranted delays are not justified simply because an overall statute of limitations may not have expired by the time they were submitted."
Dugaduga v. Allstate, MVI-2001-14 (CFO December 19, 2001).

Legislative Purpose – "[The] argument that an injured third party is not bound by the provisions contained in the insured's policy is not well founded. While a claimant's entitlement to personal injury protection coverage is set out by law, the extent of such entitlement may be qualified in accordance with the content of the applicable insurance policy.
Daproza-Fung v. Liberty Mutual, ATX-2001-40+ (CFO October 3, 2001).

Legislative Purpose – "The Hawaii motor vehicle insurance law requires that claimants, as well as respondents, act cooperatively in their efforts to resolve disputed issues – and prior decisions have long reflected that the system or reparations envisioned by the law is not a one way street."
Daproza-Fung v. Liberty Mutual, ATX-2001-40+ (CFO October 3, 2001).

Legislative Purpose – The extent of coverage offered by a particular insurance policy is determined by the language of that policy on the date of its issuance or, if renewed, on the date of the most recent renewal. Neither statutes nor rules enacted after that date effect policy coverages unless the legislature has expressed its intention that such laws have retroactive effect. Furthermore, informal opinions of the Insurance Commissioner are just that, and while they are often helpful they have neither the force nor the efffect of law.
Ajifu v. AIG Hawaii, ATX-2000-212 (CFO September 25, 2001).

Legislative Purpose – "A prospective denial of future benefits is contrary to the purpose of the Hawaii motor vehicle insurance law, as set forth in HRS § 431:10C-102, as a system of reparations. [citation omitted] Prospective denials can have an unfair, chilling effect on individuals who wish to pursue further treatment and are improper."
Nemec v. AIG Hawaii, MVI-97-1018-C+ (CFO July 26, 2000) [Note: affirmed on factual grounds distinguishable from this issue, Civil No. 00-1-2636-08 (4-6-01)].

Legislative Purpose – "[A}s stated in HRS § 431:10C-102, the purpose of the Hawaii motor vehicle insurance law is 'a system of *reparations'* (Emphasis added). It has also been uniformly understood … that the correct interpretation of the law governing the operation of that system requires the consideration of claims for benefits which have been asserted for *previously incurred* losses that had been subsequently denied. (Citations omitted) Although previous caselaw has also recognized limited exceptions to this interpretation under specific circumstances … the general prohibition on prospective denials has remained as the correct interpretation of both the letter of the law and the intent of the legislature. This is particularly true in the area of health care treatments."
Sickel v. GEICO, MVI-96-595 (CFO May 24, 2000).

Legislative Purpose – "The rights of insureds as reflected in [HRS] § 431:10C-303 and the obligations of insurers as reflected in HRS § 431:10C-304 require that their disputes focus on events as of the time of the denial, rather than on speculative events which may have occurred (or information that may have become available) after that time. Experience has shown … that prospective denials can have an unfair, chilling effect on individuals who wish to pursue further treatment, and it is indeed unlikely that the issuance of an additional (later) denial would constitute an unfair burden on the resources of insurers. An insurer mayy neither base a denial on the predicted occurrence/outcome of some future event, nor subsequently validate such a denial on the actual occurrence/outcome of that event. (Citations omitted)."
Sickel v. GEICO, MVI-96-595 (CFO May 24, 2000).

Legislative Purpose – "It is important to emphasize that although HRS § 431:10C-211 is entitled *Claimant's attorney's fees*, the language of the statute talks about a person making a claim, and the language of the statute does not actually use the word 'claimant' or otherwise limit the applicable class of persons....Providers may be entitled to discretionary awards of reasonable attorneys' fees and costs in accordance with the relevant statutory provisions of HRS § 431:10C-211 applicable to persons contesting a denial of no-fault benefits.
Hyman/Ream v. GEICO, MVI-95-239-P (CFO June 18, 1997).

Legislative Purpose – "The standing of providers under HRS § 431:10C-212 to contest post January 1, 1993 denials of no-fault insurance benefits [arising out of pre January 1, 1993 motor vehicle accidents] (i.e. to initiate proceedings after the

effective date of Acts 123 and 124) is a legally valid prospective right which is not based upon any retrospective application of the law."
Hyman/Ream v. GEICO, MVI-95-239-P (CFO June 18, 1997). [Note: initially overruled on this issue by *CHART/Yosores v. State Farm*, MVI-94-199-P (CFO October 3, 1997); and, *Redmond v. State Farm*, MVI-94-287-P (CFO September 18, 1997) - which were subsequently overruled/reversed on this issue by *Redmond v. State Farm & Graulty*, Civil No. 97-4270 (12-11-98); and, *GEICO v. Hyman*, 90 Haw. 1 (1999).]

Legislative Purpose – "[T]he 1992 legislative package which addressed motor vehicle insurance reform - as embodied in Acts 123 and 124 of the 1992 Session Laws of Hawaii contained *multiple* amendments to HRS Chapter 431 which were by no means limited to the peer review process. One of these amendments (§ 7 of Act 124) specifically provided that a provider of services who objected to an insurer's denial of benefits was entitled to request a review by the Insurance Commissioner. This right, which had previously been reserved to claimants, was a valid prospective right which took effect on January 1, 1993....Neither the caselaw created by *Richard* [*v. Metcalf*, 82 Haw. 249 (1996)], nor any other provision of law, precludes a provider from asserting his or her statutory right to pursue relief under such circumstances."
Hyman/Ream v. GEICO, MVI-95-239-P (CFO June 18, 1997). [Note: initially overruled on this issue by *CHART/Yosores v. State Farm*, MVI-94-199-P (CFO October 3, 1997); and, *Redmond v. State Farm*, MVI-94-287-P (CFO September 18, 1997) - which were subsequently overruled/reversed on this issue by *Redmond v. State Farm & Graulty*, Civil No. 97-4270 (12-11-98); and, *GEICO v. Hyman*, 90 Haw. 1 (1999).]

Legislative Purpose – An interpretation of the language of the Hawaii motor vehicle insurance law which limits coverage to claims involving motor vehicles - exclusive of motorcycles, motor scooters, and mopeds - is not inconsistent with the intent of the legislature in establishing the system of reparations reflected in the current law.
Musick v. Insurance Division, MVI-95-280-J (CFO February 13, 1997).

Legislative Purpose – The relevant law reflects an intention by the legislature to allow the use of unlicensed out of state peer review evaluations in accordance with the provisions of HRS § 431:10C-308.6. The PRO evaluation is basically an IME evaluation but limited to a "documents only" review, and the legislature contemplated the validity of IMEs conducted by out-of-state providers as reflected in HRS § 431:10C-308.5(b) which addresses charges for such examinations within and outside of Hawaii.
Nutter/Garot v. State Farm, MVI-93-278-P (CFO September 11, 1995).

Legislative Purpose – "A number of previous decisions have pointed out that claimants and respondents 'have an obligation to act in good faith to resolve no-fault disputes prior to pursing formal administrative remedies.'"

Tillmon v. AIG Hawaii, MVI-94-312 (CFO September 11, 1995).

Legislative Purpose – "An "owned vehicle" exclusion in a no-fault insurance policy which is reasonably worded in keeping with HRS 431:10C-102 is not rendered void by the application of other sections of the Hawaii motor vehicle insurance law, such as HRS §§ 431:10C-103(11) or 431:10C-305(b)."
Alameida v. Allstate, MVI-94-161 (CFO April 21, 1995).

Legislative Purpose – "The intention of this legislation [HRS § 431:10C-305(c)(2)] was to make vehicle coverage coincide with vehicle control by holding a repair shop accountable for no-fault obligations incurred while a customer's vehicle was being worked on during the course of the repair shop's business activities."
Yoshioka v. Transamerica, MVI-94-23 (CFO April 21, 1995).

Legislative Purpose – "Neither the language of that statute [HRS § 431:10C-308.6], nor its legislative history, support the contention that it restricted no-fault hearings to a form of secondary review limited to the examination of procedural issues relating to the peer review process. Administrative hearings on no-fault denials which are based upon challenges initiated under HRS § 431:10C-308.6 have the same procedural and substantive requirements - including the same standard of review - as all other proceedings under HRS § 431:10C-212."
Brown v. AIG Hawaii, MVI-94-91-C (CFO March 28, 1995).

Legislative Purpose – The amended provision of HRS §§ 431:10C-103(6) and 431:10C-103(B)(i) which increased the maximum limit of the total no-fault benefits payable per person from $15,000 to $20,000, as well as the amended provisions of HRS § 431:10C-103(10)(A)(iii) which increased the maximum monthly earnings loss no-fault benefits from $900 to $1,200 which became effective January 1, 1993 were applicable to insurance policies issued prior to that time in evaluating benefits resulting from motor vehicle accidents occurring subsequent to that time.
Sensano v. Liberty Mutual, MVI-92-209 (CFO April 19, 1994).

Legislative Purpose – "A plain reading of the statutory language that sets forth the definition of "accident harm" reveals that the legislative intent was to cover several categories of harm or consequence that a person might incur as a result of involvement in a motor vehicle accident[.] ... Nothing in the language of the statute directs that no-fault benefits for death, sickness, or disease are to be limited to only such mental sickness or disease that might flow from a physical harm incurred by the claimant. ... Additionally, to say that the term "accidental harm" includes only ***bodily*** (physical) sickness and ***bodily*** (physical) disease would be inconsistent with the provision of the statute authorizing payment of no-fault benefits for psychiatric therapy and rehabilitation[.]"
Kekuewa v. Alexsis, MVI-93-13 (CFO September 10, 1993).

Legislative Purpose – "The provisions in HRS Chapter 431, as set out in Article 10C focus largely on the rights of insureds and the responsibility of insurers,

but the system of reparations envisioned by HRS § 431:10C-102 is not a one-way street. While the no-fault system is expansive in scope and lends itself to a liberal application, it is not a system without limits, and Claimants must still establish that they are qualified for benefits in accordance with the inclusions and exclusions specifically set out by statute."
Aina/Ferreira/Ganir v. AIG Hawaii, MVI-92-163 (CFO September 1, 1993).

Legislative Purpose – Where a party desires to present post-hearing oral arguments to the Insurance Commissioner pursuant to the provisions of HAR §§ 16-201-44 and 16-201-46 that party must submit its request concurrent with its written exceptions to the Hearings Officers recommendations or, if replying to another party's written exceptions, concurrent with its statement in support of the Hearings Officers recommendations.
Spangler v. Pacific Ins., MVI-91-131 (CFO-R October 30, 1992).

Legislative Purpose – "The provisions in HRS Chapter 431 as set out in Article 10C (The Hawaii Motor Vehicle Insurance Law) focused largely on the rights of insureds and on the responsibilities of insurers. Nevertheless, the system of reparations envisioned by this law is not a one-way street. Independent of any contractual obligations which may exist based upon the insurance policy, both parties have an obligation to act in good faith to resolve no-fault disputes prior to entering this administrative forum."
Spangler v. Pacific Ins., MVI-91-131 (CFO September 16, 1992); and, *Lissauer v. AIG Hawaii*, MVI-92-5 (CFO July 28, 1992).

Legislative Purpose – "[T]he most reasonable interpretation of the language in HRS § 431:10C-103(13)(B) is that the "business exception" applies to employees of a business which includes - as a major part of its activities - repairing, servicing or otherwise maintaining vehicles, even if that is not its primary business activity. Such construction would accord a reasonable meaning to the statute; would be consistent with the legislatively established purposes of the Hawaii Insurance Code; and would not lead to injustice, appression, or absurd consequences. It would also accord a certain degree of protection to no-fault insurers to unwarranted liability for on-the-job injuries sustained by employees in the course of repairing, servicing, or otherwise maintaining company motor vehicles on company premises.
Tahi v. MTL, Inc., MVI-91-86 (CFO August 19, 1992).

Legislative Purpose – The purpose of HRS Subchapter 431:10C was to create system of reparations for determining entitlement to no-fault benefits without regard to fault, and this statutory system obviates the need to address the issue of fault in administrative proceedings of this nature.
Gabayan v. MTL Inc./Alexsis, MVI-91-69 (CFO March 25, 1992).

Legislative Purpose – The legislature did not intend that the seller of a motor vehicle should retain liability for its operation after its transfer to a buyer simply because new certificates of ownership and registration had not been issued.

Suka v. Budget, MVI-91-15 (CFO October 7, 1991).

Legislative Purpose – The no-fault system of reparations, as envisioned by the legislature and as further defined in HRS § 294-2(10)(b) [HRS 431:10C-103(10)(A)(iii)] includes vocational rehabilitation services to the extent that they are both reasonable (in cost) and necessary (in purpose).
Tanigawa v. First Ins., MVI-89-109 (CFO August 16, 1990).

Legislative Purpose – The public policy considerations of the legislature with respect to no-fault insurance benefits do not extend the concept of "causal connection" so far as to include injuries sustained by a third party who was not involved in the motor vehicle accident. This is true within the Hawaii no-fault system of reparations even if the person did sustain subsequent damages as a result of learning that a family member had been killed in the motor vehicle accident. "While the determination of an individual claimant's qualifications require an evaluation of the factual circumstances which are unique to that matter, every individual must establish a sufficient legal 'nexus' of spatial and temporal causation as a threshold requirement."
Dodson v. GEICO, MVI-87-50 (CFO October 11, 1989).

MOTOR VEHICLE ACCIDENT

Motor Vehicle Accident – Injuries sustained by the occupant of a motor vehicle during the course of an unrelated person's attempt to steal the vehicle are considered to have arisen out of the operation, maintenance or use of the motor vehicle.
Holt v. State Farm, ATX-2000-59 (CFO September 27, 2001).

Motor Vehicle Accident – A claimant's assumption that severe cuts to his fingers were caused by some object that he touched while alighting from a bus, without presenting evidence to substantiate such an assumption, was insufficient to show that the injuries were the result of a motor vehicle accident.
Rafael v. Oahu Transit, ATX-99-221 (CFO November 30, 2000).

Motor Vehicle Accident – A number of prior cases have adopted the general proposition that a claimant's injuries were not caused by "the operation, maintenance or use of a motor vehicle" under factual circumstances where "the injuries did not occur as a result of the normal use of an automobile for transportation purposes, that the motor vehicle context was simply incidental and fortuitou, that the motor vehicle was merely the situs of the injury but not an active accessory to the injury…[which] could have occurred in any number of settings."
Modica v. State Farm, MVI-97-1487 (CFO October 5, 2000).

Motor Vehicle Accident – A claimant who intentionally acts to sustain injuries, even though they result from the operation of a motor vehicle, has not sustained them as a result of an "accident" and thus is not eligible to receive no-fault benefits arising out of such injuries.
Rivera v. State Farm, MVI-96-1354 (CFO August 10, 1999).

Motor Vehicle Accident – Where a motor vehicle accident is a "substantial factor" in bringing about a claimant's injury and it is shown that "but for" the motor vehicle accident the injury in question would not have occurred, the claimant has established that the accident was the cause of the injury.
Corpus v. State Farm, MVI-95-744 (CFO September 4, 1998).

Motor Vehicle Accident – It is elementary that where a claimant has sustained injuries as a result of his or her own deliberate conduct, the injuries are not accidental regardless of whether they arose out of the operation, maintenance or use of a motor vehicle. Furthermore, under such circumstances it is unnecessary to proceed with an analysis of whether the event may have been perceived as accidental by the insured in those instances where the claimant and the insured are not the same person.
Queja v. Island Ins., MVI-94-284 (CFO November 4, 1996).

Motor Vehicle Accident – In order to establish that an event involving the operation, maintenance or use of a motor vehicle was "accidental" a claimant must show that it was not precipitated by his or her own deliberate conduct, but rather was the result of a sudden, unexpected, or unintentional occurrence.
Queja v. Island Ins., MVI-94-284 (CFO November 4, 1996); and, *Ganal v. Travelers*, MVI-94-385 (CFO July 11, 1996).

Motor Vehicle Accident – The principle focus for determining whether an injury arose out of a motor vehicle accident is whether the operation, maintenance or use of the vehicle was actively involved in causing the injury rather than simply being the situs where the incident occurred. Where a claimant, as a pedestrian, was standing next to a parked vehicle whose driver pushed her away, the resulting injury was the result of the deliberate conduct of the driver without direct involvement of his vehicle.
Will v. State Farm/Hartford, MVI-94-171+ (CFO July 10, 1996).

Motor Vehicle Accident – Where a claimant has deliberately initiated a sequence of events which are not directly related to his or her "operation, maintenance, or use" or a motor vehicle (but rather are simply the situs where a subsequent injury has occurred) the claimant's injury does not qualify as the result of "accidental harm" for which an insurer is obligated to pay no-fault insurance benefits.
Keating v. State Farm, MVI-94-646 (CFO March 12, 1996).

Motor Vehicle Accident – Where the driver of a stationary motor vehicle was assaulted by a driver who had alighted from a second motor vehicle as a response to a verbal insult (based upon a perceived lack of courtesy in the operation of the second motor vehicle) the resulting injury was the result of an intentional intervening act rather than the direct operation or use of a motor vehicle and was not accidental.
Keating v. State Farm, MVI-94-646 (CFO March 12, 1996).

Motor Vehicle Accident – The deliberate, voluntary conduct of a claimant which arises after a motor vehicle accident and results in self-inflicted injuries generally precludes that claimant form receiving no-fault benefits for such injuries because they are considered to be the result of his or her subsequent conduct rather than the motor vehicle accident itself.
Shi v. AIG Hawaii, MVI-94-236 (CFO July 31, 1995).

Motor Vehicle Accident – "The determination of whether a particular occurrence meets the definition of a motor vehicle accident as set out in the applicable no-fault statutes is generally resolved through an analysis of the applicable circumstances by the trier of fact. In conducting this analysis one looks to see whether the injuries occurred as a result of the normal use of the vehicle for transportation purposes; whether the vehicle was an active accessory to the injury and not merely the situs of the injury or incidentally/fortuitously connected to it; and whether the injuries are foreseeably identifiable with the normal use of the vehicle."

Shi v. AIG Hawaii, MVI-94-236 (CFO July 31, 1995); *Rapoza v. Hartford Underwriters*, MVI-94-197 (CFO June 22, 1995); and, *Luyt v. State Farm*, MVI-87-30 (CFO November 12, 1987).

