* * * NOT FOR PUBLICATION * * *

NO. 26743

IN THE SUPREME COURT OF THE STATE OF HAWAI'I

AIG HAWAI'I INSURANCE COMPANY, INC., Plaintiff-Appellee,

vs.

PAIN MANAGEMENT CLINIC OF HAWAI'I, INC., Defendant-Appellant,

and

ROBERT HYMAN, M.D., JOHN DOES 1-10 and DOE CORPORATIONS 1-10, Defendants.

APPEAL FROM THE FIRST CIRCUIT COURT
(CIVL NO. 97-4379)

MEMORANDUM OPINION
(By: Moon, C.J., Levinson, Nakayama, and Acoba, JJ.;
Circuit Judge Hirai, in place of Duffy, J., recused)

Plaintiff-appellee AIG Hawai'i Insurance Company, Inc. (AIG) filed suit, seeking reimbursement of no-fault/personal injury protection (PIP)[1] benefits paid to defendant-appellant Pain Management Clinic of Hawai'i, Inc. (PMC)[2] for treatment and/or services that had been determined as inappropriate or

[1] On June 19, 1997, the legislature enacted wide-ranging amendments to the no-fault law, HRS chapter 413:10C, that included the universal replacement of the term "no fault" with the term "personal injury protection," effective January 1, 1998. See 1997 Haw. Sess. L. Act 251.

[2] Robert Hyman, M.D. was also a defendant. However, during trial, at the close of AIG's case, Dr. Hyman moved to dismiss AIG's claims against him, pursuant to Rule 52(c) of the Hawai'i Rules of Civil Procedure, because "all of the evidence offered by [AIG], including all of the documentary evidence, states a claim or, if at all, it's only as to [PMC], and there's no evidence whatsoever [of] the claim as to Dr. Hyman personally[.]" AIG did not object and the motion was granted. The trial court entered an order dismissing all claims against Dr. Hyman on October 4, 2001.

unreasonable. PMC filed a counterclaim against AIG for the amount of unpaid services rendered to AIG's insureds, alleging that AIG failed to comply with the written denial notice requirement, in violation of Hawai'i Revised Statutes (HRS) § 431:10C-304(3)(B) (1993), quoted infra, [hereinafter, HRS § 431:10C-304(3)(B), Section (3)(B), or the subject statute]. Following a one-day jury-waived trial in the Circuit Court of the First Circuit, the Honorable Gary W.B. Chang entered final judgment on June 25, 2004 in favor of AIG on all claims.

PMC appeals the trial court's dismissal of its counterclaim with prejudice, specifically challenging those conclusions of law (COLs) that form the basis of the court's dismissal. On appeal, PMC contends that the trial court erred in concluding that: (1) AIG was not obligated to act in accordance with HRS § 431:10C-304(3)(B) for any of PMC's bills that were not certified as required by Hawai'i Administrative Rules (HAR) § 16-23-116 (1993), quoted infra; (2) AIG complied with the subject statute and HAR § 16-23-120 (1993), quoted infra; (3) AIG was relieved of its obligation to pay no-fault benefits for claimants whose insurance policies were exhausted; (4) PMC was not entitled to recover treatment charges with respect to claimants whose claims had been decided by the Department of Commerce and Consumer Affairs (DCCA); and (5) AIG was not required to make any payment to PMC for treatment rendered to a

claimant whose treatment was found to be unrelated to his accident.

For the reasons discussed more fully herein, we vacate that portion of the trial court's June 25, 2004 final judgment dismissing PMC's counterclaim and remand this case for further proceedings consistent with this opinion.

I. BACKGROUND

The facts of this case are relatively simple and largely uncontroverted. PMC is a medical clinic which, at the times relevant hereto, was licensed to provide medical services to patients. Between 1996 and 1998, PMC submitted to AIG (1) treatment plans to be rendered to persons insured by AIG who were injured in automobile accidents for pre-approval, pursuant to HRS § 431:10C-308.6(d) (1993)[3] and (2) billings for services rendered. With respect to the billings, AIG paid some in full, partially paid others, and made no payment on a number of others.

---

[3] HRS § 431:10C-308.6 was repealed effective January 1, 1998. At the relevant times herein, section 431:10C-308.6(d) provided in pertinent part:

> A provider may request prior approval from the insurer for treatment exceeding the workers' compensation schedules or treatment guidelines. The request shall include a treatment plan with a time schedule of measurable objectives and an estimate of the total cost of services. The insurer shall respond to such a request within five working days of mailing of the request, giving authorization or stating in writing the reasons for refusal to the provider and the insured. Any such refusal shall be filed concurrently for submission to the peer review organization. Failure by the insurer to respond within five working days shall constitute approval of the treatment.

(Emphasis added.) "'[W]orkers' compensation schedules'" means the schedules adopted . . ., establishing fees and frequency of treatment guidelines[.]" HRS § 431:10C-308.5(a) (1993).

It is the latter two categories, where AIG made either no payment or only partial payment, that are the subject of PMC's counterclaim in this case.

AIG timely challenged PMC's treatment plans for services that PMC had already rendered and billed, which AIG paid in full. AIG also challenged treatment plans that had been submitted by PMC for pre-approval, pursuant to HRS § 431:10C-308.6(a).[4] Upon receipt of AIG's challenges, the DCCA forwarded the disputes to independent peer review organizations (PROs). During the pendency of the PRO review, PMC apparently proceeded with the proposed treatment plans and billed AIG for those services. Notwithstanding the fact that the PRO-process was ongoing, AIG paid the bills submitted by PMC.[5]

Thereafter, the PROs determined that the treatment plans and proposed treatment plans submitted for various claimants were inappropriate and/or unreasonable. Armed with the

---

[4] HRS § 431:10C-308.6(a) provided in relevant part:

> If an insurer desires to challenge treatment and rehabilitative services . . ., the insurer may do so by filing, within five working days of a request made pursuant to subsection (d), a challenge with the commissioner for submission to a peer review organization[.]

