HB 1352 - AS INTRODUCED

2026 SESSION

26-3155
12/06

HOUSE BILL ***1352***

AN ACT relative to payment and dispute resolution for medical bills under workers compensation.

SPONSORS: Rep. MacKenzie, Hills. 40

COMMITTEE: Labor, Industrial and Rehabilitative Services

ANALYSIS

This bill extends the amount of time insurance carriers, self-insurers, or payors acting on behalf of an insurance carrier or self-insurer have to pay uncontested claims, and establishes an optional mediation process where claims are contested. The bill also modifies the reasonable effort standard for resolving claims with a good faith standard, and increases civil penalties for failure to engage in good faith efforts relative to payment of claims.

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Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

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STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Twenty-Six

AN ACT relative to payment and dispute resolution for medical bills under workers compensation.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 Payment for Reasonable Value of Services; Dispute Resolution. Amend RSA 281-A:24, I to read as follows:

I.(a) The employer or the employer's insurance carrier shall pay the reasonable value of medical services provided under this chapter.

(b) The health care provider shall have the burden of establishing that its bill for services is reasonable.

(c) [~~Effort~~] ***A good faith effort*** shall be made to resolve any dispute as to the reasonable value of [~~service~~] ***services*** prior to applying to the commissioner for resolution of such a dispute. ***To expedite the resolution of a dispute, either party may request the appointment of an impartial mediator, whose role shall be to facilitate communication, define issues and explore alternatives, and remain neutral for the purpose of helping the parties reach a mutually agreeable solution.***

(d) Whenever an injured employee receives medical or hospital service or other remedial care under the provisions of this chapter and a dispute arises between the employer or the employer's insurance carrier and the person, firm, or corporation rendering such service or care as to the reasonable value of the service or care, the commissioner shall have exclusive jurisdiction to determine the reasonable value of such service or care. Any interested party may petition for a hearing and all interested parties shall be entitled to notice and hearing if it is determined that all [~~reasonable~~] ***good faith*** efforts to resolve the dispute have failed.

(e) The commissioner or the commissioner's authorized representative shall make a finding as to the reasonable value of such services or care rendered.

(f) Any party in interest aggrieved by such a finding may appeal to the compensation appeals board under RSA 281-A:43.

(g) The department of labor shall promulgate rules pursuant to RSA 541-A relative to the process of mediation described in subparagraph (c).

2 Medical, Hospital, and Remedial Care; Civil Penalties Increased. Amend RSA 281-A:23, V to read as follows:

V.(a)(1) The act of the worker in applying for workers' compensation benefits constitutes authorization to any physician, hospital, chiropractor, or other medical vendor to supply all relevant information regarding the worker's occupational injury or illness to the insurer, the insurer's

representative, the worker's employer, the worker's representative, the worker's employer's representative, and the department. Medical information relevant to a claim includes a past history of complaints of, or treatment of, a condition similar to that presented in the claim. Any party authorized to request medical information under this subparagraph shall include the following notice in their request for medical records in bold print in a font size at least 2 points larger than that used in the request:

"This request is strictly limited to medical information relevant to the occupational injury or illness that underlies the patient's workers' compensation claim, including any past history of complaints of, or treatment of, a condition similar to that presented in the claim."

(2) Any person who supplies information in accordance with this paragraph and with rules adopted by the commissioner shall be immune from any liability, civil or criminal, that might otherwise be incurred for such action. The physician may require evidence from the workers' representative in his or her representative capacity. This authorization shall be valid for the duration of the work-related injury or illness.

(3) The commissioner may assess a civil penalty of up to [~~$2,500~~] ***$5,000*** on any insurance carrier, self-insurer, or payor acting on behalf of such insurance carrier or self-insurer if any recipient of medical records receives a medical record which is clearly irrelevant to the workers' compensation claim and sends such record, or a copy of it, to another party not authorized to receive such record.