Motor Vehicle Accident – Where a bus driver attempts to break up a fight between certain of his passengers while awaiting for police assistance and is thereby injured by one or more of the persons involved in the fight, his injury is sufficiently related to the operation and/or use of the bus to qualify as being caused by a motor vehicle accident.
Rapoza v. Hartford Underwriters, MVI-94-197 (CFO June 22, 1995).

Motor Vehicle Accident – An incident involving a motor vehicle is considered to be accidental where it arises out of a sudden, unexpected, or unintentional event, as distinguished from something that is gradual, anticipated or planned.
Luna v. Alamo/GAB, MVI-91-109 (CFO September 29, 1994).

Motor Vehicle Accident – An event is considered to be accidental to the extent that it arises out of a sudden, unexpected, or unintentional occurrence, and an injury arising out of a series of expected occurrences which take place over an extended period of time while driving a motor vehicle is not generally considered to be the result of an accident and resulting injuries do not qualify for no-fault benefits.
Yuen v. Alexsis, MVI-93-205 (CFO August 10 1994), and *Araujo v. Alexsis*, MVI-91-96 (CFO June 12, 1992).

Motor Vehicle Accident – An incident in which a motorcycle crash occurs without the involvement of any car, truck, or similarly qualifying motor vehicle as set out in HRS § 431:10C-103(8) is not considered to meet the definition of a "motor vehicle accident" as set out in HRS § 431:10C-103(9).
Kaneaiakala v. AIG Hawaii, MVI-93-175 (CFO June 28, 1994).

Motor Vehicle Accident – Where the deliberate conduct of a claimant (in striking the center exit pole on a bus) was the direct cause of his having sustained an injury, it could not be found that the injury was accidentally incurred since the event was neither sudden, unexpected, nor unintended.
Ah-Nee v. Alexsis, MVI-93-130 (CFO February 23, 1994).

Motor Vehicle Accident – Where a claimant's injury resulted from a long period of repetitive activity (driving a bus) it was not the result of a sudden, unexpected, or unintended event and it is reasonable to conclude that the claimant's injury was not caused by a motor vehicle accident.
Naito v. Alexsis, MVI-92-228 (CFO January 6, 1994).

Motor Vehicle Accident – "While there are obvious factual distinctions among Hawaii decisions, the principle focus of the law is to require that some active involvement of the motor vehicle (through operation, maintenance, or use) play a

causative role in a Claimant's injuries in order to allow the Claimant to recover no-fault benefits."
Meheula v. Alexsis, MVI-92-205 (CFO May 14, 1993).

Motor Vehicle Accident – "The legal determination of a person's qualifications for worker's compensation benefits under HRS chapter 386 is best made by DLIR, and is not crucial to threshold questions of a person's qualifications for no-fault benefits as determined by DCCA."
Spangler v. Pacific Ins., MVI-91-131 (CFO September 16, 1992).

Motor Vehicle Accident – The mere occupancy of a motor vehicle does not - in and of itself - constitute "operation, maintenance, or use" of a motor vehicle as required to qualify an incident as a motor vehicle accident. Recent cases have discounted the "situs" or "nexus" approach to such determinations and injuries sustained by a claimant which are not the reasonably foreseeable results of - nor caused by - the occupation of a motor vehicle do not qualify for inclusion under the no-fault system of reparations.
Rice v. AIG Hawaii, MVI-91-88 (CFO April 10, 1992).

Motor Vehicle Accident – "To fall under the protection of the no-fault statute, an injured person must establish a cause or connection between the operation, maintenance, or use of the vehicle and the accident for which he desires compensation. Such a cause or connection must be more than incidental or fortuitous; the injury must be foreseeably identifiable with the normal use of the vehicle ..."
Rice v. AIG Hawaii, MVI-91-88 (CFO April 10, 1992).

Motor Vehicle Accident – The public policy considerations of the legislature with respect to no-fault insurance benefits do not extend the concept of "causal connection" so far as to include injuries sustained by a third party who was not involved in the motor vehicle accident. This is true within the Hawaii no-fault system of reparations even if the person did sustain subsequent damages as a result of learning that a family member had been killed in the motor vehicle accident. While the determination of an individual claimant's qualifications require an evaluation of the factual circumstances which are unique to that matter, every individual must establish a sufficient legal 'nexus' of spatial and temporal causation as a threshold requirement."
Santiago v. Industrial/AIG Hawaii, MVI-90-125 (CFO November 19, 1991); and *Dodson v. GEICO*, MVI-87-50 (CFO October 11, 1989).

Motor Vehicle Accident – A claimant who was not physically involved in, nor in the immediate proximity of, a spouse's motor vehicle accident, is not entitled to no-fault benefits for health care services relating to subsequent emotional distress.
Santiago v. Industrial/AIG Hawaii, MVI-90-125 (CFO November 18, 1991); and *Dodson v. GEICO*, MVI-87-50 (CFO October 11, 1989).

Motor Vehicle Accident – Under Hawaii Revised Statutes § 431:10C-103(13), a person who is injured while alighting from a motor vehicle during the course of inspecting the motor vehicle, is entitled to receive no-fault benefits.
Perreira v. Royal Ins., MVI-91-29 (CFO October 17, 1991).

Motor Vehicle Accident – A claimant's injuries which occurred upon exiting from a motor vehicle during the course of inspecting it as a prospective purchaser while in the company of a sales representative arose out of a motor vehicle accident as defined in HRS §§ 431:10C-103(9) and (13).
Perreira v. Royal Ins., MVI-91-29 (CFO October 16, 1991).

Motor Vehicle Accident – "[T]he Insurance Commissioner has determined that in order for injuries to arise out of the operation, maintenance, or use of [a] motor vehicle, the claimant must prove by a preponderance of the evidence the following: 1) the injuries must occur as a result of the normal use of an automobile for transportation purposes; 2) the motor vehicle context must be an active accessory to the injury and not merely the situs of the injury or incidentally and fortuitously connected to the injury; and 3) the injuries must be foreseeably identifiable with the normal use of the vehicle."
Phillips v. Island Ins., MVI-90-46 (CFO September 27, 1990); and *Pali v. Carriers Ins.*, MVI-85-10 (CFO March 24, 1986).

Motor Vehicle Accident – A claimant's injuries which were sustained as a result of touching the exhaust pipe of a parked motor vehicle, without a further showing that the claimant was involved in its operation, maintenance, or use, or that the injuries were otherwise foreseeably identifiable with its normal use, do not qualify for no-fault benefits under HRS § 431:10C-103(13).
Thompson v. AIG Hawaii, MVI-89-41 (CFO January 8, 1990) [Note: overruled?].

Motor Vehicle Accident – A pedestrian's preemptive action to avoid what he perceived as a potential motor vehicle accident, when such action was in fact unnecessary and unrelated to actual events, did not qualify the injuries which he sustained as resulting from a "motor vehicle accident".
Kanae v. Travelers, MVI-89-33 (CFO October 23, 1989).

NOTIFICATION OF DENIAL

Notification of Denial – "[W]hen an insurer's conduct in issuing a denial is determined to be procedurally improper behavior because the insurer had failed to comply with applicable statutory and/or regulatory provisions, the insurer is obligated to pay for the contested no-fault benefits and no further proceedings to address the substantive merits, if any, of the denial is required."
Ramos v. Liberty Mutual, MVI-99-34-C (CFO September 9, 1999).

Notification of Denial – A respondent's partial payment of no-fault benefits without issuing written notification of a denial for the unpaid balance of the claim(s) constitutes a violation of the requirements in HRS § 431:10C-304(3).
HEPA/Adams v. State Farm, MVI-96-1024 (CFO August 4, 1998).

Notification of Denial – Where a respondent's request for peer review was based upon a challenge to "continued treatment or service" pursuant to HRS § 431:10C-308.6(c) and not to a "treatment plan" pursuant to HRS § 431:10C-308.6(d) the treatment proposed in a specific treatment plan was not properly challenged and thus was approved by default.
Yamada v. State Farm, MVI-94-398-C (CFO July 15, 1997); and, *Tanksley/Melim v. State Farm*, MVI-95-414-P (CFO May 5, 1997).

Notification of Denial – A purported denial of future benefits that had either not been accrued by the claimant or not been the subject for a demand for payment by the claimant is improper and contrary to the provisions of HRS § 431:10C-304.
Kang v. State Farm, MVI-95-76 (CFO June 18, 1997). [Note: reversed in part on this issue and remanded by *Kang v. State Farm & Graulty*, Civil No. 97-2944-07 (12-14-98)].

Notification of Denial – "[W]here a respondent has not pursued one of the three authorized options provided under HRS § 431:10C-304(3) and has instead issued a procedurally improper denial, it is precluded from asserting a substantive basis to legitimize its procedurally unlawful conduct and must pay for the contested benefits which were incurred during the time covered by its failure to follow the statutory requirements."
Ho v. Hawaiian Insurance, MVI-94-391 (CFO February 14, 1997).

Notification of Denial – A respondent's unlimited denial of certain no-fault benefits, which was construed in conjunction with a peer review report, was intended to deny future no-fault benefits to the claimant in excess of those proposed by the treatment plan, and thus at least that portion of the denial was improper and invalid on its face.
Federico v. Allstate, MVI-94-157-C (CFO January 15, 1997).

Notification of Denial – Where, after receiving bills for purported no-fault benefits, a respondent has failed to pursue any of the three options available under HRS § 431:10C-304(3) the respondent has, by its own procedural inaction, precluded itself from subsequently asserting any substantive basis for a valid denial of those bills.
Lucas v. AIG Hawaii, MVI-94-165 (CFO October 30, 1996). [Note: affirmed by summary dispositional order - S.C. No. 21464 (12-28-98)].

Notification of Denial – "While the provisions of HRS § 431:10C-304(3) allow thirty days for an insurer to make pay/deny type decisions on past no-fault benefits under subparts (A) and (B), and may allow for withholding future no-fault benefits if the insurer has complied with the provisions of subpart (C), the law does not otherwise allow for the retroactive implementation of denials, and such conduct may constitute not only a procedurally improper denial of benefits, but also a violation of HRS § 431:10C-117(b) or (c)."
Lucas v. AIG Hawaii, MVI-94-165 (CFO October 30, 1996). [Note: affirmed by summary dispositional order - S.C. No. 21464 (12-28-98)]; and, *Calatrava v. AIG Hawaii*, MVI-93-76+ (CFO March 4, 1994).

Notification of Denial – "Where a specific treatment plan is being challenged under HRS § 431:10C-308.6, it is procedurally improper for a Respondent to check the block for "Continued treatment or service" on the challenge form. Such challenges have generally been construed as applying to the treatment plan for which they were intended. The alternative approach of strictly construing the language of the challenge form would result in a determination that the Treatment Plan Request itself had not been challenged (and was therefore "approved" by default) although continued treatment or service under the plan would be challenged."
Dunn v. GEICO, MVI-94-574-C (CFO July 12, 1996).

Notification of Denial – A respondent's denial of certain no-fault insurance benefits (based upon the content of a peer review evaluation) after a specified date (i.e. to continue ad infinitum) constitutes a future denial which is improper and should be rejected.
Ares v. AIG Hawaii, MVI-94-20-C (CFO July 10, 1996).

Notification of Denial – The failure of an insurer to specifically address a provider's treatment plan in accordance with either HRS § 431:10C-308.6(d) or HAR § 16-23-95(e) results in the approval of the plan by operation of law.
Ares v. AIG Hawaii, MVI-94-20-C (CFO July 10, 1996).

Notification of Denial – The issuance of a denial of no-fault benefits based upon a peer review report stating - that a claimant's condition could not be attributed to his motor vehicle accident was invalid on its face, as causation is not an issue for determination by peer review and thus not a proper basis for the subsequent issuance of a denial pursuant to a peer review report.
Randall v. USAA, MVI-94-625-C (CFO July 10, 1996).

Notification of Denial – Where a respondent has failed to respond to a treatment plan in compliance with the requirements of HRS § 431:10C-308.6(d) the treatments are deemed to have been approved by the respondent.
Rapanut v. State Farm, MVI-94-80-C (CFO July 10, 1996).

Notification of Denial – Where a provider has submitted a treatment plan request pursuant to HRS § 431:10C-308.6(d), a respondent's attempted challenge on the basis of "continued treatment" pursuant to HRS § 431:10C-308.6(c) - without challenging the treatment plan request pursuant to HRS § 431:10C-308.6(d) - was procedurally defective and an ineffective response to the treatment plan request which resulted in an approval of the treatment as set out in the plan.
Shirota v. State Farm, MVI-94-101-C (CFO May 15, 1996).

Notification of Denial – Under the long-standing provisions of HRS § 431:10C-304(3) an insurer, upon receipt of a health care provider's bill for treatment or services is required to respond to the provider and the claimant within 30 days by (1) paying the billing, (2) denying the billing and stating a reason for the denial, or (3) requesting further information or documentation concerning the treatment or services or billing. Under the more recently enacted provisions of HRS § 431:10C-308.6, however, an insurer may delay its payment or denial of payment beyond the 30-day period, by filing a challenge of the bill for submission to a peer review evaluation within 10 days of receiving it.
*Ching v. AIG Hawaii**,*** MVI-94-89-C (CFO January 5, 1996).

Notification of Denial – A respondent's partial payment of no-fault benefits for which the amount of the changes was being disputed in accordance with the provisions of HAR § 16-23-120 was effectively a partial denial which required compliance with the provisions of HRS § 431:10C-304(3)(B) and a respondent's failure to comply with these statutory provisions constituted an unlawfully constructive denial. An insurer's refusal to pay a claim on the basis that the change is not reasonable, regardless of whether it is submitted by the provider or the claimant, must be accompanied by appropriate written notification.
HEPA/Matthews v. State Farm, MVI-93-160-P+ (CFO December 12, 1995).

Notification of Denial – Where a respondent has proceeded to deny no-fault insurance benefits, in whole or part, to a claimant on a procedurally improper basis (e.g. a constructive denial), it may be precluded from subsequently asserting a substantive basis for the denial and may be required to pay the contested amounts without further proceedings.
HEPA/Matthews v. State Farm, MVI-93-160-P+ (CFO December 12, 1995).

Notification of Denial – A respondent must, in accordance with the requirements of HRS § 431:10C-308.6(d) and HAR § 16-23-95(e), state its reasons for refusing to approve a treatment plan request in a written notice (such as the challenge form or a suitable letter) to both the provider and the claimant. Where a respondent has failed to meet these requirements the result is an ineffective refusal and a procedurally improper denial of the contested benefits.
Guray v. State Farm, MVI-94-3-C (CFO October 26, 1995).

Notification of Denial – A respondent's failure to comply with HRS § 431:10C-308.6(d) and HAR § 16-23-95(e) by not concurrently filing a challenge to a provider's treatment plan request with the Insurance Commissioner (for submission to a peer review organization) constitutes tacit approval of the proposed treatment plan, and the subsequent issuance of a denial of no-fault benefits based upon that challenge is procedurally improper and invalid.
Neal v. State Farm, MVI-94-275-C+ (CFO October 26, 1995).

Notification of Denial – "Where the conduct of a respondent in issuing a denial has been determined to be procedurally improper (by failing to comply with mandatory statutory requirements) the respondent is obligated to pay the claimant's contested no-fault benefits, and it is unnecessary to conduct any further proceedings to address the substantive merit, if any, of the denial itself."
Pecson v. GEICO, MVI-94-254-C (CFO September 15, 1995).

Notification of Denial – "Where a specific treatment plan is being challenged under HRS § 431:10C-308.6, it is procedurally inappropriate for a respondent to check the block for "Continued treatment or service" on the challenge form." Furthermore, it is improper for a respondent to submit a summarization of its own interpretation of a claimant's history as an attachment to the challenge form.
Pecson v. GEICO, MVI-94-254-C (CFO September 15, 1995).

Notification of Denial – The controlling statute, HRS § 431:10C-308.6(d), and rule, HAR § 16-23-95(c) require a respondent to respond to a provider's treatment plan request within five working days of the mailing of the request. Where the respondent has failed to act within that time frame the treatment plan request is considered to have been approved by default as a procedural matter and its merits may not be controverted as a substantive issue.
Nutter/Garot v. State Farm, MVI-93-278-P (CFO September 11, 1995).

Notification of Denial – "The failure of a respondent to challenge a treatment plan within five workings days as required by HRS § 431:10C-308.6(d) constituted approval of the proposed treatment plan, and there is no legitimate basis for any further administrative proceedings with respect to the substantive basis of the subsequent denial."
Speers/Skeen v. AIG Hawaii, MVI-94-52-P (CFO June 22, 1995).

Notification of Denial – "Where the conduct of a respondent in issuing a denial has been determined to be procedurally improper (by failing to comply with mandatory statutory requirements) the respondent is obligated to pay the claimant's contested no-fault benefits, and it is unnecessary to conduct any further proceedings to address the substantive merit, if any, of the denial itself."
Speers/Skeen v. AIG Hawaii, MVI-94-52-P (CFO June 22, 1995).

Notification of Denial – In light of the respondent's procedurally improper denial, the respondent is precluded from asserting any substantive basis for the denial and must pay, regardless of merit, the claims for medical expenses and wage loss submitted by the claimant.
Drummondo v. USAA, MVI-94-78 (CFO April 21, 1995).

Notification of Denial – "Where, after receiving bills for purported no-fault benefits, a respondent has failed to pursue any of the three options available under HRS § 431:10C-304(3) the respondent has, but its own procedural inaction, precluded itself from subsequently asserting any substantive basis as a valid denial of those bills."
Kersting v. AIG Hawaii, MVI-93-181 (CFO December 1, 1994), *Alpuro v. AIG Hawaii*, MVI-92-154 (CFO June 15, 1993).

Notification of Denial – The provisions of HRS § 431:10C-308.6(a) and (e) as well as HAR § 16-23-95(e) make it clear that if an insurer refuses to accept a provider's treatment plan request it must notify the insured and the provider of its refusal within five working days (of the mailing of the treatment plan) ***and*** must concurrently file its challenge for submission to a PRO evaluation. Where an insurer has failed to act in accordance with these provisions the result is a de facto approval of the plan.
Masungsong v. State Farm, MVI-94-31-C (CFO November 30, 1994).

Notification of Denial – "The provisions of HRS § 294-4(3) [HRS § 431:10C-304(3)] require that an insurer make, and communicate to its insured, a determination of the insurer's position regarding any no-fault claim within 30 days after receiving it. The law does not otherwise allow for the retroactive implementation of denials and such conduct may constitute not only a substantively and procedurally improper denial of benefits but may also constitute a violation of HRS § 294-39(b) [HRS § 431:10C-117(b)] and/or HRS § 294-39(c) [HRS § 431:10C-117(c)]."
Pacubas v. AIG Hawaii, MVI-93-184 (CFO October 10, 1994).