[5] At trial, Carol Himalaya-Fidele, a senior claim representative of AIG, testified that, "[i]f we challenge a treatment plan, any bills that come in within that plan had to be paid." HRS § 431:10C-308.6(h) stated that:

> If a peer review organization determines that treatment or rehabilitative services were appropriate and reasonable, the insurer shall pay to the provider the outstanding amount plus interest at a rate of one and one-half per cent per month on any amount withheld by the insurer pending the peer review.

(Emphases added.)

PROs' reports, AIG (1) notified PMC, in writing, of the PROs' findings and (2) requested reimbursement of the amounts it had paid for the inappropriate or unreasonable treatments. PMC did not respond to AIG's request but instead sought a hearing with the DCCA on a number of the PROs' reports, including reports pertaining to claimants Cecilia Birch, Victoria Hart, and Wendy Van Houten [hereinafter, the DCCA Hearing Claimants], which are the subject of this appeal.

On October 24, 1997, AIG filed a complaint against PMC, asserting two claims for relief: (1) reimbursement of $62,884.36 in no-fault benefits paid to PMC for treatments that were found to be inappropriate and/or unreasonable by the independent PROs, pursuant to HRS § 431:10C-308.6(j) (1993), quoted infra, (Count I); and (2) unfair and deceptive business practices, based upon PMC's submission of duplicative and/or "unbundled"[6] billings to AIG, in violation of HRS §§ 480-2 and 480-13 (1993) (Count II). A stipulation to dismiss Count II without prejudice was filed on December 30, 1999.

[6] In its complaint, AIG defined "unbundling" as the willful and/or intentional submission "on a continuous basis . . . billing for services that were included in other billing statements."

On January 26, 1998, PMC filed a counterclaim, asserting that AIG failed to provide the written denial notice required by HRS § 431:10C-304(3)(B) on a number of its billings. Consequently, PMC maintained that AIG owed it a total principal amount of $413,059.88, plus statutorily mandated interest, penalties, and attorneys' fees.

On August 6, 2001, the case was tried, without a jury, before the Honorable Gary W.B. Chang. The evidence admitted at trial revealed, inter alia, that: (1) AIG failed to pay 6,539 bills submitted by PMC; (2) for each of these bills, AIG did not: (a) pay the bill in full; (b) issue a denial for the unpaid portions; or (c) request further information; and (3) for each of these bills, AIG either (a) made no payment or (b) paid the undisputed portion of the bill and offered to respond to any of PMC's questions as to the disputed amounts. At the conclusion of the trial, the parties presented oral argument, and the court requested the parties to submit reply posttrial memoranda, including proposed findings of facts (FOFs) and COLs.

In its September 7, 2001 memorandum, PMC summarized and reasserted its contention that AIG must strictly and literally comply with Section (3)(B). It maintained that AIG's noncompliance rendered the subject bills due and owing, with

penalties and interest in accordance with HRS §§ 431:10C-304(4) and (6), and 431:10C-117(b) and (c) (1993).[7]

On the same day, AIG filed its memorandum, arguing that it is obligated to issue a denial under the subject statute or seek peer review only when benefits to a claimant are denied or when a treatment plan is challenged. AIG contended that the appropriate billing dispute resolution mechanism required payment of the undisputed amount and negotiation as to the remainder, as provided in HAR § 16-23-120 and the 2000 amendments to HRS §§ 431:10C-304(6) and 431:10C-308.5 (Supp. 2004).[8] AIG further

---

[7] HRS § 431:10C-304(4) states:

> Amounts of benefits which are unpaid thirty days after the insurer has received reasonable proof of the fact and the amount of benefits accrued, and demand for payment thereof, after the expiration of the thirty days, shall bear interest at the rate of one and one-half per cent per month.

Section 431:10C-304(6) provides that "[a]ny insurer who violates this section shall be subject to section 431:10C-117(b) and (c)." Section 431:10C-117, entitled "Penalties," provides in relevant part:

> . . . .
> (b) Any person, in the capacity of a licensed or unlicensed motor vehicle insurer, self-insurer, general agent, subagent, solicitor, or other representative, who violates any provision of this article shall be assessed a civil penalty not to exceed $5,000 for each violation.
> (c) Any person, in the capacity of a licensed or unlicensed motor vehicle insurer . . ., who knowingly violates any provision of this article shall be assessed a civil penalty of not less than $3,000 and not to exceed $10,000 for each violation.

[8] In May 2000, HRS §§ 431:10C-304 and 431:10C-308.5 were amended by Act 138, which added subparagraph 6 to HRS § 431:10C-304 and section (e) to HRS § 431:10C-308.5. The new subparagraph (6) states:

> Disputes between the provider and the insurer over the amount of a charge or the correct fee or procedure code to be used under the workers' compensation supplemental medical fee schedule shall be governed by section 431:10C-308.5[.]

HRS § 431:10C-304(6) (Supp. 2004). The new section (e) states:

(continued...)

maintained that all of PMC's bills were not properly certified as required by HAR § 16-23-116. With respect to specific claimants, AIG asserted that: (1) their respective no-fault benefits had been exhausted (specifically, for claimants Rossano Bunao, Melba Sagisi, Garibaldi Guhit, Melanie Kusaka, Zi Hang Ruan, Vannessa Rumph, and Luzviminda Velasco [hereinafter, collectively, the PIP Limit Claimants]); (2) their claims had been ruled upon by the DCCA (specifically, for the DCCA Hearing Claimants); and (3) a medical examination had determined that the treatment rendered was not related to the particular motor vehicle accident (specifically, for claimant Derrick Domingcil).