(b) The commissioner shall develop a form on which health care providers and health care facilities shall report medical, surgical or other remedial treatment. The report shall include, but is not limited to, information relative to the up-to-date medical status of the employee, any medical information relating to the employee's ability to return to work, whether or not there are physical restrictions, what those restrictions are, the date of maximum medical improvement, and, where applicable, the percentage of permanent impairment in accordance with the "Guides to the Evaluation of Permanent Impairment" published by the American Medical Association and as set forth in RSA 281-A:32, and any other information to enable the employer or insurance carrier to determine the benefits, if any, that are due and payable. In addition to the report required under this section, the health care provider shall furnish a statement confirming that the treatment or services rendered were reasonable and necessary with respect to the bodily injury sustained. The statement shall read as follows: "I certify that the narrative descriptions of the principal and secondary diagnosis and the major procedures performed are accurate and complete to the best of my knowledge." The health care provider shall date and sign the statement.

(c) The commissioner may assess a civil penalty of up to [~~$2,500~~] ***$5,000*** on any health care provider who without sufficient cause, as determined by the commissioner, bills an injured employee or his or her employer for services covered by insurers or self-insurers under this chapter. There shall be no reimbursement for services rendered, unless the health care provider or health

care facility giving medical, surgical, or other remedial treatment furnishes the report required in subparagraph (b) to the employer, insurance company, or claims adjusting company within 10 days of the first treatment. First aid treatment is excluded from the 10-day reporting requirement. Additionally, for good cause, a hearing officer may waive the 10-day reporting requirement and order remuneration paid. The employer, claims adjustment company, self-insurer or insurer shall pay the health care provider or health care facility within [~~30~~] ***45*** days of receipt of a bill for services.

(d) Any employer, insurance carrier, injured employee, or attorney representing any such person, who receives any medical report, which includes, but is not limited to, information relative to the remedial treatment, care and attendance of the injured employee, shall file the report with the commissioner within 15 days after receipt of such report. Any medical report which has not been previously filed with the commissioner shall not be received in evidence in a contested case unless the party offering the report has furnished a copy thereof to the opposing party or his attorney at least 5 days prior to the hearing at which it is offered. The health care provider or health care facility shall also provide to the injured employee, or to his attorney, on demand, a copy of each medical report. The injured employee shall only be charged an amount reflecting the actual cost to the health care provider or health care facility in furnishing the copy. Each such health care provider or health care facility shall provide any additional information relating to the remedial treatment, care, and attendance of an injured employee that the commissioner may reasonably request as part of its investigation of a claim for benefits under this chapter. Failure to provide such reports may result in imposition by the commissioner of a civil penalty of up to $2,500.

(e) The commissioner [~~may~~] ***shall*** assess a civil penalty of up to [~~$2,500~~] ***$5,000*** on any insurance carrier, self-insurer, or payor acting on behalf of such insurance carrier or self-insurer, which without sufficient cause, as determined by the commissioner, fails, within [~~30~~] ***45*** days after receipt of a medical bill:

(1) To make payment of such medical bill pursuant to this section; or

(2) To deny such payment, notifying the health care provider, employee, and labor department of such denial. This denial shall give a valid reason for the denial and shall advise the claimant of the right to petition the commissioner for a hearing.

(f) Where an insurance carrier, self-insurer, or payor acting on behalf of such insurance carrier or self-insurer determines they are responsible for medical bill payments and fails to make such payment in accordance with subparagraph (e)(1), the insurance carrier, self-insurer, or payor acting on behalf of such insurance carrier or self-insurer shall be required within 5 days following the 45 day period defined in subparagraph (e) to electronically submit to the commissioner:

(1) A notice of determination of their responsibility for medical bill payments;

(2) A statement of when the claim was received; and

(3) An explanation of any sufficient reason that may justify the delay.

(A) Any insurance carrier, self-insurer, or payor acting on behalf of such insurance carrier or self-insurer that fails to electronically submit such information within the 5 day period following the 45 day period defined in subparagraph (e) shall be required to notify the commissioner of the disposition of the claim and if payment was required the date the claim was paid.

(B) Failure to comply with this subparagraph shall result in a civil penalty as determined by the commissioner in accordance with subparagraph (e).

3 Effective Date. This act shall take effect 60 days after its passage.