Notification of Denial – A respondent is required by statute to respond to a claimant's request for payment of no-fault benefits within 30 days of such request by taking one of three alternative courses of action prescribed in HRS § 431:10C-304(3), and a failure to do so makes the respondent liable to pay the claimant's contested no-fault benefits regardless of the substantive merit of the claim.
Goria v. Pacific Ins./Hartford, MVI-93-125 (CFO October 5, 1994).

Notification of Denial – The failure of a respondent to challenge a proposed treatment plan within the mandatory time limit required by HRS § 431:10C-308.6(d) constitutes approval of the plan as a procedural matter, and no further inquiry is needed at the hearing to determine its substantive merit.
Parengit v. GEICO, MVI-93-208/94-8-C (CFO July 23, 1994).

Notification of Denial – "This [HRS §431:10(C)-304(3)] is not one of the most complex statutes in American jurisprudence and should pose no great interpretive problems for educated persons with or without law degrees. It clearly provides that a respondent shall, within 30 days of receiving a bill for alleged no-fault benefits ***make payment*** where reasonable proof exists as to the validity of the benefits, ***or issue a denial*** together with the reasons supporting the election to deny the claim, ***or request required documents*** from the claimant where the insurer cannot reasonably comply with either of the first two options."
Calatrava v. AIG Hawaii, MVI-93-76+ (CFO March 4, 1994); and, *Hinzo v. AIG Hawaii*, MVI-91-128 (CFO September 3, 1992).

Notification of Denial – Where a respondent did not take one of the authorized actions provided under HRS § 431:10C-304(3) but instead devised an alternative action (which was procedurally defective and improper) in response to a claim for no-fault benefits, the respondent became obligated to pay the claimant's outstanding bills without further proceedings to consider the substantive merit of the denial.
Ea v. State Farm, MVI-93-20 (CFO September 23, 1993).

Notification of Denial – Where it has been established that a respondent has issued a procedurally improper denial, it is precluded from successfully asserting a substantively valid basis for having denied no-fault benefits during the time when the basis of the denial was the procedural impropriety. A respondent must therefore pay, regardless of merit, bills which it had rejected without following the procedural requirements of HRS § 431:10C-304(3).
Boyle v. State Farm, MVI-92-103 (CFO September 14, 1993).

Notification of Denial – In the event an insurer reasonably believes it needs additional information before paying or denying a claim, HRS § 431:10C-304(3)(C) allows the insurer to "forward to the claimant an itemized list of all the required documents". The required documents should be in existence and within the claimant's possession or control, since the claimant has the burden of providing information and documents in support of the claim for no-fault benefits.
Boyle v. State Farm, MVI-92-103 (CFO September 14, 1993).

Notification of Denial – A claimant has established his or her case by a preponderance of the evidence where the claimant has shown that the respondent's denial was procedurally defective on its face, because it clearly terminated all benefits until an IME and a records review could be completed. Such a denial is prospective in nature and procedurally improper.
Plouffe v. State Farm, MVI-93-41 (CFO August 25, 1993).

Notification of Denial – "The provisions of HRS § 294-4(3) [HRS § 431:10C-304(3)] require that an insurer make, and communicate to its insured, a determination of the insurer's position regarding any no-fault claim within 30 days after receiving it. The law does not otherwise allow for the retroactive implementation of denials and such conduct may constitute not only a substantively and procedurally improper denial of benefits but may also constitute a violation of HRS §294-39(b) [HRS § 431:10C-117(b)] and/or HRS § 294-39(c) [HRS § 431:10C-117(c)]."
Ho/Tran v. Royal Ins., MVI-91-66+ (CFO July 1, 1993); and, *Metzger v. GEICO*, MVI-88-55 (CFO May 25, 1990).

Notification of Denial – "Although subsequent [pre-hearing] corrective action by a respondent to bring a flawed denial of benefits up to the standards set out in HRS § 431:10C-304 will not necessarily shield the respondent from the imposition of sanctions, it may well preclude a claimant from successfully challenging the denial on a procedural basis in the absence of some other showing of prejudice."
Kennedy v. AIG Hawaii, MVI-92-28 (CFO September 9, 1992).

Notification of Denial – "This statute [HRS § 431:10C-304(3)] clearly provides that a respondent shall, within 30 days of receiving a bill for alleged no-fault benefits, make payment where reasonable proof exists as to the validity of the benefits, ***or*** issue a denial together with the reasons supporting the election to deny the claim, ***or*** request required documents from the claimant where the insurer cannot reasonably comply with either of the first two options."
Kennedy v. AIG Hawaii, MVI-92-28 (CFO September 9, 1992).

Notification of Denial – "The options set out in HRS § 431:10C-304(3) provide for three mutually exclusive types of situations, and do not afford additional protection to respondents who simultaneously exercise more than one. Where multiple options have been exercised, or where it is unclear as to which option a

respondent has selected, it will be determined for the purposes of a hearing that the respondent has selected the option which is most favorable to a claimant's interest."
Kennedy v. AIG Hawaii, MVI-92-28 (CFO September 9, 1992); and, *Hinzo v. AIG Hawaii*, MVI-91-128 (CFO September 3, 1992).

Notification of Denial – "The law requires that an insurer make, and communicate to its insured, a determination of the insurer's position regarding any no-fault claim within 30 days of receipt and does not otherwise allow for the retroactive implementation of denials." Instances in which a respondent attempts to impose retroactive denials may result in the imposition of sanctions under the provisions contained in HRS § 431:10C-117(b), (c) or (d).
Uyematsu v. AIG Hawaii, MVI-91-49 (CFO February 14, 1992).

Notification of Denial – Under circumstances where an insurer declines to pay <u>any</u> <u>part</u> of the no-fault benefits requested by its insured such conduct constitutes a "denial" which must be handled in compliance with HRS § 431:10C-304(3)(B). That statute clearly requires the insurer to notify the claimant within thirty days of any denial (whether it addresses the whole or only part of the claim) and state the basis for the denial.
Felisi v. AIG Hawaii, MVI-90-128 (CFO December 2, 1991).

Notification of Denial – The provisions of HRS § 294-4(3) [HRS § 431:10C-304(3)] set out the requirements which a respondent must follow in assessing the propriety of claims and/or denying benefits. "The law requires that an insurer make, and communicate to its insured, a determination of the insurer's position regarding any no-fault claim within 30 days after receiving it. It does not otherwise allow for the retroactive implementation of denials."
McIntosh v. GEICO, MVI-90-138 (CFO June 3, 1991).

Notification of Denial – An insurer's use of a denial form which materially misstates the law and misrepresents a claimant's rights in pursuing an administrative review of the denial is a violation of the Insurance Code and constitutes a procedurally improper denial of benefits.
Young v. Transamerica, MVI-90-27 (CFO November 15, 1990).

Notification of Denial – "HRS § 431:10C-304(3) sets forth the statutory time frame in which the insurer must pay, deny, or question the appropriateness of a claim submitted for no-fault benefits. If the insurer questions the appropriateness of the claim, the insurer must forward an itemized list of required documents to the claimant. In the present case, there is a variable dearth of evidence concerning the reasons for respondent's protracted and ultimately retroactive denial of claimant's request for wage loss benefits. Under the provisions of HRS §§ 431:10C-304(6) and 431:10C-117(b) and (c), civil penalties up to $10,000 per violation may be assessed upon an insurer that has failed to comply with the provisions of HRS § 431:10C-304."
Paaoao v. Liberty Mutual, MVI-89-90 (CFO June 12, 1990).

Notification of Denial – "Specifically, HRS § 294-4(3) [HRS §431:10C-304(3)] provides that payment of no-fault benefits must be made within 30 days after the insurer has received reasonable proof of the fact and amount of the benefits accrued and the demand for payment thereof. This particular section also provides that if the insurer elects to deny a claim for benefits in whole or part, the insurer must notify the claimant in writing of the denial and the reasons for denial within 30 days. Additionally, if the insurer cannot pay or deny the claim for benefits because additional information or a lost documentation is needed, the insurer is required to forward to the claimant an itemized list of all the required documents within 30 days. HRS § 294-4(6) [HRS § 431:10C-304(5)] provides that any violation of HRS § 294-4 [HRS § 431:10C-304] subjects the insurer to the penalty provisions of HRS §§ 294-39(b) and (c) [HRS § 431:10C-117(b) and (c)] which *inter alia* provides for a civil penalty not to exceed $5,000 for each violation."
Santos v. Allstate, MVI-87-40 (CFO July 6, 1989).

PAIN MANAGEMENT

Pain Management – Palliative care has been supported by a series of administrative and/or court decisions as a compensable benefit under the provisions of HRS Chapter 431 on the same basis as curative care.
Ajifu v. AIG Hawaii, ATX-2001-52+ (CFO November 1, 2001).

Pain Management – Where a claimant has established that palliative care produced significant pain relief, the fact that such relief was temporary in nature did not, in itself, show such care to be unreasonable or inappropriate.
Gamache v. Allstate, MVI-2000-62-C (CFO August 9, 2001).

Pain Management – A respondent's fallacious assumption that a claimant's palliative care does not qualify as a legitimate no-fault benefit, is not a valid basis for issuing a denial.
Ma v. Liberty Mutual, MVI-96-1422-P (CFO February 26, 1999).

Pain Management – It has already been held in cases - both before and after the adoption of HRS § 431:10C-308.5 - that palliative treatment which is appropriate, reasonable, and necessarily incurred, qualifies as a valid no-fault benefit.
Nonaka v. Fireman's Fund, MVI-94-160-C (CFO January 16, 1997).

Pain Management – Neither the 1992 legislative amendments to the Hawaii motor vehicle insurance law nor their implementing regulations eliminated palliative treatment as a no-fault benefit. "Palliative treatments continue to be a valid no-fault benefit when the same requirements established for other treatment or services for which payment is demanded are satisfied".
Federico v. Allstate, MVI-94-157-C (CFO January 15, 1997).

Pain Management – "The Insurance Commissioner has consistently upheld a claimant's right to reasonable and appropriate palliative care, either alone or in conjuction with curative care."
Larita v. State Farm, MVI-94-215+ (CFO September 26, 1996).

Pain Management – "The Insurance Commissioner has consistently upheld a claimant's right to palliative care, either alone or in conjunction with curative care, when the claimant establishes that the treatments received were appropriate, reasonable and necessarily incurred."
Antolin v. State Farm, MVI-94-538-C (CFO September 23, 1996); *Malang v. State Farm*, MVI-94-572-C (CFO September 23, 1996); *Brigoli v. State Farm*, MVI-94-318-C (CFO July 10, 1996); and, *Virtucio v. State Farm*, MVI-94-185-C (CFO September 11, 1995).

Pain Management – A claimant is entitled to all appropriate and reasonable expenses necessarily incurred for health care and rehabilitative care, including chiropractic treatment received for pain management even though the claimant has reached a stable medical condition.
Shirota v. State Farm, MVI-94-101-C (CFO May 15, 1996); and *Yamashita v. State Farm*, MVI-93-40 (CFO March 10, 1994).

Pain Management – A claimant has an obligation to pursue a reasonable course of conduct to regain pre-injury status, and under certain factual circumstances this may require his or her meaningful participation in curative modalities in conjunction with his or her receipt of treatment for pain management in order to qualify the pain management treatments as appropriate, reasonable, and necessarily incurred.
Shirota v. State Farm, MVI-94-101-C (CFO May 15, 1996).

Pain Management – A considerable number of previous cases have consistently upheld a claimant's right to palliative care as a legitimate no-fault insurance benefit, either alone or in combination with curative care, so long as the claimant has established that the treatments were "appropriate, reasonable, and necessarily incurred."
Flores v. State Farm, MVI-94-309-C/MVI-94-399-C (CFO March 12, 1996); and, *McMorris v. GEICO*, MVI-94-194-C (CFO October 26, 1995).

Pain Management – "A number of previous cases have recognized the difficulty in making medical assessments (even when there has been an IME of the claimant) with respect to validating and/or treating pain as a subjective symptom of a claimant's injury. Nevertheless, they have consistently upheld a claimant's right to reasonable and appropriate palliative care, either alone or in conjunction with curative care."
Brown v. AIG Hawaii, MVI-94-91-C (CFO March 28, 1995).

Pain Management – A claimant is entitled to appropriate and reasonable expenses necessarily incurred for medical care, physical/occupational therapy and rehabilitation, and other services to effect recovery from his or her injuries as well as for comfort and pain management.
Goria v. Pacific Ins./Hartford, MVI-93-125 (CFO October 5, 1994).

Pain Management – A claimant is entitled to medical and chiropractic treatments and massage therapy that are appropriate, reasonable and necessarily incurred to give comfort and assist in pain management.
Anastacio v. AIG Hawaii, MVI-93-52 (CFO May 16, 1994).

Pain Management – A claimant's entitlement under the provisions of HRS §§ 431:10C-103(10)(A)(i) and (ii) includes appropriate and reasonable expenses necessarily incurred for chiropractic and massage therapy services when provided for pain management purposes.

Colon v. State Farm, MVI-93-26 (CFO March 31, 1994).

Pain Management – "A considerable number of cases have made it clear that health care treatments which meet the definitional requirements of HRS § 431:10C-103(10)(A)(i) are proper when provided for either a curative or a pain management purpose."
Naito v. USAA Casualty, MVI-92-174 (CFO August 30, 1993); *Tadeo v. AIG Hawaii*, MVI-92-118 (CFO March 8, 1993); and, *Rodrigues v. Maryland Casualty*, MVI-90-123 (CFO June 3, 1991).

Pain Management – "In the matter of *Daoang v. State Farm*, MVI-88-38 (Insurance Commissioner, December 4, 1988) it was restated and re-emphasied that suitable and reasonable costs incurred for comfort and pain management are legitimate no-fault benefits. Furthermore, a number of recent cases involving this respondent, such as *Calicdan v. AIG Hawaii*, MVI-89-81 (Insurance Commissioner, March 23, 1990), *Fujimoto v. AIG Hawaii*, MVI-89-97 (Insurance Commissioner, June 22, 1990), *Troche v. AIG Hawaii,* MVI-90-14 (Insurance Commissioner, September 13, 1990) and *Curnell v. AIG Hawaii*, MVI-90-13 (Insurance Commissioner, September 13, 1990) have all addressed similar factual and legal issues."
Bagaoisan v. AIG Hawaii, MVI-90-40 (CFO December 17, 1990).

Pain Management – "While no claimant has carte blanche ability to select methods of treatment, it has been consistently held that reasonably incurred costs for comfort and pain management are included in no-fault benefits."
Lovejoy v. National Union, MVI-90-48 (CFO December 17, 1990); and, *Curnell v. AIG Hawaii*, MVI-90-13 (CFO September 13, 1990).

Pain Management – While an objective standard should be applied in assessing the merit of claims regarding pain management, the subjective testimony of a claimant may constitute part of the evidence weighed by the trier of fact in applying an objective standard.
Fujimoto v. AIG Hawaii, MVI-89-97 (CFO June 22, 1990); and *Yeh v. Royal Ins.*, MVI-89-54 (CFO May 10, 1990).

PEDESTRIANS

Pedestrians – Any pedestrian (including a bicyclist) as specified in HRS §431:10C-304(1)(A)(ii) may qualify for no-fault benefits in the same manner as an owner, operator, occupant, or user of an insured motor vehicle.
Kanae v. Travelers, MVI-89-33 (CFO October 23, 1989).

Pedestrians – A pedestrian's preemptive action to avoid what he perceived as a potential motor vehicle accident, when such action was in fact unnecessary and unrelated to actual events, did not qualify the injuries which he sustained as resulting from a "motor vehicle accident".
Kanae v. Travelers, MVI-89-33 (CFO October 23, 1989).

PEER REVIEW

Peer Review – Although a claimant may be a real party in interest where – under a peer review generated denial – he or she makes an assertion that his or her purpose in pursuing a hearing is to preserve the right to sue in tort (which is dependent upon meeting tort threshold), such an assertion must be a reasonable one in light of the bills which have been, or reasonably may be, incurred. It is not enough for a claimant to simply make an unsupported assertion of such a purpose, or one that is inconsistent with the underlying evidence regarding his or her billings.
Punzal v. Progressive Ins., MVI-2000-30-C (CFO October 26, 2000).

Peer Review – The basis of a respondent's denial of no-fault benefits is primarily determined from the face of the denial form, and where a respondent knew or should have known that an additional basis existed but failed to assert it at any time before making its closing arguments at the conclusion of the hearing, the respondent was considered to have effectively waived that additional basis as a defense in the proceedings.
Arrocena v. AIG Hawaii, et. al., MVI-97-172-C+ (CFO October 5, 2000).

Peer Review – "Although a peer review evaluator may request additional information under HAR § 16-23-118(c), she is not required to do so and may make a determination that there was insufficient documentation to substantiate the appropriateness and reasonableness of the challenged treatment as a valid basis for concluding that the challenged treatment did not meet the criteria required by HRS § 431:10C-308.6(c)."
Pedro v. AIG Hawaii, MVI-98-495-C (CFO August 24, 2000).

Peer Review – "[T]he Claimant's attack on the credibility of the peer review report, without presentation of substantive evidence establishing that the treatment … was appropriate, was insufficient to meet her burden of proof that the denial of no-fault benefits by the Respondent was improper."
Pedro v. AIG Hawaii, MVI-98-495-C (CFO August 24, 2000).

Peer Review – Although the peer review process allows an evaluator to request additional or supporting documentation during the course of evaluating a challenged treatment plan, he or she is not obligated to do so, and may base the evaluation solely on the records submitted with the plan.
Daso/Sapp v. Progressive Ins., MVI-99-117-P (CFO June 23, 2000).

Peer Review – A number of cases reflect that in order to comply with the "prior approval" provisions of HRS § 431:10C-308.6(d) a provider must not submit a treatment plan request with a commencement date prior to the time within which it could be prospectively evaluated as a whole and challenged by the insurer. Where a

provider has submitted an untimely request it is procedurally invalid as a matter of law, and does not warrant further consideration of its substantive content.
Action Rehab/Kim v. AIG Hawaii, MVI-99-2-P (CFO June 6, 2000); *Hyman/Peralta v. AIG Hawaii*, MVI-97-68-P+ (CFO) May 31, 2000); *Hyman/Lau v. State Farm*, MVI-96-1415-P+ (CFO May 31, 2000); *Hyman/Aio v. Liberty Mutual*, MVI-97-1640-P (CFO May 31, 2000); and *Hyman/Savannah v. AIG Hawaii*, MVI-97-136-P+ (CFO January 31, 2000).