On September 21, 2001 and September 24, 2001, AIG and PMC submitted their respective proposed FOFs and COLs. Thereafter, on April 20, 2004, the trial court entered its FOFs and COLs, essentially adopting AIG's proposal and adding only a

---

[8](...continued)

> In the event of a dispute between the provider and the insurer over the amount of a charge or the correct fee or procedure code to be used under the workers' compensation supplemental medical fee schedule, the insurer shall:
>
> (1) Pay all undisputed charges within thirty days after the insurer has received reasonable proof of the fact and amount of benefits and demand for payment thereof; and
>
> (2) Negotiate in good faith with the provider on the disputed charges for a period up to sixty days after the insurer has received reasonable proof of the fact and amount of benefits accrued and demand for payment thereof.
>
> If the provider and the insurer are unable to resolve the dispute, the provider, insurer, or claimant may submit the dispute to the commissioner, arbitration, or court of competent jurisdiction. The parties shall include documentation of the efforts of the insurer and the provider to reach a negotiated resolution of the dispute.

HRS § 431:10C-308.5(e) (Supp. 2004).

reference to prejudgment interest that stated, "the amount thereof to be determined by motion and notice." The trial court's FOFs appear to address solely AIG's affirmative claims and make no mention of PMC's counterclaim.

As discussed more fully infra, the trial court essentially concluded that: (1) PMC's failure to properly certify any of its billings submitted to AIG provided "an independent basis for an insurer's rejection of the bill," COL No. 39; (2) AIG's compliance with HAR § 16-23-120, i.e., paying the undisputed portion of the bill and negotiating the remainder, relieved it of its obligation to issue denial notices under HRS § 431:10C-304(3)(B); (3) with respect to the PIP Limit Claimants, AIG's obligation to pay no-fault benefits ended upon the exhaustion of their policy benefits; (4) with respect to the DCCA Hearing Claimants, AIG was not required to pay PMC for treatments that the DCCA determined to be inappropriate and/or unreasonable; and (5) AIG had no obligation to pay PMC for Domingcil's treatment that was found to be unrelated to his June 7, 1997 accident.

On June 25, 2004, the trial court entered judgment in favor of AIG and against PMC in the amount of $62,884.36, plus prejudgment interest, and dismissed PMC's counterclaim with

prejudice. PMC timely filed its notice of appeal on August 27, 2004.[9]

II. STANDARDS OF REVIEW

A. Conclusions of Law

We review the trial court's COLs de novo under the right/wrong standard. Janra Enterprises, Inc. v. City & County of Honolulu, 107 Hawai'i 314, 319, 113 P.3d 190, 195 (2005) (citation omitted); Leslie v. Estate of Tavares, 91 Hawai'i 394, 399, 984 P.2d 1220, 1225 (1999) (citation omitted). Under this standard, this court must examine the facts and answer the pertinent question of law without being required to give any weight or deference to the trial court's answer to it. Robert's Hawai'i Sch. Bus, Inc. v. Laupahoehoe Transp. Co., Inc., 91 Hawai'i 224, 239, 982 P.2d 853, 868 (1999) (citation omitted). "Thus, a [COL] is not binding upon the appellate court and is freely reviewable for its correctness." Fujimoto v. Au, 95 Hawai'i 116, 137, 19 P.3d 699, 720 (2001) (citations and internal quotation marks omitted). A COL that is supported by the trial court's FOFs and that reflects an application of the correct rule of law will not be overturned. Robert's Hawai'i Sch. Bus, 91 Hawai'i at 239, 982 P.2d at 868 (citation omitted).

[9] The time to appeal was tolled by AIG's filing of its motion for costs on July 1, 2004, pursuant to Hawai'i Rules of Appellate Procedure (HRAP) Rule 4(a)(3) (2004) ("If, not later than 10 days after entry of judgment, any party files a motion that seeks . . . attorney's fees or costs, the time for filing the notice of appeal is extended until 30 days after entry of an order disposing of the motion[.]"). AIG withdrew its motion on August 2, 2004, thus requiring any appeal from the June 25, 2004 judgment to be taken within thirty days thereof.

B. Statutory Interpretation

"The standard of review for statutory construction is well-established. The interpretation of a statute is a question of law which this court reviews de novo. Where the language of the statute is plain and unambiguous, our only duty is to give effect to its plain and obvious meaning." Liberty Mut. Fire Ins. Co. v. Dennison, 108 Hawai'i 380, 384, 120 P.3d 1115, 1119 (2005) (quoting Labrador v. Liberty Mut. Group, 103 Hawai'i 206, 211, 81 P.3d 386, 391 (2003)) (internal quotation marks omitted).

III. DISCUSSION

Inasmuch as PMC delineates its points of error into five categories (i.e., (1) certification; (2) billing disputes; (3) exhaustion of benefits; (4) preclusion by the DCCA hearing; and (5) Domingcil's unrelated claim) -- the first two of which deal with HRS § 431:10C-304, -- we group the trial court's COLs accordingly and discuss each category in turn.

A. Certification under HAR § 16-23-116

With respect to certification, the trial court's COLs provided:

> 19. [PMC] did not certify any of its statements as being in compliance with [the] fee schedule.
>
> . . . .
>
> 24. [PMC] has failed to establish by a preponderance of evidence that the amount of monies being sought from AIG [] for unpaid billings were within the fee schedule set forth in HRS § 431:10C-304(3) [sic] or that any of the billing invoices were certified in accordance with HAR § 16-23-116.
>
> . . . .
>
> 37. None of [PMC's] billings submitted to AIG [] were properly certified under HAR § 16-23-116.
>
> . . . .
>
> 39. Violation of HAR § 16-23-116 provides an independent basis for an insurer's rejection of the bill

> without any further action required on the part of the insurer.
>
> 40. Insurers have no obligation whatsoever to process an uncertified bill. HAR § 16-23-116.
>
> 41. The insurer may reject the uncertified bill. This rejection need not be accompanied by any partial payment, nor by the issuance of any formal denial, and requires no further action by the insurer. HAR § 16-23-116.
>
> 42. AIG [] is not obligated to pay the billings submitted by [PMC] that were not certified in compliance with HAR § 16-23-116.
>
> . . . .
>
> 53. [PMC's] failure to certify that the amounts charged were in accordance with HAR Title 16, Chapter 23 prohibits [PMC] from seeking any of the amounts set forth in its counterclaim.