Peer Review – Where it has been determined that a provider's treatment plan request was procedurally invalid because of its untimely submission to the insurer, there is no merit to the provider's argument that the insurer should have separately challenged each of the provider's bills for services rendered on dates within the period of the treatment plan.
Hyman/Lau v. State Farm, MVI-96-1415-P+ (CFO May 31, 2000).

Peer Review – Although a peer review evaluator may request more information from a provider to assist in his or her review of the provider's treatment plan request, there is no obligation to do so, as the provider should normally have included sufficient documentation to justify the plan within the existing records furnished to the peer review evaluator.
Daso/Sapp v. Progressive Ins., MVI-99-117-P (CFO June 23, 2000).

Peer Review – A provider's election to submit a treatment plan which included more treatments than the maximum number allowed to be given without prior authorization (under HAR Title 16, Chapter 23, Subchapter 17) precluded the provider from subsequently arguing that the maximum number not requiring prior authorization should be evaluated separately/individually rather than evaluating the treatment plan as a whole.
Daso/Sapp v. Progressive Ins., MVI-99-117-P (CFO June 23, 2000); and, *Ishihara/ Nguyen v. Allstate*, MVI-97-284-P (CFO January 14, 2000).

Peer Review – Where a provider has not submitted a treatment plan request to the insurer at least five days before the proposed commencement date of the treatment set out in the request, the insurer has been deprived of the opportunity to make a prospective evaluation of the merit of the request as a whole. Under such circumstances the provider's request is invalid (and may be disposed of by summary adjudication since it is undeserving of further administrative review).
Hyman/Van Houten v. AIG Hawaii, MVI-96-758-P (CFO April 7, 2000).

Peer Review – It is immaterial that any or all of the treatments provided to a claimant may have occurred after an insurer's receipt of a provider's treatment plan request if the request was not received by the insurer in a timely manner so as to allow it to be evaluated as a whole. Under such circumstances the request itself is invalid as a matter of law.
Hyman/Tabladillo v. AIG Hawaii, MVI-96-789-P+ (CFO January 27, 2000).

Peer Review – Since the purpose behind treatment plan requests is the pre-approval (or disapproval) of proposed health care services, the plan must not have a commencement date prior to the exhaustion of the time allowed for an insurer to evaluate it as a whole (i.e. five working days from date of mailing). In the situation where a provider does not even mail the plan to the insurer until after the services have begun the provider has violated the provisions of HRS § 431:10C-308.6(d) and the plan is invalid as a matter of law.
Hyman/Almodovar v. AIG Hawaii, MVI-96-918-P (CFO November 16, 1999; *Omalza v. AIG Hawaii*, MVI-98-86-C (CFO November 2, 1999); *Hyman/White v. AIG Hawaii*, MVI-97-148-P (CFO September 24, 1999); *Hyman/Arias v. Pacific Insurance*, MVI-97-19-P (CFO September 3, 1999); *Hyman/Tactacan v. AIG Hawaii*, MVI-95-800 (CFO August 17, 1999); *Hyman/Landers v. AIG Hawaii*, MVI-97-373-P+ (CFO August 10, 1999); and, *Hyman/Bowers v. State Farm*, MVI-96-1410 (CFO July 15, 1999).

Peer Review – "[T]here is no statutory mandate requiring an insurance company to challenge a treatment plan as well as bills for treatment rendered under the plan. …Consequently, since the Respondent had already denied the Provider's … treatment plan, it was not required to separately deny each billing received for services within the parameters of the plan[.]"
Hyman/White v. AIG Hawaii, MVI-97-148-P (CFO September 24, 1999); and, *Hyman/Arias v. Pacific Insurance*, MVI-97-19-P (CFO September 3, 1999).

Peer Review – An insurer (respondent) may not rely on a prior denial – which was limited in scope and did not deny future care as "continuing treatment or services" – for the purpose of subsequently denying a later treatment plan that was not separately challenged and submitted to the peer review process for an evaluation of its appropriateness and reasonableness.
Ramos v. Liberty Mutual, MVI-99-34-C (CFO September 9, 1999).

Peer Review – "A respondent is not required to separately and/or additionally challenge any bills for treatments provided under a previously challenged treatment plan."
Hyman/Tactacan v. AIG Hawaii, MVI-95-800 (CFO August 17, 1999).

Peer Review – In situations involving "peer review" denials of no-fault benefits, a claimant - from a purely procedural standpoint - is not entitled to pursue a hearing to compel a respondent to pay his or her provider's billings. In such situations a claimant is not a real party in interest because the substantive provisions of HRS §§ 431:10C-304 and 431:10C-308.6 make such payments a matter that is strictly between insurers and providers, thus removing claimants from liability for such payments and thus from any right to receive such payments on behalf of another.
Law v. Dai-Tokyo, MVI-95-400 (CFO August 16, 1999); *El-Zir v. AIG Hawaii*, MVI-95-713-C (CFO July 14, 1999); and, *Oliver v. AIG Hawaii*, MVI-96-1165 (CFO March

15, 1999) [Note: in accord on this issue - but with tort exception - *Wilson v. AIG Hawaii*, 89 Haw. 45 (1998).]

Peer Review – Where a claimant has received treatments under a proposed treatment plan which has subsequently expired the only question is whether the provider should be paid and thus the claimant has no remedial nor justiciable interest in the matter. Therefore, in accordance with *Pearson v. GEICO*, MVI-94-354-C (CFO July 11, 1996) such a matter is moot as far as the claimant is concerned and is appropriate for dismissal by summary adjudication.
Law v. Dai-Tokyo, MVI-95-400 (CFO August 16, 1999); *Toliro v. State Farm*, MVI-96-1159-C (CFO September 4, 1998); *Sato v. State Farm*, MVI-96-587-C+ (CFO September 4, 1998); and, *Melchor v. State Farm*, MVI-95-233-C (CFO August 24, 1998 [Note: in accord on this issue - but with tort exception - *Wilson v. AIG Hawaii*, 89 Haw. 45 (1998).]

Peer Review – "[A] treatment plan is invalid, and may be rejected by the insurer, if it proposes to commence treatment prior to the time in which the treatment plan may be challenged by the insurer (five working days from the date the treatment plan is mailed to the insurer)."
Hyman/Bowers v. State Farm, MVI-96-1410 (CFO July 15, 1999); and,
Hyman/Scott v. USAA, MVI-96-1376-P (CFO October 22, 1998).

Peer Review – Since treatment plan requests are created for the purpose of obtaining prior approval of proposed services, and are thus prospective in nature, such a plan is invalid (and may be rejected by the insurer) if it proposes to commence treatment prior to the time in which it may be challenged by the insurer (five working days from its date of mailing). Furthermore, a claimant's or provider's request for a hearing to contest a denied treatment plan request is moot when no services have been provided subsequent to the insurer's receipt of that plan.
Hyman/Bowers v. State Farm, MVI-96-1410 (CFO July 15, 1999); and, *Hyman/Scott v. USAA*, MVI-96-1376-P (CFO October 22, 1998).

Peer Review – In considering an HRS § 431:10C-308.6 (peer review) denial of no-fault benefits (as well as the merit of the underlying treatment plan request), one does not consider the issue of causation but rather focuses on whether the plan's health care services were appropriate or reasonable for the claimant's condition.
Ma v. Liberty Mutual, MVI-96-1422-P (CFO February 26, 1999).

Peer Review – A respondent may not use the content/conclusions of a peer review report as a separate basis/rationale in an attempt to convert a denial of no-fault benefits that was clearly articulated to be based upon the peer review process (set out in HRS § 431:10C-308.6) to a denial of no-fault benefits based upon some other standard (such as set out in HRS § 431:10C-304).
Hyman/Moore v. AIG Hawaii, MVI-95-817-P+ (CFO October 22, 1998).

Peer Review – The Hawaii Supreme Court has previously held – in the case of *Richards v. Metcalf*, 82 Haw. 249 (1996) – that utilization of the peer review provisions of HRS § 431:10-C308.6 was inapplicable as a basis for issuing denials of no-fault insurance benefits (claims) arising out of motor vehicle accidents which occurred prior to January 1, 1993.
Hyman/Moore v. AIG Hawaii, MVI-95-817-P+ (CFO October 22, 1998); *Kane v. Firemans Fund*, MVI-94-497-C (CFO May 11, 1998); and, *Medrano v. State Farm*, MVI-94-423-C+ (CFO January 22, 1998).

Peer Review – The Commissioner has determined that a provider of health care services is not a proper party to request an administrative review of an insurer's denial of no-fault benefits arising out of injuries sustained in a motor vehicle accident which occurred prior to January 1, 1993 (the effective date of the 1992 legislative amendments to the Hawaii motor vehicle insurance law).
Hyman/Moore v. AIG Hawaii, MVI-95-817-P+ (CFO October 22, 1998); *CHART/Yosores v. State Farm*, MVI-94-199-P (CFO October 3, 1997); and, *Redmond v. State Farm*, MVI-94-287-P (CFO September 18, 1997 [Note: above cases overruled/reversed on this issue by *Redmond v. State Farm & Graulty*, Civil No. 97-4270 (12-11-98), and by *GEICO v. Hyman*, 90 Haw. 1 (1999) – also *Hyman/Moore v. AIG Hawaii*, MVI-95-817-P+ *was reversed* on this issue after judicial remand (CFO October 10, 2001).]

Peer Review – "[I]t is worth reemphasizing that a treatment plan proposing p.r.n. (as needed) treatments is inherently suspicious and unlikely to meet the statutory requirements for such documents. While the preparation of treatment plan requests remains an option of the provider, the exercise of this option under HRS § 431:10C-308.6 and HAR § 16-23-95 presupposes knowledge by the provider that the patient/claimant has a specific need for regularly scheduled services for the treatment of specific injuries. It also requires that the timing of visits, the treating modalities, and the intended goals be articulated with reasonable precision.
Vea v. Liberty Mutual, MVI-96-793-C+ (CFO September 11, 1998).

Peer Review – "The submission of a speculative treatment plan - such as the one prepared for the Claimants in this matter [p.r.n. or 'as needed' care] - does not allow for a definitive assessment of its content by either a respondent or a peer reviewer, and as such does not conform to the applicable provisions of the Hawaii motor vehicle insurance law nor the administrative rules and cases adopted in support of that law.
Vea v. Liberty Mutual, MVI-96-793-C+ (CFO September 11, 1998).

Peer Review – Recent amendments to HRS §§ 431:10C-212 and 213 immunized claimants from liability for paying no-fault health care billings and entitled providers of health care services to directly contest insurers denials of such billings. With claimants thus removed from the billing/liability/payment cycle, they no longer have a justiciable or remedial interest in the matter sufficient to pursue a hearing to contest such denials.

Rosario v. State Farm, MVI-96-370-C (CFO July 15, 1998) [Note: in accord on this issue - but with tort exception - *Wilson v. AIG Hawaii*, 89 Haw. 45 (1998).]

Peer Review – A respondent's HRS § 431:10C-308.6(c) peer review challenge of "continuing treatment" does not also constitute an HRS § 431:10C-308.6(d) challenge to a particular "treatment plan" since individual plans must be specifically challenged as a basis for any subsequent denial. The provisions of subsections (c) and (d) address different situations and a challenge must accurately reflect the specific subject of the challenge.
Olipares v. State Farm, MVI-94-295-C (CFO March 23, 1998) [Note: overruled on this issue by *GEICO v. Dang & Graulty*, 89 Haw. 8 (1998).]

Peer Review – A denial of prospective no-fault insurance benefits is not necessarily improper (as a procedural issue) under circumstances where an insurer has issued a peer review challenge to such benefits pursuant to HRS § 431:10C-308.6, and thus to the extent that a contrary position is reflected in *Butuyan v. State Farm*, MVI-93-257-C (CFO January 9, 1995) that position is reversed.
Redmond v. State Farm, MVI-94-287-P (CFO September 18, 1997) [Note: in accord on this issue - *GEICO v. Dang & Graulty*, 89 Haw. 8 (1998).]

Peer Review – The peer review procedures enacted by the 1992 legislative session and effective as of January 1, 1993 are not applicable to the evaluation of claims arising out of motor vehicle accidents which occurred prior to January 1, 1993, and consequently may not be used as a basis for an insurer issuing a denial of no-fault benefits.
Yamane v. State Farm, MVI-94-298-C (CFO September 18, 1997).

Peer Review – If a claimant has no liability to pay for treatment whose benefit was disputed in a peer review report, and the timeframe covered by any additionally proposed treatment under the plan has expired, the claimant has no justiciable or remedial interest in the matter which would warrant an administrative hearing on the underlying denial.
Rosario v. State Farm, MVI-96-370-C (CFO July 15, 1997); *Niebling v. State Farm*, MVI-95-155-C (CFO July 15, 1997); and, *Tran v. AIG Hawaii*, MVI-96-406-C (CFO July 15, 1997). [Note: in accord on this issue - but with tort exception - *Wilson v. AIG Hawaii*, 89 Haw. 45 (1998).]

Peer Review – Where a claimant has received the treatment proposed in a treatment plan for a period of time which has subsequently expired the claimant lacks a personal stake in the matter (which has become moot as to the claimant) and therefore has no justiciable interest in pursing a hearing to contest a respondent's denial of the treatment plan.
Gumayagay v. State Farm, MVI-96-157-C (CFO June 18, 1997). [Note: in accord on this issue - but with tort exception - *Wilson v. AIG Hawaii*, 89 Haw. 45 (1998).]

Peer Review – It has been previously determined that "the only no-fault benefits which can be denied pursuant to an unfavorable peer review report of a treatment plan are the same no-fault benefits that could have been approved (i.e. the treatments which were proposed for that plan for the time frame covered by that plan)" (citations omitted).
Kang v. State Farm, MVI-95-76 (CFO June 18, 1997). [Note: partially reversed on this issue and remanded by *Kang v. State Farm & Graulty*, Civil No. 97-2944-07 (12-14-98)].

Peer Review – "The peer review procedure set out in HRS § 431:10C-308.6 is inapplicable to the evaluation of a claimant's treatment if it was related to injuries sustained by the claimant prior to January 1, 1993, and denials which are based upon peer review evaluations under such a scenario are invalid."
Hyman/Ream v. GEICO, MVI-95-239-P (CFO June 18, 1997).

Peer Review – "The standing of providers under HRS § 431:10C-212 to contest post January 1, 1993 denials of no-fault insurance benefits [arising out of pre January 1, 1993 motor vehicle accidents] (i.e. to initiate proceedings after the effective date of Acts 123 and 124) is a legally valid prospective right which is not based upon any retrospective application of the law."
Hyman/Ream v. GEICO, MVI-95-239-P (CFO June 18, 1997) [Note: initially overruled on this issue by *CHART/Yosores v. State Farm*, MVI-94-199-P (CFO October 3, 1997); and, *Redmond v. State Farm*, MVI-94-287-P (CFO September 18, 1997) - which were subsequently overruled/reversed on this issue by *Redmond v. State Farm & Graulty*, Civil No. 97-4270 (12-11-98), and by *GEICO v. Hyman*, 90 Haw. 1 (1999).]

Peer Review – "[T]he 1992 legislative package which addressed motor vehicle insurance reform - as embodied in Acts 123 and 124 of the 1992 Session Laws of Hawaii contained *multiple* amendments to HRS Chapter 431 which were by no means limited to the peer review process. One of these amendments (§ 7 of Act 124) specifically provided that a provider of services who objected to an insurer's denial of benefits was entitled to request a review by the Insurance Commissioner. This right, which had previously been reserved to claimants, was a valid prospective right which took effect on January 1, 1993....Neither the caselaw created by *Richard [v. Metcalf*, 82 Haw. 249 (1996)], nor any other provision of law, precludes a provider from asserting his or her statutory right to pursue relief under such circumstances."
Hyman/Ream v. GEICO, MVI-95-239-P (CFO June 18, 1997) [Note: initially overruled on this issue by *CHART/Yosores v. State Farm*, MVI-94-199-P (CFO October 3, 1997); and, *Redmond v. State Farm*, MVI-94-287-P (CFO September 18, 1997) - which were subsequently overruled/reversed on this issue by *Redmond v. State Farm & Graulty*, Civil No. 97-4270 (12-11-98), and by *GEICO v. Hyman*, 90 Haw. 1 (1999).]

Peer Review – "[W]hen the period during which the disputed treatment was to be provided to the Claimant has expired, the issue of whether that treatment would have been appropriate and reasonable became moot and presented no justiciable issue for determination by the Insurance Commissioner, and, the question of the propriety of the Respondent insurer's denial of the treatment plans, was therefore moot. The Commissioner concluded that in such situations the Claimant, insured, had no remedial interest in the matter since there was no remedy that could be directed in such situation."
Parrent v. GEICO, MVI-95-344-C (CFO June 3, 1997). [Note: in accord on this issue - but with tort exception - *Wilson v. AIG Hawaii*, 89 Haw. 45 (1998).]

Peer Review – Where a claimant has received the treatments challenged in a proposed treatment plan and has no obligation to pay the provider for them (HRS §§ 431:10C-308.5 and 431:10C-308.6(j)), the question of whether the insurer is obligated to pay the provider is solely between those persons and the claimant has no justiciable interest in the matter and thus no standing to pursue it.
Gutierrez v. AIG Hawaii, MVI-96-429-C (CFO June 3, 1997); *Morrison v. State Farm*, MVI-96-345-C (CFO April 3, 1997); and, *Maguire v. State Farm*, MVI-94-566-C/650-C (CFO September 23, 1996). [Note: in accord on this issue - but with tort exception - *Wilson v. AIG Hawaii*, 89 Haw. 45 (1998).]

Peer Review – Where a claimant has "... received treatments proposed in a treatment plan covering a period which had expired, the question of the propriety of the denial of the treatment plan was moot and the only question presented was whether the provider who rendered the treatment should or should not be paid. The Commissioner concluded that in such situations, the claimant lacked a personal stake in the matter and therefore had no justiciable interest in pursuing a hearing to contest a peer review determination that treatment proposed or rendered under an expired treatment plan was inappropriate or unreasonable."
Pacariem v. State Farm, MVI-95-856-C (CFO May 5, 1997). [Note: in accord on this issue - but with tort exception - *Wilson v. AIG Hawaii*, 89 Haw. 45 (1998).]

Peer Review – A provider, in requesting an administrative hearing to contest an insurer's denial of no-fault benefits, must comply with the mandatory provisions of HRS § 431:10C-212 and HAR § 16-23-57, including the timely submission of a written statement setting out the specific reason(s) for the request. A failure to comply with these requirements means that the provider is not entitled to an administrative hearing.
Hyman/Butuyan v. State Farm, MVI-96-74-P (CFO April 3, 1997).

Peer Review – A claimant's argument that he or she has a personal stake (and therefore a justiciable interest) in pursuing a no-fault hearing based on an HRS § 431:10C-308.6 (peer review) denial because of a need to effect payment of health care bills in order to reach the medical - rehabilitative limit (established in HRS § 431:10C-308) which would allow a tort action in civil court is not valid. In determining the tort threshold all amounts "paid or accrued" for injuries are

considered and it is unnecessary to establish which, if any, amounts have actually been paid.
Cheng v. State Farm, MVI-96-107-C (CFO February 19, 1997). [Note: reversed on this issue by *Wilson v. AIG Hawaii*, 89 Haw. 45 (1998).]

Peer Review – The July 23, 1996 decision of the Hawaii Supreme Court in *Richard v. Metcalf*, 82 Haw. 249 (1996) held that the provisions of HRS §§ 431:10C-308.5 and 308.6 are not applicable to requests for no-fault benefits arising out of accidents that occurred prior to January 1, 1993.
Nonaka v. Fireman's Fund, MVI-94-160-C (CFO January 16, 1997).

Peer Review – "The submission of a treatment plan request is not mandated by HRS § 431:10C-308.6. Rather, it is an option exercisable at the discretion of the effected health care provider. Furthermore, a respondent's demand for a treatment plan request (which is inherently prospective in nature) as a rationale for delaying/denying payment of previously rendered health care services for which bills have already been received is improper."
Arrington v. AIG Hawaii, MVI-94-710-C (CFO January 15, 1997).

Peer Review – "Since a health care provider can no longer bill a claimant for treatment but must bill the insurer directly, and since a claimant has no obligation to pay a provider's bill for treatment which has been deemed inappropriate or unreasonable by a peer review pursuant to HRS § 431:10C-308.6, claimants are not real parties in interest, nor do they have standing to pursue a cause of action to enforce the payment of such bills."
O'Neill v. AIG Hawaii, MVI-94-728-C (CFO September 26, 1996); *George v. AIG Hawaii*, MVI-95-100-C (CFO July 12, 1996); and, *Pearson v. GEICO*, MVI-94-354-C (CFO July 11, 1996) [Note: in accord on this issue - but with tort exception - *Wilson v. AIG Hawaii*, 89 Haw. 45 (1998).]

Peer Review – "A claimant has no justiciable interest in pursuing a hearing to contest a peer review determination that treatment proposed or rendered under an expired treatment plan was inappropriate or unreasonable. The hearing of a provider's potential claim under the guise of a claimant's pseudo claim is not permitted by the law."
O'Neill v. AIG Hawaii, MVI-94-728-C (CFO September 26, 1996); *George v. AIG Hawaii*, MVI-95-100-C (CFO July 12, 1996); and, *Pearson v. GEICO*, MVI-94-354-C (CFO July 11, 1996). [Note: in accord on this issue - but with tort exception - *Wilson v. AIG Hawaii*, 89 Haw. 45 (1998).]

Peer Review – "Treatment plan requests are, by law as well as by their very nature, prospective in nature and are created for the purpose of obtaining ***prior*** approval of the proposes services. Therefore, for the purpose of complying with HRS § 431:10C-308.6 a provider's treatment plan request cannot have a commencement date which precedes the date of its receipt by the insurer. Services provided to a claimant prior to the insurer's receipt of a provider's treatment plan

request are not considered to be covered by the plan and must be separately billed for separate consideration by the insurer."
George v. AIG Hawaii, MVI-95-100-C (CFO July 12, 1996).

Peer Review – "A treatment plan which proposes p.r.n. or "as needed" services rather than setting out a definitive schedule is inherently suspicious. The preparation and submission of a treatment plan request under the option presented by HRS § 431:10C-308.6 and HAR § 16-23-95 presupposes knowledge by the provider that a claimant has a specific need for regular services, and requires that this need be articulated in a reasonably precise manner."
Dunn v. GEICO, MVI-94-574-C (CFO July 12, 1996).

Peer Review – "The denial of a treatment plan request pursuant to the provisions of HRS § 431:10C-308.6 is limited to the content of the plan itself and the denial of any benefits that are not included in the plan or extend beyond the timeframe covered by the plan, is improper and misleading."
Dunn v. GEICO, MVI-94-574-C (CFO July 12, 1996).

Peer Review – "Where a claimant has received treatment under a treatment plan determined to be inappropriate or unreasonable pursuant to the peer review process set out in HRS § 431:10C-308.6 and/or the time covered by the treatment plan has expired, the issue of payment to the provider is moot as far as the claimant is concerned and a hearing by the claimant on this issue should be dismissed."
Pearson v. GEICO, MVI-94-354-C (CFO July 11, 1996). [Note: in accord on this issue - but with tort exception - *Wilson v. AIG Hawaii*, 89 Haw. 45 (1998).]

Peer Review – "Although prudence may suggest that a reconsideration of a PRO evaluator's determination should be obtained when significant additional information concerning the insured's condition becomes available to the insurer prior to the issuance of its denial of benefits ... neither statutory nor regulatory provisions require such action."
Ares v. AIG Hawaii, MVI-94-20-C (CFO July 10, 1996).

Peer Review – A respondent's denial of certain no-fault insurance benefits (based upon the content of a peer review evaluation) after a specified date (i.e. to continue ad infinitum) constitutes a future denial which is improper and should be rejected.
Ares v. AIG Hawaii, MVI-94-20-C (CFO July 10, 1996).

Peer Review – The issuance of a denial of no-fault benefits based upon a peer review report stating - that a claimant's condition could not be attributed to his motor vehicle accident was invalid on its face, as causation is not an issue for determination by peer review and thus not a proper basis for the subsequent issuance of a denial pursuant to a peer review report.
Randall v. USAA, MVI-94-625-C (CFO July 10, 1996).

Peer Review – A respondent's denial of future no-fault benefits based upon a peer review report which was completed pursuant to a challenge to "continued treatment or service" is improper. Such a challenge addresses treatment which either has been or is being received, and the scope of the denial depends upon whether bills had been submitted for the treatment. If bills where submitted the provisions of HRS § 431:10C-304(3) or 431:10C-308.6(c) would govern; if no bills were submitted the denial would be applicable to identified treatments or services up to its date of issuance.
Lau v. State Farm, MVI-94-433-C (CFO July 10, 1996); and, *Dang v. GEICO*, MVI-94-244-C (CFO May 15, 1996) [Note: overruled on this issue by *GEICO v. Dang & Graulty*, 89 Haw. 8 (1998).]

Peer Review – Where a respondent has replied to a provider's treatment plan request within five working days, but has - in its request for submission to peer review - indicated that the challenge was to "continued treatment or service" pursuant to HRS § 431:10C-308.6(c) and not to the treatment plan request pursuant to HRS § 431:10C-308.6(d), the treatment proposed by the plan was not challenged and thus was approved by default.
Lau v. State Farm, MVI-94-433-C (CFO July 10, 1996) [Note: overruled on this issue by *GEICO v. Dang & Graulty*, 89 Haw. 8 (1998).]

Peer Review – "[A] PRO reviewer's determination was not entitled to special deference similar to that given to a determination arrived at after an administrative hearing in the context of a contested case proceeding (citation). Review of the PRO proceeding revealed that the claimant had no opportunity to make any presentation to the PRO reviewer on his behalf. Consequently, such a proceeding could not qualify as a contested case proceeding as envisioned in the provisions of HRS § 91-14."
Rapanut v. State Farm, MVI-94-80-C (CFO July 10, 1996).

Peer Review – "The provisions of HRS § 431:10C-308.6(c) which provide insurers with an avenue to obtain an evaluation of continuing treatment or service received by a claimant require the PRO reviewer to make a determination that the continuing treatment or service was or was not appropriate or reasonable." Where the PRO reviewer has failed to make a clearly articulated determination, but rather has implied or suggested that appearances point one way or the other he has not presented an adequate basis for a denial of no-fault benefits.
Rapanut v. State Farm, MVI-94-80-C (CFO July 10, 1996).

Peer Review – "A PRO determination does not rise to the level of a determination arrived at after a contested case administrative proceeding, and therefore is not entitled to any greater evidentiary weight than other evidence that might be presented to the fact finder in these matters."
Shirota v. State Farm, MVI-94-101-C (CFO May 15, 1996).

Peer Review – The only ground for an insurer to issue a denial of benefits pursuant to a peer review organization determination is that the treatment in question is not appropriate or reasonable. HAR § 16-23-118(e). Other grounds such as causation are simply not subject to the peer review process outlined in HRS § 431:10C-308.6.
Hilario v. State Farm, MVI-93-193 (CFO March 12, 1996).

Peer Review – "Only challenges based on whether treatment is appropriate or reasonable shall be filed with the commissioner for submission to a peer review organization. Denials or partial denials of claims based on other grounds, such as coverage questions, shall not be subject to peer review. Section 16-23-118."
Hilario v. State Farm, MVI-93-193 (CFO March 12, 1996).

Peer Review – "The disapproval (or even the non-submission) of a treatment plan request is not necessarily a bar to eventually obtaining compensation/reimbursement of otherwise valid no-fault benefits. The provisions of HRS § 431:10C-308.6 (a) and (d) provide an optional approach whereby an approved treatment plan request will serve to assure a provider/claimant of payment for services rendered in accordance with that plan. Nevertheless, a provider may still treat a claimant in the absence of an approved treatment plan request and if that treatment is subsequently determined by the insurer (or through the hearing process) to have been a valid no-fault benefit, the provider/claimant is still entitled to compensation/reimbursement."
Valdez v. GEICO, MVI-94-340-C+ (CFO January 10, 1996); and, *Sumter v. GEICO*, MVI-94-61-C (CFO February 2, 1995).

Peer Review – "The provisions of HRS § 431:10C-308.6 do not mandate the submission of a treatment plan as a condition precedent to reimbursement for no-fault benefits provided to a claimant. Rather, it provides a permissive option by which a health care provider may submit a treatment plan with respect to proposed health care services in an effort to reach agreement with the insurer prior to performing such services."
Valdez v. GEICO, MVI-94-340-C+ (CFO January 10, 1996).

Peer Review – "It should be readily apparent that psychotherapy must be billed at the correct codes/rates for such services (even if they were to be provided by a licensed practitioner who could bill at a higher rate where psychiatric or psychological services were actually provided)."
Valdez v. GEICO, MVI-94-340-C+ (CFO January 10, 1996).

Peer Review – The statutory provisions that became effective January 1, 1993 providing for peer review organization ("PRO") procedures apply to the evaluation of treatments received by claimants after that date even though the injuries being treated were sustained before January 1, 1993. Such an approach does not constitute a retroactive application of the statutory provisions.

Ching v. AIG Hawaii, MVI-94-89-C (CFO January 5, 1996). [Note: overruled on this issue by *Richard v. Metcalf*, 82 Haw. 249 (1966)].

Peer Review – The provision contained in HRS § 431:10C-308.6(c) which allows that a challenge of continuing treatment or services "may be made at any time" does not give an insurer/respondent an avenue to circumvent the 10 day requirement for filing a challenge to a health care provider's bill for treatment or services already rendered to an insurer/claimant.
Ching v. AIG Hawaii, MVI-94-89-C (CFO January 5, 1996).

Peer Review – It should be noted that issues other than the appropriateness and reasonableness of health care treatment and services for injuries - such as the cause of an injury claimed to have been the result of an accident - are not subject to the PRO evaluation process envisioned by HRS § 431:10C-308.6 and HAR § 16-23-118(e).
Ching v. AIG Hawaii, MVI-94-89-C (CFO January 5, 1996).

Peer Review – The peer review process offers insurers an alternative to an IME as a basis for evaluating whether treatment for an accident related injury is appropriate and reasonable. It provides an assessment by a medical (or other) peer similar to what might be rendered by an IME, is rebuttable, and is not entitled to any greater validity than other evidence that may be received on the question of whether an insurer's denial of no-fault benefits was proper.
Ching v. AIG Hawaii, MVI-94-89-C (CFO January 5, 1996).

Peer Review – A PRO reviewer's evaluation does not result in a deprivation of Claimant's property without due process of law since the loss of benefits would not occur until after a review of the insured's denial of benefits in an administrative hearing, or arbitration or judicial proceeding at the Claimant's option.
Ching v. AIG Hawaii, MVI-94-89-C (CFO January 5, 1996).

Peer Review – Peer review evaluations conducted in accordance with HRS § 431:10C-308.6 and HAR § 16-23-117 thru 119 do not have to be conducted by health care reviewers who are licensed to practice their profession in the State of Hawaii in order to be valid for consideration as evidence in contested no-fault insurance proceedings.
Guray v. State Farm, MVI-94-3-C (CFO October 26, 1995); *Nutter/Garot v. State Farm*, MVI-93-278-P (CFO September 11, 1995); and, *Toda/Lahr v. State Farm*, MVI-93-223-P (CFO April 3, 1995).

Peer Review – Where a respondent has limited its challenge to a specific treatment plan or to specific bills for treatment that has been rendered it may not thereafter issue a denial which includes prospective benefits beyond the scope of either the existing plan or the existing bills.
Eder v. State Farm, MVI-94-135-C (CFO September 15, 1995); and, *Butuyan v. State Farm*, MVI-93-257-C (CFO January 9, 1995) [Note: overruled on this issue by

Swords v. Commercial Union, MVI-95-126 (CFO September 18, 1997) - affirmed, Civil No. 97-4064-10 (11-4-98) – (pending further appeal)].

Peer Review – "Any determination of the merits of a denial based on a peer review recommendation under HRS § 431:10C-308.6 has the same procedural and substantive requirements - including same standard of review - as all other administrative proceedings initiated under HRS § 431:10C-212."
Pecson v. GEICO, MVI-94-254-C (CFO September 15, 1995).

Peer Review – "Every separate treatment plan request submitted by a provider must be separately addressed by a respondent, and unless it is the subject of its own correctly completed and timely issued challenge the treatment plan is considered as approved. The issuance of a letter seeking to sweep a subsequent treatment plan request under the umbrella of an earlier challenge does not comply with statutory requirements and is not a valid basis for the issuance of a denial with respect to the subsequent treatment plan request."
Pecson v. GEICO, MVI-94-254-C (CFO September 15, 1995).

Peer Review – "Where a person conducting a medical records review does not testify at the hearing and where little, if any, material information is introduced on the reviewer's background and qualifications, his or her opinion is suspect since it can only be as good as the information upon which it is based *and* the qualifications of the reviewer to interpret that information."
Pecson v. GEICO, MVI-94-254-C (CFO September 15, 1995).

Peer Review – A peer review evaluation of a claimant's planned or actual health care treatment which has been challenged by a respondent falls far short of satisfying the procedural requirements of a contested case proceeding pursuant to HRS Chapter 91 (Hawaii Administrative Procedure Act). Accordingly, proceedings conducted pursuant to HRS § 431:10C-212 and HRS Chapter 91 to determine whether a respondent's denial of no-fault insurance benefits was proper is necessarily a de novo inquiry.
Nutter/Garot v. State Farm, MVI-93-278-P (CFO September 11, 1995).

Peer Review – The relevant law reflects an intention by the legislature to allow the use of unlicensed out of state peer review evaluations in accordance with the provisions of HRS § 431:10C-308.6. The PRO evaluation is basically an IME evaluation but limited to a "documents only" review, and the legislature contemplated the validity of IMEs conducted by out-of-state providers as reflected in HRS § 431:10C-308.5(b) which addresses charges for such examinations within and outside of Hawaii.
Nutter/Garot v. State Farm, MVI-93-278-P (CFO September 11, 1995).

Peer Review – Although a peer review evaluator may request additional documentation under HAR § 16-23-118(c), he or she is not required to do so and may make a determination that there was insufficient documentation to substantiate the appropriateness and reasonableness of the challenged treatment as a valid basis for concluding that the challenged treatment did not meet the criteria required by HRS § 431:10C-308.6(c).
Nutter/Garot v. State Farm, MVI-93-278-P (CFO September 11, 1995).

Peer Review – In the event that a provider establishes a conflict of interest based upon a prior relationship between the respondent and the peer reviewer, the PRO report is not invalidated per se but the conflict should be considered in weighing the merits of the report as a basis for issuing a denial of no-fault benefits.
Nutter/Garot v. State Farm, MVI-93-278-P (CFO September 11, 1995).

Peer Review – Where a provider can establish its factual assertion that a peer review evaluation conducted pursuant to HRS § 431:10C-306.6 utilized a higher standard of "medical necessity" rather than "appropriate and reasonable care," the evaluation may well be an improper basis for the issuance of a denial of no-fault benefits.
Nutter/Garot v. State Farm, MVI-93-278-P (CFO September 11, 1995).

Peer Review – The provisions of the Medical Fee Schedule which state that Codes 97260 & 97261 "may not be used more than once, whether singularly or in combination for a single office visit" do not limit consideration of the spine as a single, unitary area. A provider may request payment for separate manipulations of distinct areas of a claimant's spine, although only two separate manipulations are allowed as the maximum charge under the fee schedule. The first would be under Procedure Code 97260 and the second would be under Procedure Code 97261.
Nutter/Garot v. State Farm, MVI-93-278-P (CFO September 11, 1995).

Peer Review – The PRO provisions of HRS Chapter 431:10C as enacted by Act 123 and Act 124, (effective January 1, 1993) and the implementing provisions of HAR Title 16, Chapter 23, Subchapter 17 (effective June 1, 1993) are applicable for evaluating the treatment of injuries sustained in accidents that occurred prior to January 1, 1993 where the claimed no-fault benefits are for treatments received after January 1, 1993. The defining event for determining what law is applicable under these circumstances is not the motor vehicle accident causing a claimant's injury but rather the actual or proposed treatment of the injury at some later date. Where that later date is after the effective date of the statute/rule then their provisions apply.
Vanderberg v. AIG, MVI-93-224 (CFO September 11, 1995). [Note: overruled on this issue by *Richard v. Metcalf*, 92 Haw. 249 (1966)].