On appeal, PMC argues that the trial court erroneously concluded that, because PMC failed to certify its bills in accordance with HAR § 16-23-116, AIG was permitted to "reject the uncertified bill . . . [without making] any partial payment, [or without] the issuance of any formal denial[,]" COL No. 41, pursuant to HRS § 431:10C-304(3)(B).

HAR § 16-23-116, entitled "Certification by physicians and non-physicians," provides:

> Each physician shall certify on the bill or charges that the charges are in accordance with this chapter. Any service performed by a non-physician shall be similarly certified.

(Emphases added.) The above administrative rule, which has been in effect since 1993, is intended to ensure that all bills submitted for payment are properly calculated in accordance with the mandatory fee schedules referred to in HRS § 431:10C-308.5 (1993) because the rule was expressly adopted to implement HRS § 431:10C-308.5. See HAR § 16-23-116 (citing history of the promulgated rule, including "Imp. HRS § 431:10C-308.5"). Section 431:10C-308.5, entitled "Limitations on charges," provides in relevant part:

> (a) As used in this article, the term "workers' compensation schedules" means the schedules adopted . . . establishing fees and frequency of treatment guidelines[.]
>
> (b) [T]he charges and frequency of treatment for services specified in section 431:10C-103(10)(A)(i) and (ii)[(1993)[10]] . . . shall not exceed the charges and frequency of treatment permissible under the worker's compensation schedules, except as provided in section 431:10C-308.6[, which governs charges and treatment in excess of fee schedules or treatment guidelines.]

PMC specifically contends that all of its bills were, in fact, certified, and, even assuming arguendo the bills were uncertified, such failure did not excuse AIG from complying with the subject statute. The record, however, does not support PMC's contention. Nowhere on PMC's bills does the mandated certification "that the charges are in accordance with this chapter[, i.e., HRS § 431:10C-308.5,]" appear.[11] HAR § 16-23-116 (emphasis added). Therefore, the trial court properly concluded that "[n]one of the bills submitted by [PMC] . . . were properly certified in accordance with HAR Section 16-23-116." COL No. 37. Accordingly, COL Nos. 19, 24, and 37 are correct.

---

[10] HRS § 431:10C-103(10)(A) states in relevant part:

> No-fault benefits, sometimes referred to as personal injury protection benefits, with respect to any accidental harm means:
>
> (i) All appropriate and reasonable expenses necessarily incurred for medical, hospital, surgical, professional, nursing, dental, optometric, ambulance, prosthetic services, products and accommodations furnished, and x-ray. . . .
>
> (ii) All appropriate and reasonable expenses necessarily incurred for psychiatric, physical, and occupational therapy and rehabilitation[.]

[11] PMC directs us to the bottom right corner of each of its bills that states nothing more than "FORM HCFA-1500 (12-90); FORM OWCP-1500; FORM RRB-1500." These acronyms, without more, do not carry any significance in determining whether PMC's charges are certified in accordance with HAR Title 16, Chapter 23.

Nonetheless, we cannot agree with the trial court that PMC's failure to certify its bills allowed AIG to ignore the requirement of HRS § 431:10C-304(3)(B). As more fully discussed in Section III.B., infra, HRS § 431:10C-304(3)(B) essentially requires an insurer to notify the claimant, in writing, of a denial of benefits and the reasons therefor. HAR § 16-23-116, as previously indicated, requires that the providers include a certification on the billings submitted to insurers for payment. The rule, however, does not indicate -- either expressly or impliedly -- that a provider's noncompliance with the certification requirement relieves an insurer of its obligations under Section (3)(B). Indeed, the certification administrative rule was adopted to implement HRS § 431:10C-308.5 and not Section (3)(B). See HAR § 16-23-116.

AIG argues that the trial court correctly concluded that "[v]iolation of HAR § 16-23-116 provides an independent basis for an insurer's rejection of the bill without any further action required on the part of the insurer." COL No. 39. In support of its position, AIG relies upon an Insurance Commissioner's decision in GEICO v. DCCA, Ins-DR-2000-1 (Sept. 18, 2000). First, we note that the GEICO decision was issued after the instant billing dispute. Second, an Insurance Commission's decision is not binding on this court. And, third, we fail to comprehend how GEICO supports AIG's position. AIG specifically quotes the following from GEICO as indicating that

an insurer need not issue a formal denial or take any further action when a provider presents an uncertified bill:

> Finally, in instances where the provider has failed to certify that the amount charged is in accordance with HAR Title 16, Chapter 23, (as required by HAR § 16-23-116), the insurer may reject the uncertified bill. This rejection need not be accompanied by any partial payment, nor by the issuance of any formal denial, and required no further action by the insurer . . . .

(Emphases added.) AIG, however, conveniently omitted the remainder of the last sentence, which states, "beyond notifying the provider of the fact and reason for the rejection." Thus, even if this court were to give any weight or deference to the Insurance Commissioner's decision in GEICO, it seems, in our view, to be contrary to AIG's position.

Based on the foregoing, coupled with the discussion in Section III.B., infra, we hold that the trial court's COL Nos. 39 through 42 are wrong, including its conclusion that PMC's "failure to certify that the amounts charged . . . prohibits [PMC] from seeking any of the amounts set forth in its counterclaim." COL No. 53.

B. Billing Disputes

With respect to billing disputes, the trial court's COLs provided:

> 2. As to every invoice at issue in this litigation, AIG [] complied with the PIP statute and Administrative Rules by: (1) paying the charges not in dispute, and (2) offering the opportunity to [PMC] to discuss billing disputes.
>
> . . . .