Peer Review – The difficulty of making medical assessments - even where there has been a physical examination (IME) of a claimant - with respect to validating and/or treating pain (a subjective symptom of a claimant's injury) has been

recognized in previous cases. Further consideration of this topic raises serious questions about the adequacy of using the peer review process as a means of evaluating health care treatments which are at least partially palliative in nature.
Ringer v. AIG Hawaii, MVI-94-127-C (CFO July 14, 1995).

Peer Review – A respondent's failure (unintentional or otherwise) to include relevant and material health care documentation regarding a claimant together with its challenge to the claimant's health care treatment may result in a deficient PRO report which may therefore result in an invalid denial.
Reyes v. State Farm, MVI-94-265-C (CFO June 23, 1995).

Peer Review – "A provider should be allowed to pursue an administrative hearing even where the insurer has paid the full amount of its obligation under the no-fault policy because otherwise the provider would be precluded from receiving compensation from its client/patient (the insured) for services which might be determined - as a result of the hearing - to be legitimate health care services. Such services, once determined to be legitimate, could then represent health care costs for which the client/patient would bear a contractual obligation to compensate the provider."
Speers/Skeen v. AIG Hawaii, MVI-94-52-P (CFO June 22, 1995).

Peer Review – "Where a provider's client/patient (the insured) has not participated as a party (claimant) in the administrative proceedings, the provider may still have to litigate the issue of the insured's obligation in a judicial proceeding. This would seem to be particularly true if the outcome of the administrative hearing was based upon a procedural issue without any substantive determination of the merit of the peer review's recommendations regarding the provider's services. Accordingly, under certain circumstances an administrative hearing may be a forum non-conveniens for this type of hearing."
Speers/Skeen v. AIG Hawaii, MVI-94-52-P (CFO June 22, 1995).

Peer Review – "It is worth noting that the recent legislative amendments to HRS § 431:10C-212 (effective January 1, 1993) extended to a "provider of services" essentially the same right to request an administrative hearing that had previously been a right reserved for claimants."
Speers/Skeen v. AIG Hawaii, MVI-94-52-P (CFO June 22, 1995). [Note: initially overruled on this issue by *CHART/Yosores v. State Farm*, MVI-94-194-P (CFO October 3, 1997); and, *Redmond v. State Farm*, MVI-94-287-P (CFO September 18, 1997) - which were subsequently overruled/reversed on this issue by *Redmond v. State Farm & Graulty*, Civil No. 97-4270 (12-11-98); and, *GEICO v. Hyman*, 90 Haw. 1 (1999).]

Peer Review – Neither the provisions of Hawaii Revised Statutes § 431:10C-308.6, nor Hawaii Administrative Rules Chapter 23, require health care professionals performing peer review organization (PRO) evaluations, to be licensed to practice in the State of Hawaii.
Igancio v. State Farm, MVI-93-230 (CFO May 12, 1995).

Peer Review – Health care professionals who conduct evaluations for PROs should be: 1) licensed and competent to practice in the state where the health care professionals practice; and 2) able to apply the generally accepted standards of practice and treatment in the State of Hawaii, for the health care specialty that is the subject of PRO review.
Igancio v. State Farm, MVI-93-230 (CFO May 12, 1995).

Peer Review – "[I]f the scope of administrative hearings originating from HRS § 431:10C-308.6 peer review challenges were to be limited to a search for procedural errors, without any substantive evaluation of the report underlying the denial ... [i]t would also result in an unfair outcome, violate the intent of the system of reparations established by HRS Chapter 431, Article 10C, and quite possibly force an unconstitutional application of the statute in such areas as due process, equal protection, or contractual rights."
Brown v. AIG Hawaii, MVI-94-91-C (CFO March 28, 1995).

Peer Review – "[A] broader analysis raises serious questions about the adequacy of the peer review process as a means of evaluating health care treatments which are substantially palliative in nature. The primary difference between a PRO evaluation and an IME evaluation is the absence of any direct examination of the claimant by the PRO evaluator, which generally means that the peer review process is less comprehensive and a less dependable basis for terminating a claimant's eligibility for no-fault benefits."
Brown v. AIG Hawaii, MVI-94-91-C (CFO March 28, 1995).

Peer Review – "Neither the language of that statute [HRS § 431:10C-308.6], nor its legislative history, support the contention that it restricted no-fault hearings to a form of secondary review limited to the examination of procedural issues relating to the peer review process. Administrative hearings on no-fault denials which are based upon challenges initiated under HRS § 431:10C-308.6 have the same procedural and substantive requirements - including the same standard of review - as all other proceedings under HRS § 431:10C-212."
Brown v. AIG Hawaii, MVI-94-91-C (CFO March 28, 1995).

Peer Review – "Substantial injustice could result if no-fault administrative hearings treated peer review reports as summary adjudications of health care issues rather than examining them through a *de novo* review of their substantive value as a basis for any denial on no-fault benefits."
Brown v. AIG Hawaii, MVI-94-91-C (CFO March 28, 1995).

Peer Review – "In order to fairly and properly reach a conclusion regarding the propriety of a respondent's denial of benefits based upon a peer review report, it is necessary to examine that report from both a procedural and substantive perspective. ... [A] peer review report does not enjoy any special evidentiary status, has no presumption of irrebuttable validity, and is clearly not the equivalent of an administrative determination reached through a contested case hearing."
Sumter v. GEICO, MVI-94-61-C (CFO February 2, 1995).

Peer Review – "Administrative hearings on no-fault denials which are based upon challenges initiated under HRS § 431:10C-308.6 have the same procedural and substantive requirements - including the same standard of review - as all other proceedings under HRS § 431:10C-212."
Sumter v. GEICO, MVI-94-61-C (CFO February 2, 1995).

Peer Review – When a respondent challenges a claimant's health care treatment by utilizing the peer review process, it may not subsequently issue a valid denial of such treatment for a reason (even if supported by the PRO evaluation) other than a determination that the treatment was not appropriate or reasonable. A correct reading of HRS § 431:10C-308.6 (in conjunction with the less authoritative and somewhat conflicting provisions of HAR § 16-23-118) precludes use of PROs as a basis for determining other issues.
Aoki v. AIG Hawaii, MVI-93-281-C (CFO October 26, 1994); and, *Germano v. State Farm*, MVI-94-18-C+ (CFO June 1, 1995).

Peer Review – Where the language used by a respondent in articulating the basis for issuing a denial of no-fault benefits shows that the denial is invalid on its face, a full hearing is not warranted to search beyond its face to see if the denial was nevertheless based upon meritorious intentions.
Aoki v. AIG Hawaii, MVI-93-281-C (CFO October 26, 1994).

Peer Review – Where a respondent has challenged a claimant's health care treatment by utilizing the peer review process outlined in HRS § 431:10C-308.6, it is not permitted to thereafter issue a denial of no-fault benefits which is based on the peer review report for any reason other than its assertion that the treatment was inappropriate or unreasonable, even if some other reason (such as lack of causation) is supported by the content of the report.
Aoki v. AIG Hawaii, MVI-93-281-C (CFO October 26, 1994).

PENALTY PROVISIONS

Penalty Provisions – Under circumstances where a respondent has knowingly and deliberately violated a provision of HRS Chapter 431, Article 10C, it becomes appropriate to impose sanctions pursuant to HRS § 431:10C-117 which are commensurate with the role of the respondent and the extent of its violations. *HEPA/Adams v. State Farm*, MVI-96-1024 (CFO August 4, 1998).

Penalty Provisions – HRS § 431:10C-304(3) sets forth the statutory time frame in which the insurer must pay, deny, or question the appropriateness of a claim submitted for no-fault benefits. . . . Under the provisions of HRS § 431:10C-304(6) and 431:10C-117(b) and (c) civil penalties up to $10,000.00 per violation may be assessed upon an insurer that has failed to comply with the provisions of HRS § 431:10C-304.
Lucas v. AIG Hawaii, MVI-94-165 (CFO October 30, 1996). [Note: affirmed by summary dispositional order - S.C. No. 21464 (12-28-98)].

Penalty Provisions – A pattern of issuing repeated denials of no-fault benefits on a basis which has consistently been held to be invalid flaunts the law, wrongs persons entitled to its benefits, and constitutes abusive conduct which warrants the assessment of civil penalties. . . . Such conduct also warrants the assessment of administrative costs pursuant to the provisions of HRS § 431:10C-212(d) which state that, "The commissioner may assess the cost of the hearing upon either or both of the parties."
Lucas v. AIG Hawaii, MVI-94-165 (CFO October 30, 1996). [Note: affirmed by summary dispositional order - S.C. No. 21464 (12-28-98)].

Penalty Provisions – "A respondent may be partially correct in determining that a claimant is not entitled to particular no-fault benefits, and yet may have acted improperly by issuing a blanket denial of any benefits without a reasonable basis for such action." While such conduct may warrant the imposition of sanctions under the penalty provisions contained in HRS § 431:10C-117(b) and (c), it is generally not a sufficient reason for invalidating the entire denial.
Brown v. AIG Hawaii, MVI-94-91-C (CFO March 28, 1995); and, *Sumter v. GEICO*, MVI-94-61-C (CFO February 2, 1995).

Penalty Provisions – Where legal obligations have been established as a result of no-fault hearing, but a specific dollar award cannot be made because of insufficient evidence, the parties have an obligation to attempt to determine that amount in good faith without further administrative proceedings. Where a further hearing is allowed and/or required to make such a determination, the parties may be subject to an assessment of administrative costs pursuant to HRS § 431:10C-212(d); and award of attorney's fees and/or costs pursuant to HRS § 431:10C-211; or the imposition of sanctions pursuant to HRS § 431:10C-117.

Elarmo v. Island, MVI-93-260 (CFO January 24, 1995).

Penalty Provisions – "Although subsequent [pre-hearing] corrective action by a respondent to bring a flawed denial of benefits up to the standards set out in HRS § 431:10C-304 will not necessarily shield the respondent from the imposition of sanctions, it may well preclude a claimant from successfully challenging the denial on a procedural basis in the absence of some other showing of prejudice."
Kennedy v. AIG Hawaii, MVI-92-28 (CFO September 9, 1992).

Penalty Provisions – A pattern of issuing repeated denials of no-fault benefits on a basis which has consistently been held to be invalid not only flaunts the law and wrongs persons entitled to benefits, it is abusive conduct which warrants the assessment of civil penalties as well as administrative costs associated with a hearing.
Siu v. AIG Hawaii, MVI-92-4 (CFO August 28, 1992).

Penalty Provisions – A pattern of disregard for existing law and precedent by a respondent - contrary to the provisions of the no-fault statutes and detrimental to those persons rightfully claiming health care benefits - is inappropriate and abusive of the administrative process which was legislatively established to provide an efficient and equitable system of reparations. Such conduct by a respondent is a valid basis for assessing the cost of the hearing against the respondent under the provisions of HRS § 431:10C-212(d) as well as for the imposition of civil penalties under HRS § 431:10C-117(b) and (c).
Bagaoisan v. AIG Hawaii, MVI-90-40 (CFO December 17, 1990).

Penalty Provisions – "HRS § 431:10C-304(3) sets forth the statutory time frame in which the insurer must pay, deny, or question the appropriateness of a claim submitted for no-fault benefits. If the insurer questions the appropriateness of the claim, the insurer must forward an itemized list of required documents to the claimant. In the present case, there is a variable dearth of evidence concerning the reasons for respondent's protracted and ultimately retroactive denial of claimant's request for wage loss benefits. Under the provisions of HRS §§ 431:10C-304(6) and 431:10C-117(b) and (c), civil penalties up to $10,000 per violation may be assessed upon an insurer that has failed to comply with the provisions of HRS § 431:10C-304."
Paaoao v. Liberty Mutual, MVI-89-90 (CFO June 12, 1990).

Penalty Provisions – The provisions of HRS § 294-4(3) [HRS § 431:10C-304(3)] require that an insurer make, and communicate to its insured, a determination of the insurer's position regarding any no-fault claim within 30 days after receiving it. The law does not otherwise allow for the retroactive implementation of denials and such conduct may constitute not only a substantively and procedurally improper denial of benefits but may also constitute a violation of HRS § 294-39(b) [HRS § 431:10C-117(b)] and/or HRS § 294-39(c) [HRS § 431:10C-117(c)].

Metzger v. GEICO, MVI-88-55 (CFO May 25, 1990).

Penalty Provisions – Where a respondent has issued a denial of no-fault benefits which is (if not legally invalid on its face) clearly inappropriate and abusive of the administrative hearing process (as part of the statutory system of reparations envisioned by the legislature) an assessment of costs may be imposed under the provisions of HRS § 431:10C-212(d).
Huynh v. State Farm, MVI-88-9 (CFO June 26, 1989).

PROSPECTIVE DENIALS

Prospective Denials – "[A]s stated in HRS § 431:10C-102, the purpose of the Hawaii motor vehicle insurance law is 'a system of *reparations'* (Emphasis added). It has also been uniformly understood … that the correct interpretation of the law governing the operation of that system requires the consideration of claims for benefits which have been asserted for *previously incurred* losses that had been subsequently denied. (Citations omitted) Although previous caselaw has also recognized limited exceptions to this interpretation under specific circumstances … the general prohibition on prospective denials has remained as the correct interpretation of both the letter of the law and the intent of the legislature. This is particularly true in the area of health care treatments."
Sickel v. GEICO, MVI-96-595 (CFO May 24, 2000).

Prospective Denials – "The rights of insureds as reflected in [HRS] § 431:10C-303 and the obligations of insurers as reflected in HRS § 431:10C-304 require that their disputes focus on events as of the time of the denial, rather than on speculative events which may have occurred (or information that may have become available) after that time. Experience has shown … that prospective denials can have an unfair, chilling effect on individuals who wish to pursue further treatment, and it is indeed unlikely that the issuance of an additional (later) denial would constitute an unfair burden on the resources of insurers. An insurer mayy neither base a denial on the predicted occurrence/outcome of some future event, nor subsequently validate such a denial on the actual occurrence/outcome of that event. (Citations omitted)."
Sickel v. GEICO, MVI-96-595 (CFO May 24, 2000).

Prospective Denials – "The Commissioner finds that public policy considerations favor eliminating the limitation which prevents the insurer from issuing a denial as to future benefits…. Allowing an insurer to deny a future benefit for a specified reason will serve the public interest by reducing the cost of providing no-fault benefits and increasing the efficiency of the no-fault system."
Swords v. Commercial Union, MVI-95-126 (CFO September 18, 1997) [Note: affirmed on this issue, Civil No. 97-4064-10 (11-4-98) - (pending further appeal)].

Prospective Denials – A respondent's denial of treatment (based upon an asserted lack of causation) only includes claims for payment submitted within the thirty days prior to the date of the denial, and is improper with respect to any future benefits which may have been incurred after that date.
Luke/Eda v. State Farm, MVI-94-628-P (CFO June 20, 1997).

Prospective Denials – A purported denial of future benefits that had either not been accrued by the claimant or not been the subject for a demand for payment by the claimant is improper and contrary to the provisions of HRS § 431:10C-304.

Kang v. State Farm, MVI-95-76 (CFO June 18, 1997). Note: reversed in part on this issue and remanded by *Kang v. State Farm & Graulty*, Civil No. 97-2944-07 (12-14-98)].

Prospective Denials – A respondent's unlimited denial of certain no-fault benefits, which was construed in conjunction with a peer review report, was intended to deny future no-fault benefits in excess of those proposed by the treatment plan, and thus at least that portion of the denial was improper and invalid on its face.
Federico v. Allstate, MVI-94-157-C (CFO January 15, 1997).

Prospective Denials – "A respondent may not withhold/deny benefits under HRS § 431:10C-304(3)(C) pending the outcome of a future independent medical examination, or any other unilaterally imposed and clearly impermissible basis. The language of the statute simply does not permit an insurer to impose such conditions, as distinguished from making a reasonable request for existing documents, as a basis for withholding/denying no-fault insurance benefits."
Lucas v. AIG Hawaii, MVI-94-165 (CFO October 30, 1996) [Note: affirmed by summary dispositional order - S.C. No. 21464 (12-28-98)]; *Pacubas v. AIG Hawaii*, MVI-93-184 (CFO October 10, 1994); and, *Calatrava v. AIG Hawaii*, MVI-93-76+ (CFO March 4, 1994).

Prospective Denials – "The denial of a treatment plan request pursuant to the provisions of HRS § 431:10C-308.6 is limited to the content of the plan itself and the denial of any benefits that are not included in the plan or extend beyond the timeframe covered by the plan, is improper and misleading."
Dunn v. GEICO, MVI-94-574-C (CFO July 12, 1996).

Prospective Denials – An insurer's refusal to pay no-fault insurance benefits pending an IME constitutes a prospective denial and has consistently been ruled to be a violation of HRS § 431:10C-304(3)(c) since it does not qualify as a "required document" which could be requested in the case where an insurer needs "additional information or loss documentation."
Khan-Miyasaki v. State Farm, MVI-94-276 (CFO March 12, 1996).

Prospective Denials – "Where a respondent's denial of benefits is based on a peer review report under HRS § 431:10C-308.6 the unqualified denial of whole or partial benefits after a future date is improper and misleading. The only no-fault benefits which can be denial pursuant to an unfavorable peer review report of a treatment plan are the same no-fault benefits that could have been approved (i.e. the treatments which were proposed in that plan for the time frame covered by that plan). The unlimited prospective denial of future treatments results in a denial which, with few exceptions, is at least partially invalid."
Pecson v. GEICO, MVI-94-254-C (CFO September 15, 1995).

Prospective Denials – Where a respondent has limited its challenge to a specific treatment plan or to specific bills for treatment that has been rendered it may

not thereafter issue a denial which includes prospective benefits beyond the scope of either the existing plan or the existing bills.
Eder v. State Farm, MVI-94-135-C (CFO September 15, 1995); and, *Butuyan v. State Farm*, MVI-93-257-C (CFO January 9, 1995). [Note: overruled on this issue by *Swords v. Commercial Union*, MVI-95-126 (CFO September 18, 1997) – affirmed, Civil No. 97-4064-10 (11-4-98) - (pending further appeal)].