> 5. AIG complied with the administrative regulations concerning denial of no-fault/PIP benefits to a Claimant/Insured. See HAR § 16-23-57 [(1993)[12]].
>
> . . . .
>
> 20. All of the requests for payments submitted by [PMC] to AIG [] were in excess of the workers' compensation or Medicare fee schedule.
>
> . . . .
>
> 23. [PMC] failed to establish by a preponderance of evidence that it is entitled to payment of any monies from AIG [] on billings submitted that were not paid.
>
> . . . .
>
> 48. AIG [] had paid the undisputed amount of the billings submitted by [PMC] and the remaining issues involve billing disputes on the unpaid portion of the bill, no formal denial or requirement to seek peer review was required by [AIG].
>
> 49. Where the insurer has accepted the treatment or service as legitimate and the only disagreement is over the correct amount to be paid for that benefit, the issuance of a formal denial of benefits is not required under the provision of HRS § 431:10C-304(3)(B).
>
> 50. AIG [] was not required to submit a formal denial of benefits to the DCCA [sic] when it paid [PMC's] billings in accordance with the applicable fee schedule and provided it with an explanation of review.
>
> . . . .
>
> 52. [PMC] has failed to establish by a preponderance of evidence that AIG [] improperly denied payment on any billings submitted for payment.

(Emphases in original.)

PMC contends that AIG failed to fulfill its obligation under HRS § 431:10C-304(3)(B) to provide written notice of its complete or partial denial of PMC's billings for treatment rendered to its insureds. At the time PMC's claim arose, Section (3)(B) provided:

> (B) Subject to section 431:10C-308.6, relating to peer review, if the insurer elects to deny a claim for benefits in whole or in part, the insurer shall within thirty days notify the claimant in writing of the

---

[12] HAR § 16-23-57 provides in relevant part:

> If an insurer or self-insurer denies a claim for personal injury protection in whole or in part, it shall mail to the claimant in triplicate a notice of the denial as required by section 431-10C-304(3)(B), HRS. In the case of benefits for services in section 431:10C-103.5, HRS, the insurer or self-insurer shall also mail a copy of the denial to the health care provider or alternative health care provider.

> denial and the reasons for the denial. The denial notice shall be prepared and mailed by the insurer in triplicate copies and be in format approved by the commissioner. In the case of benefits for services specified in section 431:10C-103(10)(A)(i) and (ii), the insurer shall also mail a copy of the denial to the provider.

(Emphases added.) AIG, however, argues that it was not obligated to issue a formal written denial where the sole dispute was over the amounts to be paid for PIP benefits and "that [such] simple bill[ing] disputes [should] be resolved by payment of the undisputed amount and negotiation as to the remainder," pursuant to HAR § 16-23-120, quoted infra, and the new HRS § 431:10C-308.5(e), see supra note 7. HAR § 16-23-120, entitled "Dispute regarding charges," states in pertinent part:

> (a) In the event of a dispute between the provider and the insurer over the amount of a charge or the correct fee and procedure code to be used pursuant to exhibit A to the workers' compensation schedules, the insurer shall pay all charges not in dispute and shall negotiate in good faith with the provider on the disputed charges. Such disputes shall not be filed with the commissioner for submission to peer review.
>
> (b) If the provider and the insurer cannot resolve the dispute, either party may make a request to the commissioner for a hearing.

(Emphases added.)

During the pendency of this appeal, this court, in a published opinion in Orthopedic Associates of Hawai'i, Inc. v. Hawai'i Ins. & Guar. Co., Ltd., No. 24634 (Haw. Dec. 7, 2005) [hereinafter, Orthopedic], decided the precise questions presented in the instant case: (1) whether insurers are required to issue formal written notices of denial for partial payment of medical bills pursuant to HRS § 431:10C-304(3)(B); (2) whether HAR § 16-23-120 applies to the subject billing disputes; and

(3) whether the subsequent legislative amendments resulting in the promulgation of the new HRS § 431:10C-308.5(3) are applicable to the billing disputes. The answers to those questions are controlling here.

In Orthopedic, we first noted that "an insurer's obligation to pay no-fault benefits is set forth in HRS § 431:10C-304(3)(A), which provides that '[p]ayment of no-fault benefits shall be made within thirty days after the insurer has received reasonable proof of the fact and amount of benefits accrued, and demand for payment thereof.'" Slip op. at 18 (quoting HRS § 431:10C-304(3)(A)) (emphasis in original) (footnote omitted). Stated differently, "an insurer shall pay no-fault benefits within thirty days of receipt of a provider's billing statement showing 'the fact,' i.e., the treatment services, and 'the amount of benefits,' i.e., the charges or cost of treatment services." Id. at 18-19. We stated that:

> Section (3)(B) . . . does not limit an insurer's obligation to provide notice only when the insurer elects to deny a claim for treatment services. In reading the first and second sentences of Section (3)(B), it is clear that "a claim for benefits" includes both treatment services and the charges attendant thereto. The first sentence of Section (3)(B) indicates that any denial of "a claim for benefits," either in whole or in part, requires the issuance of a denial notice to the claimant. The second sentence states: "In the case of benefits for services . . . the insurer shall also mail a copy of the denial to the provider." In other words, if an insurer elects to deny a claim for treatment services and/or cost, in whole or in part, it must notify the claimant; if the denial involves treatment services, the insurer -- in addition to notifying the claimant -- must also notify the provider of the denial. If we were to limit the phrase "claims for benefits" as used in the first sentence of Section (3)(B) to treatment services only, . . . the second sentence would be rendered superfluous.

Id. at 20-21 (some emphases and some ellipsis in original) (some emphasis and ellipsis added) (citation omitted). Accordingly, this court concluded that the plain and unambiguous language of Section (3)(B) requires an insurer to provide written notice of its denial where the denial -- whether in whole or in part -- relates to the treatment service and/or the charges therefor. Id. at 22-23.

With respect to HAR § 16-23-120, we stated:

> Under HAR § 16-23-120, disputes relating to "the amount of a charge or the correct fee and procedure code" need not "be filed with the [Insurance] Commissioner for submission to [p]eer [r]eview." Rather, it authorizes insurers to make partial payment of charges "not in dispute" and negotiate with the providers on "the disputed charges." The peer review exemption, however, clearly conflicts with the plain language of HRS § 431:10C-304(3)(B) in existence before the repeal of the peer review statute. Prior to the repeal, an insurer's denial of benefits, in whole or in part, was "[s]ubject to section 431:10C-308.6, relating to peer review." HRS § 431:10C-304(3)(B). Inasmuch as HAR § 16-23-120 exempts insurers from the peer review procedure for controversies relating to treatment services and/or the costs attendant thereto, we hold that HAR § 16-23-120 contravenes the express requirement of Section (3)(B) and is therefore void and unenforceable to this limited extent.

Id. at 24-25. The court in Orthopedic recognized that, as a result of the January 1, 1998 repeal of the peer review statute, the phrase "[s]ubject to section 431:10C-308.6, relating to peer review" was deleted from Section (3)(B) as part of the 2000 amendments to HRS § 431:10C-304, thus removing the conflict between the administrative rule and the subject statute. We emphasized, however, that "nothing in HAR § 16-23-120 . . . relieves the insurers of their obligation to provide the written notice required by HRS § 431:10C-304(3)(B) when the insurer wishes to challenge, in whole or in part, a bill for medical

treatment[.]" Id. at 25. We, therefore, held that, to the extent that HAR § 16-23-120 was consistent with the subject statute after January 1, 1998, the insurers remained obligated to provide formal denial notices of a claim for benefits in accordance with Section (3)(B). Id. at 25-26.

Therefore, consistent with our decision in Orthopedic, we hold that the trial court's COL Nos. 2, 5, 20, 23, 48-50, and 52 are incorrect to the extent they relieve and/or provide support for relieving AIG of its obligation to comply with the subject statute.

C. Exhaustion of Benefits

The court's conclusions with respect to the exhaustion of benefits is as follows:

> 29. AIG's obligation to pay no-fault/PIP benefits on behalf of the Claimants whose medical billings are at issue is limited to the amount of no-fault/PIP benefits that remain available to make any payments that might be due.
>
> . . . .
>
> 31. No-Fault/PIP benefits were exhausted as to Rossano Bunao, Melba Sagisi, Garibaldi Guhit, Melanie Kusaka, Zi Hang Ruan, Vannessa Rumph, [and] Luzviminda Velasco.

PMC asserts that the above trial court's COLs are incorrect because "AIG presented no evidence from which a determination could be made as to when each of these claimants actually reached his or her policy limits or what was the status of the remaining benefits at the time AIG received bills from PMC" and, at the very least, "AIG, if its claims of exhaustion are meritorious, should have issued the required denial."

HRS § 431:10C-301(a) (1993) outlines the basic no-fault policy requirement and provides in pertinent part:

> **Required motor vehicle policy coverage.** (a) In order to meet the requirements of a no-fault policy as provided in this article, an insurance policy covering a motor vehicle shall provide:
>
> (1) Coverage specified in section 431:10C-304[.]

(Bold emphasis in original.) HRS § 431:10C-304 provides in pertinent part:

> **Obligation to pay no fault benefits**. . . . Every no-fault insurer shall provide no-fault benefits for accidental harm as follows:
>
> (1) Except as otherwise provided in section 431:10C-305(d):
>
> (A) In the case of injury arising out of a motor vehicle accident, the insurer shall pay, without regard to fault, to the following persons who sustain accidental harm as a result of the operation, maintenance, or use of the vehicle, an amount equal to the no-fault benefits payable for wage loss and other expenses to that person . . . as a result of the injury.
>
> (B) In the case of injury arising out of a motor vehicle accident, the insurer shall pay, without regard to fault, to a provider of services on behalf of persons . . ., charges for services covered . . . .

(Bold emphasis in original.) (Underscored emphasis added.) Based upon the above provisions, AIG's obligation to pay no-fault/PIP benefits to its insureds is clearly limited to the "amount equal to the no-fault benefits[,]" that is, to the amount of benefits that remains available to make any payment that might be due. Once AIG paid the full amount of the policy limits, its obligation to pay any additional outstanding bills due to the providers was extinguished.

At trial, Carol Himalaya-Fidele, a senior claim representative of AIG, testified that she had reviewed the information concerning the no-fault/PIP policy as it related to

the PIP Limit Claimants. Himalaya-Fidele prepared a two-page summary sheet showing: (1) the claimant's names; (2) the date of the motor vehicle accident; (3) the no-fault/PIP policy limits; (4) the amount of benefits paid; (5) the amount of benefits that was available for payment of medical benefits; and (6) the status of the policy, i.e., whether such policy limit was exhausted. On direct examination by AIG's counsel, Himalaya-Fidele explained her summary sheet in more detail:

> Q: [With respect to the two-page summary sheet,] if you can please tell us as to each heading, starting the first part says claimant's name, correct?
> A: Yes
> Q: MVA, is that the date of the motor vehicle accident?
> A: Yes
> Q: Claim number, what claim number is that?
> A: Each accident claim received by AIG is given a claim number.
> Q: Policy number?
> A: No, policy numbers are not listed.
> Q: Okay. Policy limit, what does that represent?
> A: The amount of benefits available for the date of loss.
> Q: Okay. Benefits paid?
> A: Amount paid out in benefits under the no-fault file.
> Q: Okay. And the balance of -- dollar figure, that's the balance available?
> A: Balance of funds available.
> Q: Under [the next column, entitled,]status, as for Ms. Arrocena, it says 10 and 10?
> A: Yes.
> Q: What does that mean?
> A: Policy limits is allowed 10,000 for medical and 10,000 for wage loss.
> Q: Okay. How were you able to determine that as to Ms. Arrocena that there was only 10,000 medical and 10,000 in wage loss.
> A: That's what they're allowed, 10,000 for meds, 10,000 for wage loss. They're able to allocate funds back and forth between the medicals and wage loss upon written consent.
> Q: If an individual did make an allocation between medicals and wage loss, did you make any type of notation in the status column []?
> A: Yes.
> Q: And what type of notation would you make to indicate that an allocation has been made?
> A: It's indicated as meds only.
> Q: And again going with Ms. Arrocena, besides 10 and 10, it has a little asterisk beside it. What does that mean?
> A: Yes, she's exhausted the 10,000 in medical benefits and the asterisk is we've had a hearing in DCCA.
> . . . .

Q: [A]s to Rossano, R-o-s-s-a-n-o, Bunao, B-u-n-a-o, the status says exhausted?
A: Yes.
Q: What does that mean"
A: He's exhausted all of the 20,000 available to him.

Specifically, with respect to the PIP Limit Claimants, the summary sheet reflects the following information:

CLAIMANT'S NAMES	MVA	CLAIM #	POL. LIMIT	BENEFITS PD.	BAL. OF $	STATUS
Bunao, Rossano	04/28/95	95004706	20,000.00	20,000.00		EXHAUSTED
Sagisi, Melba	08/26/95	95009788	20,000.00	20,000.00		EXHAUSTED
Guhit, Garibaldi	10/28/97	97013974	20,000.00	10,624.33	9,375.67	EXHAUSTED
Kusaka, Melanie	06/26/99	99008483	10,000.00	10,000.00		EXHAUSTED
Ruan, Zi Hang	12/31/95	96000002	20,000.00	13,393.19	6,606.81	EXHAUSTED
Rumph, Vannessa	03/24/97	97003371	20,000.00	20,000.00		EXHAUSTED
Velasco, Luzviminda	09/11/97	97010723	20,000.00	10,000.00	10,000.00	EXHAUSTED

According to the status column on the summary sheet, no-fault benefits for four of the seven PIP Limit Claimants were clearly exhausted, i.e. the amount of benefits paid equaled the policy limit. Thus, AIG was not required to pay any further medical bills with respect to those four PIP Limit Claimants. However, based on the summary sheet, we are unable to determine whether the policies for the remaining three PIP Limit Claimants have been exhausted.

At trial, PMC's counsel cross-examined Himalaya-Fidele on her summary sheet, taking as an example claimant Mercedes Arrocena, who is not a disputed claimant in this appeal. The summary sheet reveals the following information as to Arrocena:

CLAIMANT'S NAMES	MVA	CLAIM #	POL. LIMIT	BENEFITS PD.	BAL. OF $	STATUS
Arrocena, Mercedes	09/08/95	95009892	20,000.00	14,223.91	5,776.06	10 & 10 *EXH

A colloquy between PMC's counsel and Himalaya-Fidele indicated the following:

> Q: Now in situation, lets take -- let's take Mrs. Mercedes Arrocena for a moment, the first claimant on page one . . ., if I understand your testimony correctly, AIG has paid benefits of $14,223, correct?
> A: Yes.
> Q: And leaving a balance of 5,776?
> A: Yes.
> Q: But this particular policy has the 10 and 10, meaning 10 is available for meds and 10's available for wages, is that right?
> A: Correct.
> Q: Have you ever had a situation where a claimant having balance remaining did not elect to use that balance for medical treatment?
> A: Yes.
> Q: They just leave the balance there, not use it for medical treatment?
> A: Yes.
> Q: Why would they do that?
> A: I have no idea.

It appears from the above testimony and the summary sheet that the balance of monies for Arrocena was reserved for wage loss payments because of the "10 & 10 *EXH" in the status column. Such, however, is not the case with three of the PIP Limit Claimants. According to the summary sheet, each has a remaining balance, but there is no indication in the status column - or from the testimony at trial - that these claimants are "10 & 10," i.e., $10,000 for medical treatment and $10,000 for wage loss.

Assuming they are, the balance (based on the explanation regarding Arrocena above) would clearly be reserved for wage loss payments. However, on the state of the record before us, we are unable to determine whether policy limits for the remaining three PIP Limit Claimants have, in fact, been exhausted. We, therefore, remand this case to the circuit court for such determination. To the extent that the COL Nos. 29 and 31 relate to the other four PIP Limit Claimants, the trial court properly concluded that AIG has no further obligation to pay benefits in excess of the insureds' policy limits.

We emphasize, however, that the exhaustion of no-fault/PIP policy limits does not exempt AIG from complying with the notice requirements of Section (3)(B). Although HRS § 431:10C-304(1) makes clear that the insurer's obligation to pay no-fault benefits extends only to "an amount equal to the no-fault benefits," Section (3)(B), as discussed supra, expressly mandates that, "if the insurer elects to deny a claim for benefits in whole or in part, [i.e., treatment services and/or the costs of those treatments,] the insurer shall within thirty days notify the claimant in writing of the denial and the reasons for the denial. . . . In the case of benefits for services [], the insurer shall also mail a copy of the denial to the provider." (Emphases added.)

When asked about AIG's procedure regarding a policy that has been exhausted, Himalaya-Fidele testified that "[w]e send out an exhaust letter to the claimant and CC the providers." However, Himalaya-Fidele did not indicate whether AIG had, in fact, done so in the instant case, and the record does not reveal whether such letters were issued. We, therefore, remand this case for a determination whether AIG met its obligation to provide written notice to all of the PIP Limit Claimants and/or PMC.