REQUEST FOR HEARING

Request for Hearing – Although a claimant may be a real party in interest where – under a peer review generated denial – he or she makes an assertion that his or her purpose in pursuing a hearing is to preserve the right to sue in tort (which is dependent upon meeting tort threshold), such an assertion must be a reasonable one in light of the bills which have been, or reasonably may be, incurred. It is not enough for a claimant to simply make an unsupported assertion of such a purpose, or one that is inconsistent with the underlying evidence regarding his or her billings.
Punzal v. Progressive Ins., MVI-2000-30-C (CFO October 26, 2000).

Request for Hearing – Where a respondent has subsequently paid a claimant's health care bill(s) that had previously been denied that particular issue has become moot and thus requires no further hearing, but other issues, if any, may provide a basis for further proceedings.
Jou/Asahi et. al. v. GEICO, MVI-99-44-P (CFO July 5, 2000).

Request for Hearing – When the time set in HRS § 431:10C-315(b) – the statute of limitations – during which a claimant could have filed a court action has passed, the issue of whether his or her denied no-fault benefits might have been applied toward the tort threshold is moot and thus does not provide a legitimate basis for the claimant's assertion that he or she is a real party in interest to contest the no-fault denial in an administrative proceeding.
Goldstein v. State Farm, MVI-95-92-C (CFO November 2, 1999).

Request for Hearing – A provider of health care services is not permitted to intervene in a proceeding if the provider has failed to file its motion to intervene within the sixty day window allowed under HRS § 431:10C-212(a) for both claimants and providers to request an administrative hearing for the purpose of contesting an insurer's (respondent's) denial of no-fault benefits. The granting of such an untimely motion would have the effect of allowing the provider to circumvent the law by exercising a right which had already been forfeited and thus no longer existed.
Goldstein v. State Farm, MVI-95-92-C (CFO November 2, 1999).

Request for Hearing – "[T]he 1992 legislative package which addressed motor vehicle insurance reform - as embodied in Acts 123 and 124 of the 1992 Session Laws of Hawaii contained *multiple* amendments to HRS Chapter 431 which were by no means limited to the peer review process. One of these amendments (§ 7 of Act 124) specifically provided that a provider of services who objected to an insurer's denial of benefits was entitled to request a review by the Insurance Commissioner. This right, which had previously been reserved to claimants, was a valid prospective right which took effect on January 1, 1993....Neither the caselaw created by *Richard* [*v. Metcalf*, 82 Haw. 249 (1996)], nor any other provision of law,

precludes a provider from asserting his or her statutory right to pursue relief under such circumstances."
Hyman/Ream v. GEICO, MVI-95-239-P (CFO June 18, 1997) [Note: initially overruled on this issue by *CHART/Yosores v. State Farm*, MVI-94-194-P (CFO October 3, 1997); and, *Redmond v. State Farm*, MVI-94-287-P (CFO September 18, 1997) - which were subsequently overruled/reversed on this issue by *Redmond v. State Farm & Graulty*, Civil No. 97-4270 (12-11-98); and, *GEICO v. Hyman*, 90 Haw. 1 (1999).]

Request for Hearing – A provider, in requesting an administrative hearing to contest an insurer's denial of no-fault benefits, must comply with the mandatory provisions of HRS § 431:10C-212 and HAR § 16-23-57, including the timely submission of a written statement setting out the specific reason(s) for the request. A failure to comply with these requirements means that the provider is not entitled to an administrative hearing.
Hyman/Butuyan v. State Farm, MVI-96-74-P (CFO April 3, 1997).

Request for Hearing – A request for a hearing by either a claimant or a provider (to contest a respondent's denial of no-fault benefits) must comply with all of the requirements specified in HRS § 431:10C-212(a) and the result of a failure to do so is that the requesting party is not entitled to a hearing.
Hyman/Butuyan v. State Farm, MVI-96-74-P (CFO April 3, 1997).

Request for Hearing – Compliance with the time requirements (60 days) for requesting an administrative hearing under HRS § 431:10C-212(a) is a mandatory threshold requirement for obtaining such a hearing, but a failure to comply does not necessarily preclude a claimant from obtaining a review by way of arbitration or court proceedings as alternatives under HRS § 431:10C-308.6(f) where the denial has been based upon a peer review organization determination.*Hayes v. State Farm*, MVI-95-143-C (CFO March 12, 1996).

Request for Hearing – A claimant's compliance with the requirements of HRS § 431:10C-212(a) that "[T]wo copies of the denial; a written request for review; and a written statement setting forth specific reasons for the objections" be filed "within sixty days after the date of denial of the claim" is mandatory in nature and non-compliance will, as a rule, deprive this forum of jurisdiction to hear the merits of the case.
Hayes v. State Farm, MVI-95-143-C (CFO March 12, 1996).

Request for Hearing – The sixty day period within which a request must be made to contest a denial of no-fault benefits begins from the date of the denial's issuance and in the absence of a basis for applying the doctrine of equitable estoppel this period cannot be measured from any other date.
Hayes v. State Farm, MVI-95-143-C (CFO March 12, 1996).

Request for Hearing – "The procedural requirements governing a claimant's request for administrative review where his or her policy of insurance has been canceled are contained in HAR § 16-23-16, and the failure to make such a request within ten days of receiving notice of cancellation deprives this forum of jurisdiction to hear the matter."
McBeth v. Allstate, MVI-94-439 (CFO March 12, 1996).

Request for Hearing – Compliance with the time requirements (60 days) for requesting an administrative hearing under HRS § 431:10C-212(a) is a mandatory threshold requirement for obtaining such a hearing, but a failure to comply does not necessarily preclude a claimant from obtaining a review by way of arbitration or court proceedings as alternatives under HRS § 431:10C-308.6(f) where the denial has been based upon a peer review organization determination.
Hayes v. State Farm, MVI-95-143-C (CFO March 12, 1996).

Request for Hearing – "It is worth noting that the recent legislative amendments to HRS § 431:10C-212 (effective January 1, 1993) extended to a "provider of services" essentially the same right to request an administrative hearing that had previously been a right reserved for claimants."
Speers/Skeen v. AIG Hawaii, MVI-94-52-P (CFO June 22, 1995) [Note: initially overruled on this issue by *CHART/Yosores v. State Farm*, MVI-94-199-P (CFO October 3, 1997); and, *Redmond v. State Farm*, MVI-94-287-P (CFO September 18, 1997) - which were subsequently overruled/reversed on this issue by *Redmond v. State Farm & Graulty*, Civil No. 97-4270 (12-11-98); and, *GEICO v. Hyman*, 90 Haw. 1 (1999).]

Request for Hearing – The requirements in HRS § 431:10C-212(a) are mandatory in nature and must be strictly complied with. Thus, where a claimant has failed to submit a meaningful "written statement setting forth specific reasons" for his or her objections to a respondent's denial of benefits within the allotted time, the claimant is precluded from pursuing an administrative hearing to contest the denial.
Le v. State Farm, MVI-94-324-C (CFO June 22, 1995).

Request for Hearing – "Compliance with the statutory requirements of HRS § 431:10C-212(a) is mandatory in nature, and where a claimant has failed to submit his or her request for an administrative hearing within the prescribed time, there is no jurisdiction to hear the matter."
Bridge v. AIG Hawaii, MVI-94-51-C (CFO June 1, 1995).

Request for Hearing – In the absence of any compelling justification for non-compliance with the provisions of HRS § 431:10C-212(a) the Hearings Office does not have jurisdiction in matters where a request for a hearing has not been filed within 60 days from the date on which no-fault benefits were denied.
Zych v. GEICO, MVI-91-43 (CFO February 12, 1992).

Request for Hearing – A claimant seeking retroactive coverage for an accident which occurred after his policy expired but after payment of an attempted renewal must factually establish both detrimental and reasonable reliance on representations of the insurer that such coverage existed in order to benefit from the doctrine of equitable estoppel.
Lee v. GEICO, MVI-90-132 (CFO July 18, 1991).

STANDING (RPII)

Standing (Real Party in Interest) – Where a claimant has presented no evidence to show that his or her pursuit of a hearing – to contest a denial based upon the asserted unreasonableness, inappropriateness, or lack of necessary for health care treatment – was for the purpose of reaching tort threshold, the claimant is not a real party in interest and thus is not entitled to pursue such relief. As noted in *Wilson v. AIG Hawaii Ins. Co*., 89 Haw. 45 (1998) any such dispute is strictly between the insurer and the health care provider.
Sugai v. AIG Hawaii, ATX-2001-19 (CFO September 27, 2001).

Standing (Real Party in Interest) – "The Supreme Court in *Wilson [v. AIG Hawaii Ins. Co*., 89 Haw. 45 (1998)] determined that where a provider's bill was deemed inappropriate or unreasonable by peer review, an injured party played no role in the billing or payment process for medical services and that any dispute relating to the payment of medical bills was strictly between the provider and the insurer. The Court further found that an injured party was not a real party in interest with respect to her claim against the insurer for no-fault benefits to satisfy the provider's unpaid bill."
Chong v. AIG Hawaii, MVI-98-1129-C (CFO July 20, 2001); *and, Pedro v. AIG Hawaii*, MVI-98-496-C (CFO March 28, 2001).

Standing (Real Party in Interest) – Under the exception noted in *Wilson v. AIG Hawaii Ins. Co*., 89 Haw. 45 (1998) a claimant may be a proper party to contest a denial of health care benefits – that was issued on the basis of a peer review report deeming them to be inappropriate or unreasonable – if the claimant demonstrates that he or she is pursuing the matter in an attempt to reach the civil tort threshold for the purpose of establishing an ability to sue in tort.
Chong v. AIG Hawaii, MVI-98-1129-C (CFO July 20, 2001); *and, Pedro v. AIG Hawaii*, MVI-98-496-C (CFO March 28, 2001).

Standing (Real Party in Interest) – In contrast to a denial of payment for *past* health care benefits on the asserted basis that the care was unreasonable or inappropriate, a denial of *future* health care benefits may be contested by a claimant as a real party in interest without a showing that he or she is attempting to meet the tort threshold for initiating a civil lawsuit.
Pedro v. AIG Hawaii, MVI-98-496-C (CFO March 28, 2001).

Standing (Real Party in Interest) – Although a claimant may be a real party in interest where – under a peer review generated denial – he or she makes an assertion that the purpose in pursuing a hearing is to preserve his or her right to sue in tort (which is dependent upon meeting tort threshold), such an assertion must be a reasonable one in light of the bills which have been, or reasonably may be,

incurred. It is not enough for a claimant to simply make an unsupported assertion of such a purpose, or one that is inconsistent with the underlying evidence.
Punzal v. Progressive Ins., MVI-2000-30-C (CFO October 26, 2000).

STATUTE OF LIMITATIONS

Statute of Limitations – The provisions of HRS § 431:10C-315 which set time limits on the filing of a ”suit” are equally applicable to the filing of an administrative request for a hearing to contest a denial of no-fault benefits, and where its provisions are not met there is a threshold, procedural absence of jurisdiction to proceed with a hearing.
Santos v. AIG Hawaii, MVI-2000-57 (CFO April 20, 2001).

Statute of Limitations – The portion of HRS § 431:10C-315(a)(2) which states that suits may not be brought more than “two years after the last payment of motor vehicle insurance benefits” refers to *payment* of a bill and the statute of limitations is not tolled by a bill simply being generated, prepared, or placed in the mail.
O’Green v. State Farm, MVI-2000-24 (CFO April 20, 2001).

Statute of Limitations – It has been judicially determined by *Wright v. State Farm Mut. Auto Ins. Co*., 86 Haw. App. 357 (1997) “ that: 1) an insured may bring suit on an unresolved no-fault claim after the two year limitations period has expired if the insured had made a claim for benefits before the statute expired, and the two year period is tolled from the time the claim was submitted until any denial is issued.”
Jou/Asahi et. al. v. GEICO, MVI-99-44-P (CFO July 5, 2000).

Statute of Limitations – When the time set in HRS § 431:10C-315(b) – the statute of limitations – during which a claimant could have filed a court action has passed, the issue of whether his or her denied no-fault benefits might have been applied toward the tort threshold is moot and thus does not provide a legitimate basis for the claimant’s assertion that he or she is a real party in interest to contest the no-fault denial in an administrative proceeding.
Goldstein v. State Farm, MVI-95-92-C (CFO November 2, 1999).

Statute of Limitations – “Although the law does not specifically require an insurer to inform a policyholder of the applicability of HRS § 431:10C-315 [Statute of limitations], when an insurer does offer an explanation it is obliged to be complete and accurate in providing such information.” Where such is not the case and the claimant has reasonably and detrimentally relied upon representations made by the insurer, the principle of equitable estoppel may be applicable in preventing an unjust result from arising out of a perfunctory application of that statute.
Au v. Liberty Mutual, MVI-94-616 (CFO September 4, 1998).

Statute of Limitations – Where a health care provider erroneously submitted medical bills to the wrong insurance carrier, with the result that more than two years passed since the last payment of no-fault benefits by the respondent, the provisions

of HRS § 294-36(a)(2) [HRS § 431:10C-315] bar the claimant from receiving any further no-fault benefits.
Young v. First Ins., MVI-92-173 (CFO September 1, 1993).

Statute of Limitations – The Insurance Commissioner has previously reiterated the principle that equitable estoppel is a means to prevent the statute of limitations from barring a claim for no-fault benefits, and has adopted the elements set out in *Doherty v. Hartford Ins. Group*, 58 Haw. 570, 573 (1978), which stated: "One invoking equitable estoppel must show that he or she has detrimentally relied on the representation or conduct of the person sought to be estopped, and that such reliance was reasonable." (citations omitted)
Toyama v. State Farm, MVI-92-211 (CFO August 30, 1993); and, *Livsey v. Allstate*, MVI-87-1 (CFO November 10, 1987).

Statute of Limitations – The statute of limitations is not tolled where no bills are submitted by or on behalf of the claimant prior to the end of the two year statutory period even though the respondent knew that the claimant intended to seek medical treatment during that time.
Yamamoto v. Island Ins., MVI-92-87 (CFO March 8, 1993).

Statute of Limitations – A claimant is procedurally barred from pursuing an administrative hearing to substantively determine whether he or she is entitled to no-fault benefits where there has been a failure on the part of the claimant to comply with the two-year limitation set out in HRS §431:10C-315. Compliance with the statute of limitations is a threshold requirement which goes to jurisdiction, and cannot be stipulated to by the parties.
Pires v. First Insurance, MVI-91-38 (CFO January 16, 1992).

Statute of Limitations – Hawaii Revised Statutes § 431:10C-315(a)(2) is a bar to no-fault benefits for claims made more than two years after the last payment of no-fault or optional additional benefits.
Ford v. Allstate, MVI-91-27 (CFO September 30, 1991).

Statute of Limitations – There are no statutory or case authorities which specifically require a no-fault insurer to inform an insured of the applicability of the statute of limitations set forth in HRS § 431:10C-315.
Ford v. Allstate, MVI-91-27 (CFO September 23, 1991).

Statute of Limitations – All no-fault benefits are paid secondarily and net of any workers' compensation benefits that a person is entitled to receive because of harm sustained in a motor vehicle accident. If, however, a claimant's injuries are not established to have been caused by an accident which also qualifies as a motor vehicle accident under the no-fault statutes, any payment of workers' compensation benefits is not in lieu of (primary of) no-fault benefits and does not constitute payments which would otherwise extend the statute of limitations.
Botelho v. Commercial Union, MVI-89-55 (CFO September 13, 1990).

Statute of Limitations – Where a single company was assigned to adjust both no-fault and workers' compensation files regarding a particular claimant, and made payments on both claims on behalf of the underlying insurance carriers, such conduct alone is unlikely to be a valid basis for the claimant to assert equitable estoppel against either insurance company based upon knowledge which the adjuster had in servicing the other insurance company. This is especially true in the absence of any misleading representations or conduct made by the adjuster to the claimant during the course of handling the respective claims.
Botelho v. Commercial Union, MVI-89-55 (CFO September 13, 1990).

Statute of Limitations – The submission by a claimant of an application for benefits serves as notification to the insurer of a motor vehicle accident but it is not the equivalent of a claim for benefits and does not toll the statute of limitations.
Uratani v. Industrial Ins., MVI-90-29 (CFO September 13, 1990). [Note: overruled by *Wright v. State Farm Mvt. Auto Ins. Co.*, 86 Haw. App. 357 (1997)].

Statute of Limitations – A claimant is not entitled to no-fault benefits when the respondent has raised a statute of limitations defense and the claimant cannot affirmatively establish that a claim was actually submitted to the respondent within the two-year time frame set out in HRS § 431:10C-315(a)(2).
Aguinaldo v. Island Ins., MVI-89-103 (CFO July 17, 1990).

Statute of Limitations – "[T]he date of notification of a motor vehicle accident does not toll the statute of limitations as set forth in HRS §431:10C-315."
Poire v. American International, MVI-89-63 (CFO January 8, 1990).

Statute of Limitations – A claimant may be able to successfully assert equitable estoppel in contesting a denial of benefits based upon the statute of limitations where the insurer has not complied with its statutory obligations under HRS § 294-4(3) [HRS § 431:10C-304(3)] and the claimant can show detrimental reliance on the insurer's conduct.
Prescott v. National Union, MVI-89-42 (CFO December 20, 1989).

Statute of Limitations – A respondent's payment of a billing for an independent medical examination of a claimant is a business expense of the insurer which is voluntarily incurred by the insurer which is voluntarily incurred at its option and for its benefit. It does not constitute the payment of a no-fault benefit to the claimant. Accordingly, such a payment does not toll the applicable statute of limitations contained in HRS § 294-36 [HRS Section 431:10C-315].
Ruperti v. State Farm, MVI-88-81 (CFO September 6, 1989).

Statute of Limitations – A claimant is barred from recovering no-fault benefits under the provisions of HRS § 294-36 [HRS §431:10C-315] where more than two years have passed since the submission of any bills to the insurer even if

the claimant has been receiving chargeable health care treatments which were unknown to the insurer.
Tan v. National Union, MVI-87-41 (CFO December 4, 1987); *Ajifu v. State Farm*, MVI-85-11 (CFO June 18, 1986); and, *Hirano v. Fireman's Fund*, MVI-86-12 (CFO November 19, 1986).

SUBSTITUTE SERVICES

Substitute Services – Reasonable amounts paid for yard work (performed by a lawn service-for-hire) in substitution of services that a claimant would have performed for herself, but was unable to do so because of injuries caused in a covered motor vehicle accident, are compensable as no-fault benefits.
Dang v. Liberty Mutual, MVI-97-289 (CFO August 2, 1999).

Substitute Services – A claimant must establish the type and extent of services he or she performed prior to the accident which he or she could not perform after the accident, thus requiring substitute services - and must establish the basis for his or her inability to perform such services as well as the reasonableness of the costs of the substitute services.
Goria v. Pacific Ins./Hartford, MVI-93-125 (CFO October 5, 1994).

SUMMARY JUDGMENT

Summary Judgment – "The well established standard of review applicable to motions for summary judgment is that such motions may be granted as a matter of law where the evidence presented by the non-moving party has not shown any material fact to be in controversy even though the evidence is viewed in the light most favorable to the non-moving party."
Wan-Ting Chiu v. GEICO, ATX-2001-56 (CFO October 29, 2001).

Summary Judgment – The appellate courts have generally concluded that an claimant's provider of health care services, and not the claimant, is the real party in interest in an action against a respondent for the payment of the provider's bill. A review of *Gamata v. Allstate Ins. Co.*, 90 Haw. 213 (1999) and *Wilson v. AIG Hawaii*, 89 Haw. 45 (1998) reflects a determination that – at least where the claimant has no exposure to any personal obligation for the payment of a provider's bill that has been denied on the basis that it is unreasonable, unnecessary, or inappropriate – a claimant plays no role in the billing/payment process which flows directly between the insurer/respondent and the provider.
Bui v. GEICO, MVI-97-1236+ (CFO April 20, 2001).

Summary Judgment – "In considering motions for summary judgment, or other summary disposition, the standard of review is that the motion may be granted as a matter of law where the non-moving party has not established a material factual controversy despite the motion being viewed in the light least favorable to the moving party."
Hyman/Van Houten v. AIG Hawaii, MVI-96-758-P (CFO April 7, 2000); and, *El-Zir v. AIG Hawaii*, MVI-95-713-C (CFO July 14, 1999).

Summary Judgment – "[A] motion for dismissal, or other summary disposition, may be granted as a matter of law where the non-moving party cannot establish a material factual controversy when the motion is viewed in the light least favorable to the moving party."
Law v. Dai-Tokyo, MVI-95-400 (CFO August 16, 1999); *Hyman/White v. AIG Hawaii*, MVI-97-148-P (CFO September 24, 1999); *Hyman/Bowers v. State Farm***,** MVI-96-1410 (CFO July 15, 1999); *HEPA/Adams v. State Farm*, MVI-96-1024 (CFO August 4, 1998); and, *Lee v. AIG Hawaii*, MVI-96-979-C (CFO April 14, 1998).

Summary Judgment – "Once a summary judgment movant satisfies its initial burden of showing an absence of any genuine issues of material fact, the burden shifts to the opponent to come forward with specific facts showing that there remains a genuine issue for trial…. And in this regard, a party opposing a motion for summary judgment cannot discharge his burden by alleging conclusions, nor is he entitled to a trial on the basis of some hope that he can produce some evidence at that time."

Rivera v. State Farm, MVI-96-1354 (CFO August 10, 1999).

Summary Judgment – Although the issue or basis underlying a denial of no-fault benefits is principally determined from the face of the denial form, a party is not necessarily precluded, as a procedural matter, from raising and pursuing a motion for summary judgment founded upon a legal premise which is not articulated on the face of the denial form.
Hyman/Bowers v. State Farm, MVI-96-1410 (CFO July 15, 1999).

Summary Judgment – A request by either a claimant or a provider for a hearing to contest a denied treatment plan is moot under circumstances where no services proposed by the plan have been provided subsequent to the insurer's receipt of that plan.
Hyman/Bowers v. State Farm, MVI-96-1410 (CFO July 15, 1999); and, *Hyman/Scott v. USAA*, MVI-96-1376-P (CFO October 22, 1998).

Summary Judgment – A respondent's motion for summary judgment which relies upon a rationale other than that articulated as the basis for the denial itself may be heard pursuant to the general authority vested in Hearings Officers and/or contained within HAR § 16-201-16 [sic] (HAR § 16-201-17).
Hyman/Bowers v. State Farm, MVI-96-1410 (CFO July 15, 1999).

Summary Judgment – A claimant is obligated to present a prima facie case with sufficient evidence to address each element of proof necessary to show that a respondent's denial of no-fault benefits was improper, and the failure to do so warrants the (procedural) granting of a motion to dismiss the claimants request for a hearing.
Scavitto v. State Farm, MVI-95-943 (CFO July 15, 1999).

Summary Judgment – A claimant must present credible evidence, as a threshold procedural matter, to show that some actual service/billing has been denied by the insurer, or face the prospect of having his or her request for a hearing being summarily dismissed as moot.
El-Zir v. AIG Hawaii, MVI-95-713-C (CFO July 14, 1999).

Summary Judgment – "A motion for dismissal, or other summary disposition, may be granted as a matter of law where the non-moving party cannot establish a material factual controversy when the motion is viewed in the light least favorable to the moving party."
Lee v. AIG Hawaii, MVI-96-979-C (CFO April 14, 1998).

Summary Judgment – "A motion for dismissal, or other summary disposition, may be granted as a matter of law where the non-moving party cannot establish a material factual controversy when the motion is viewed in the light least favorable to the moving party."
Pearson v. GEICO, MVI-94-354-C (CFO July 11, 1996).

Summary Judgment – A motion for summary judgment may be granted as a matter of law where the non-moving party cannot reasonably establish any genuine factual ambiguity as viewed in the light least favorable to the moving party. A motion for summary judgment should not be granted, however, where a factual question of the "reasonableness" of a party's conduct remains a material unresolved ambiguity as viewed in the light most favorable to the non-moving party.
Tillmon v. AIG Hawaii, MVI-94-312 (CFO September 11, 1995).

TRAVEL EXPENSES

Travel Expenses – A provider lacks standing to pursue a request for no-fault benefits which consist of an insured's claim for mileage reimbursement.
Redmond v. State Farm, MVI-95-65-P (CFO April 14, 1998).

Travel Expenses – A claimant has the same burden of proof to establish his or her entitlement to contested travel expenses as for any other no-fault benefit, and a claim for payment of ambulance services is not valid where it is not shown that there was a need to utilize this method of transportation nor that other, appropriate methods were not available.
Brion v. State Farm, MVI-94-182-C (CFO April 4, 1995).

Travel Expenses – "Reasonable travel costs and other expenses related to health care services may be compensable as no-fault benefits, but the reasonableness of such costs - even where they are incurred for obtaining otherwise unchallenged health care treatment - is determined in light of the factual circumstances surrounding each case."
Aina/Ferreira/Ganir v. AIG Hawaii, MVI-92-163 (CFO September 1, 1993).

Travel Expenses – The reasonableness of a claimant's travel costs for obtaining otherwise unchallenged medical or dental treatment is normally determined by weighing the evidence in light of the factual circumstances surrounding each case.
Murray v. Colonial Penn, MVI-89-24 (CFO October 23, 1989).

WAGE LOSS

Wage Loss – Generally, in order to establish entitlement to wage loss benefits a claimant must show: 1) a physical disability as a result of a motor vehicle accident which results in an inability to engage in gainful activity, and 2) available and appropriate gainful activity which the claimant could not accept because of the physical disability.
Chong v. AIG Hawaii, ATX-2001-20+ (CFO August 22, 2001); *Madison v. State Farm*, MVI-96-47+ (CFO September 14, 1998); and, *Tungpalan v. State Farm*, MVI-94-370 (CFO May 15, 1996).

Wage Loss – "The elements necessary to establish entitlement to wage loss benefits are: 1) a physical disability as a result of a motor vehicle accident which results in the inability to engage in gainful activity, and 2) available and appropriate gainful activity which the claimant could not accept because of the physical disability."
Graham v. AIG Hawaii, MVI-2000-34 (CFO February 1, 2001).

Wage Loss – In addition to proving the existence of a disability that was related to a motor vehicle accident and proving that the disability precluded an acceptance of otherwise available employment, a claimant must also establish the amount of resulting wage losses.
Ichinotsubo v. Hartford Underwriters, MVI-98-704+ (CFO October 26, 2000).

Wage Loss – "The term 'reparations' [as used in HRS § 431:10C-102(a)] refers to payments owed for actual, incurred losses – not anticipated payments for speculative losses that might be incurred at some later time. Accordingly, the issuance of a disability slip purporting to certify a person's future inability to work is not a valid basis for asserting a claim to lost wages."
Garcia v. Dai-Tokyo, ATX-99-255+ (CFO July 6, 2000).

Wage Loss – "Just as insurers cannot customarily issue denials of future personal injury protection benefits, insured's cannot legitimately assert claims to future benefits. … [W]age loss claims which are made before an actual wage loss is incurred are invalid as speculatively premature, and an insurer would normally have the option of rejecting it on that basis. If, however, an insurer elects to issue a standard form denial, then pursuant to HRS § 431:10C-304(3) the denial covers applicable bills/claims for benefits (for past losses incurred by the insured) that were received by the insurer within the thirty days preceding its issuance."
Garcia v. Dai-Tokyo, ATX-99-255+ (CFO July 6, 2000).

Wage Loss – In order to qualify for wage loss benefits a claimant must show that he or she had a reasonable expectation of actual employment but for injuries sustained in the motor vehicle accident - and thus a job offer from a nonoperational

business which had no clients and which never hired anyone for the position in question was insufficient to establish a valid wage loss claim.
Gamble v. TIG Insurance, MVI-96-1250 (CFO November 2, 1999).

Wage Loss – In order to establish entitlement to wage loss benefits a claimant must show by a preponderance of the evidence: 1) that suitable employment was available which, but for his or her disability, could have been accepted; and, 2) the monthly earnings were that would have been received as a result of such employment.
Fitzgerald v. State Farm, MVI-94-534 (CFO February 26, 1998); and, *Taylor v. First Insurance*, MVI-96-1181 (CFO February 17, 1999).

Wage Loss – "A plain and fair reading of the above statutory sections [HRS § 431:10C-103(7) and (10)(A)(iii)] dealing with "monthly earnings" supports the Respondent's contention that the term refers only to income derived from employment. The fact that a claimant was receiving social security benefits and other pension/retirement payments is not relevant to his or her claim because "loss of earnings" as a no-fault benefit does not include social security payments or other income not derived from available and appropriate gainful activity."
Cabral v. AIG Hawaii, MVI-94-551 (CFO May 15, 1996).

Wage Loss – "In order to qualify for wage loss benefits, a claimant must prove the degree of alleged disability as a threshold matter and then establish that suitable positions would have been available to the claimant but for her disability."
Gonsalves v. AIG Hawaii, MVI-93-35 (CFO October 29, 1993); and, *Miyahira v. American Home/GEICO*, MVI-90-31+ (CFO December 17, 1990).

Wage Loss – The wage loss benefits that a claimant would otherwise be entitled to receive (pursuant to HRS § 431:10C-103) were appropriately reduced by the respondent pursuant to HAR § 16-23-8(c) to adjust for income received while the claimant was on "light duty" during a portion of her recovery.
Tiletile v. GEICO, MVI-90-69 (CFO May 13, 1991).

Wage Loss – A claimant is only entitled to wage loss benefits during the period of time that he or she is unable to work because of injuries sustained in the motor vehicle accident and is not entitled to such benefits thereafter on the asserted basis of an inability to find available work after reaching pre-injury status.
Tiletile v. GEICO, MVI-90-69 (CFO May 13, 1991).

Wage Loss – The qualification of a claimant for wage loss benefits under HRS § 431:10C-103, or for reduced wage loss benefits pursuant to HAR § 16-23-8(c) is determined by an examination of the factual evidence presented by the parties. It is up to the claimant to establish wage loss entitlement under the statute and it is up to the respondent to establish any reduction of such benefits in accordance with the rule.
Tiletile v. GEICO, MVI-90-69 (CFO May 10, 1991).

Wage Loss – An insured is not entitled to a double recovery by collecting payments from a second insurer (as a result of a second mva) for wage loss benefits which he or she is still receiving from a first insurer (as a result of a first mva).
Tran v. Liberty Mutual/Hawaiian, MVI-90-74+ (CFO January 8, 1991).

Wage Loss – "The elements necessary to establish entitlement to wage loss benefits are: 1) a physical disability as a result of a motor vehicle accident which results in the inability to engage in gainful activity, and 2) available and appropriate gainful activity which a claimant could not accept because of the physical disability."
Haynes v. State Farm, MVI-90-9 (CFO July 19, 1990); *Ramirez v. State Farm*, MVI-88-42 (CFO April 11, 1989); and, *Holland v. State Farm*, MVI-87-35 (CFO June 9, 1988).

Wage Loss – A respondent's denial of wage loss benefits to a claimant based upon the results of an independent medical exam which predicts that a claimant will probably be able to resume employment in the near future (and therefore implicitly acknowledges that the claimant is not currently able to resume employment) was precipitous and based on an erroneous premise.
Paaoao v. Liberty Mutual, MVI-89-90 (CFO June 12, 1990).

Wage Loss – A claimant's voluntary resignation from employment in anticipation of possibly being discharged for reasons unrelated to a motor vehicle accident, at a time when the claimant could have maintained normal work activities (despite some discomfort caused by the motor vehicle accident) does not support a claim for wage loss benefits under the no-fault system.
Tagorda v. American Home, MVI-89-9 (CFO July 26, 1989).

Wage Loss – Where a claimant is discharged from employment because of an inability to work due to injuries arising from an automobile accident, and the same or other appropriate employment was available but could not be accepted by the claimant due to injuries arising from the motor vehicle accident, the claimant is entitled to wage loss no-fault benefits based on her forfeited earnings.
Malendres v. National Union, MVI-88-71 (CFO June 9, 1989).

Wage Loss – An active duty member of the armed services is not entitled to receive no-fault wage loss benefits for a period of disability when he continued to receive full military pay and benefits. A reasonable interpretation of HRS § 294-2(10)(C) [HRS § 431:10C-103(10)(A)(iii)] leads to the conclusion that a claimant must incur some kind of loss of earnings before he or she is entitled to be compensated for not having received them.
Oscar v. USAA, MVI-88-40 (CFO January 17, 1989).

Wage Loss – Although some states may allow servicemen who are disabled due to negligence to include wage loss as part of their overall claim for damages

(even though they continue to be paid during the period of their disability) this approach is readily distinguishable from the Hawaii no-fault system of reparations.
Oscar v. USAA, MVI-88-40 (CFO January 17, 1989).

Wage Loss – The appropriate method of computing monthly no-fault wage loss benefits under HRS §§ 294-2 (10)(C) and 294-5(b) [HRS §§ 431:10C-103(10)(A)(iii) and 431:10C-305(b)(2)] is as follows: 1) after calculating the monthly earnings lost for the period in issue, the amount of worker's compensation benefits paid are subtracted and 2) if the total claim is $900 or less, the claimant is entitled to receive the balance as no-fault wage loss benefits, or 3) if the total claim is more than $900, the the claimant is entitled to the remaining balance as no-fault wage loss benefits up to $900 but the combined benefits may not exceed 80% of the claimant's monthly earnings.
Manley v. Transamerica, MVI-88-4 (CFO December 4, 1988).

WORKER'S COMPENSATION

Worker's Compensation – "The provisions of HRS Chapter 431 do not preclude a claimant from being eligible for no-fault benefits simply because the same incident upon which his or her claim is based may also establish eligibility for worker's compensation benefits under HRS Chapter 386. ... Similarly, while the payment of worker's compensation benefits, or the compromise of a worker's compensation claim pursuant to HRS § 386-78, will normally impact on the source and scope of no-fault payments, neither event, in itself, extinguishes a respondent's obligation to pay no-fault benefits pursuant to HRS § 431:10C-304."
Elarmo v. Island, MVI-93-260 (CFO January 24, 1995).

Worker's Compensation – Prior to 1992 the Insurance Commissioner utilized the workers compensation medical fee schedules (adopted by the Department of Labor and Industrial Relations) as a guideline to determine if the cost of health care benefits received by claimants under the no-fault insurance laws were reasonable. In 1992, however, the legislature mandated the use of these schedules in determining the reasonable cost of such benefits when they are received from a licensed health care provider.
Mueller v. GEICO, MVI-92-59 (CFO January 12, 1994).

Worker's Compensation – A health care provider who fails to maintain a currently valid license at the time that he or she engages in a licensed activity, is prevented (under HRS § 436B-26) from receiving compensation for the cost of such work or services. On the other hand, there is no restriction in the no-fault law which would prevent an unlicensed person from receiving compensation for having provided health care services of a nature which does not require licensure by the provider. Under such circumstances, the reasonable value of such services may be determined, in part, by referring to analogous types of categories within the workers compensation fee schedules as guidelines to be used in conjunction which such other relevant evidence as may be presented during the course of the hearing.
Mueller v. GEICO, MVI-92-59 (CFO January 12, 1994).

Worker's Compensation – The provisions of HRS Chapter 431 do not preclude a Claimant from being eligible for no-fault benefits simply because the same incident upon which his or her claim is based may also establish eligibility for workers compensation benefits under HRS Chapter 386 and may ultimately result in some allocation of the source(s) of payments under the provisions of HRS § 431:10C-305.
Arashiro v. GEICO, MVI-92-219 (CFO September 17, 1993).

Worker's Compensation – "It should be noted that HRS § 431:10C-305 is entitled "Source of payment" and focuses on the origin of payments to an eligible recipient under certain designated conditions. Since it deals with allocation of

payment responsibilities, rather than eligibility for benefits, it is technically an inappropriate basis upon which to assert alleged ineligibility for such benefits."
Arashiro v. GEICO, MVI-92-219 (CFO September 17, 1993).

Worker's Compensation – While a particular "incident" may meet the definitional criteria for both a motor vehicle accident and an industrial accident, with the result that there may be an eventual allocation of benefits, it does not otherwise effect a claimant's eligibility under the Hawaii Motor Vehicle Insurance Law.
Spangler v. Pacific Ins., MVI-91-131 (CFO September 16, 1992).

Worker's Compensation – All no-fault benefits are paid secondarily and net of any workers' compensation benefits that a person is entitled to receive because of harm sustained in a motor vehicle accident. If, however, a claimant's injuries are not established to have been caused by an accident which also qualifies as a motor vehicle accident under the no-fault statutes, any payment of workers' compensation benefits is not in lieu of (primary of) no-fault benefits and does not constitute payments which would otherwise extend the statute of limitations.
Botelho v. Commercial Union, MVI-89-55 (CFO September 13, 1990).

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