D. Preclusion by the DCCA Hearing

The trial court's conclusions regarding the DCCA hearings provided:

> 34. Based on the DCCA Orders/Rulings, AIG [] does not owe any of the claims for reimbursement for Cecilia Birch, Victoria Hart, [and] Wendy Van Houten.
> 35. [PMC] is not entitled to seek recovery as to any of the Claimants whose claims had been submitted to the DCCA and rulings issued.

The trial court's undisputed FOFs in connection with the DCCA Hearing Claimants revealed that: (1) AIG challenged the treatment plans submitted by PMC for pre-approval; (2) upon receipt of the PROs' reports that the treatment plans for the DCCA Hearing Claimants were inappropriate and/or unreasonable, AIG issued denial notices to PMC, and PMC appealed to the DCCA the adverse PRO report findings; and (3) the DCCA dismissed PMC's appeal of the unreasonableness and/or appropriateness of the treatment plans on the basis that these proposed treatment plans, as previously states, had been rendered by PMC. The testimony of

Warnice Hanamaikai Silva, supervisor of PMC's billing department, confirmed the ground for the DCCA's dismissal and further stated that PMC was not permitted, in its appeal, to discuss the bills for services provided to the DCCA Hearing Claimants.

PMC argues that its appeals of the treatment plan denials, "whether those appeals were dismissed, heard on the merits, or withdrawn, are of no consequence in this proceeding[,]" because the DCCA's dismissal of PMC's appeal did not prevent it from seeking recovery of the unpaid bills in connection with these same treatments. We disagree. First, once the DCCA affirmed the PROs' determination that treatment plans were inappropriate and/or unreasonable, the billing related to those services became irrelevant. See HRS § 431:10C-308.6(j) (stating that provider shall not collect payment for services determined by PRO as not appropriate or reasonable).

Second, upon the DCCA's dismissal of PMC's appeal of the adverse PRO findings, PMC's remedy was to take a secondary appeal from the DCCA's final order, pursuant to HRS § 431:10C-212 (1993). Section 431:10C-212 provides in pertinent part:

> **Administrative hearing on insurer's denial of claim.** (a) If a claimant or provider of services objects to the denial of benefits by an insurer or self-insurer pursuant to section 431:10C-304(3)(B) and desires an administrative hearing thereupon, the claimant or provider of services shall file with the commissioner, within sixty days after the date of denial of the claim[.]
>
> . . . .
>
> (b) The commissioner has jurisdiction to review any denial of no-fault benefits.
>
> (c) The commissioner shall:

> (1) Conduct a hearing in conformity with chapter 91 to review the denial of benefits;
>
> . . . .
>
> (e) Either party may appeal the final order of the commissioner in the manner provided for by chapter 91.

(Bold emphasis in original.) (Underscored emphasis added.) PMC, however, failed to do so. Thus, the DCCA's decision regarding the DCCA Hearing Claimants was final. Consequently, PMC cannot now attempt to challenge the DCCA's decision via its counterclaim.

In light of: (1) the PROs' reports indicating that the treatments rendered to the DCCA Hearing Claimants were inappropriate and/or unreasonable; (2) the DCCA's dismissal of PMC's appeal on these PROs' reports; and (3) HRS § 431:10C-308.6(j) mandating that "[i]f a [PRO] determines that a provider has provided treatment . . . services that are not appropriate or reasonable . . ., the provider shall **not** collect payment for the inappropriate or unreasonable treatment" (emphases added), the trial court's COL Nos. 34 and 35 are correct.

E. Domingcil's Unrelated Claim

Lastly, with respect to Domingcil, the trial court concluded that:

> 32. AIG [] was not obligated to make any payments to [PMC] for treatment rendered to [] Domingcil, whose treatment was found not to be related to his June 7, 1997 accident.
>
> 33. [PMC] is not entitled to seek recovery from AIG [] for services rendered to [] Domingcil. [sic] for a total of $15,519.92.

PMC maintains that, although "at some point prior to the services and bills at issue, AIG made a determination that [Domingcil] was

not entitled to benefits and had issued a denial[,]" "the denial of past billings it received from PMC does not excuse AIG from its obligation to comply with [Section (3)(B)] with respect to future billings for [Domingcil]." (Emphases added.)

PMC fails to present any facts with regard to this claim by citation to the record in support of its contention that AIG did not comply with HRS § 431:10C-304(3)(B) on the future billings for services rendered to Domingcil. Int'l Bhd. of Elec. Workers, Local 1357 v. Hawaiian Tel. Co., 68 Haw. 316, 333, 713 P.2d 943, 956 (1986) ("[A]n appellate court is not required to sift through a voluminous record for documentation of a party's contentions."). Nor does PMC make any discernible argument or cite to any authority with respect to its position. Accordingly, insofar as PMC did not comply with HRAP Rule 28(b)(7) (2004) to provide "citations to . . . parts of the record relied on," we need not address this argument. HRAP Rule 28(b)(7); Citicorp Mortgage, Inc. v. Bartolome, 94 Hawai'i 422, 433, 16 P.3d 827, 838 (App. 2000) ("An appellate court does not have to address matters for which the appellant has failed to present discernable argument."); Norton v. Admin. Dir. of the Court, 80 Hawai'i 197, 200, 908 P.2d 545, 548 (1995) (disregarding a particular contention for lack of a "discernible argument in support of that position, in violation of [HRAP] Rule 28(b)(7)").

IV. CONCLUSION

Based on the foregoing, we vacate that part of the First Circuit Court's June 25, 2004 final judgment dismissing PMC's counterclaim and remand this case to the circuit court for further proceedings consistent with this opinion.

DATED: Honolulu, Hawai'i, January 9, 2006.

On the briefs:

Paul Maki, for defendant-appellant

Roy F. Epstein and Carlos D. Perez-Mesa (of Epstein & Perez-Mesa), for plaintiff-appellee