In the Matter of the Arbitration between

M.C.

CLAIMANT(s),

v.

Mercury Indemnity Company of America

RESPONDENT(s).

Forthright File No: NJ1109001405630
Insurance Claim File No: NJA8008944
Claimant Counsel: Law Offices of Ronald DeSimone, P.C.
Claimant Attorney File No: 10-4599
Respondent Counsel: Law Offices of David C. Harper
Respondent Attorney File No: 12-41747-89
Accident Date: 08/29/2010

Award of Dispute Resolution Professional

Dispute Resolution Professional: Christopher M. Carnelli Esq.

I, The Dispute Resolution Professional assigned to the above matter, pursuant to the authority granted under the "Automobile Insurance Cost Reduction Act", N.J.S.A. 39:6A-5, et seq., the Administrative Code regulations, N.J.A.C. 11:3-5 et seq., and the Rules for the Arbitration of No-Fault Disputes in the State of New Jersey of Forthright, having considered the evidence submitted by the parties, hereby render the following Award:

Hereinafter, the injured person(s) shall be referred to as: Patient or Claimant

Hearing Information

☐ An oral hearing was waived by the parties.
☒ An oral hearing was conducted on: 09/04/2012

Claimant or claimant's counsel appeared in person. Respondent or respondent's counsel appeared in person.

The following amendments and/or stipulations were made by the parties at the hearing:

The parties stipulated that although not submitted by either, I may utilize the CPT Manual by the American Medical Association in deciding the numerous coding issues presented.
Findings of Fact and Conclusions of Law

The eligibility of the Patient to pursue this claim for PIP benefits as a result of a motor vehicle accident that occurred on 08/29/2010, and pursuant to the terms and conditions of a policy of automobile insurance issued by the respondent, is not in dispute.

ISSUES

In accordance with N.J.A.C. 11:3-5.6d and N.J. No-Fault Arbitration Rule 43, the parties were asked to identify the issues submitted for my determination. Only the following issues have been identified; any other issues raised previously by the parties are deemed waived:

1. The propriety of a downcode from CPT 99245 to 99244 for Dr. Goldstein’s 10/28/2010 initial evaluation;
2. Whether Claimant has submitted sufficient documentation to support the billing of electrodiagnostic testing performed on 11/18/2010;
3. The purported unbundling of CPT 76140 on the 11/18/2010 date of service;
4. The purported unbundling or otherwise improper coding of two units of CPT 95861 at the 11/18/2010 date of service;
5. The applicability of a pre-certification penalty to the 01/31/2011 date of service;
6. Medical necessity of two office visits on 03/28/2011 and 06/30/2011; and
7. The medical necessity of future treatment: a left carpal tunnel release, a lumbar discogram; post-discogram CT scan and cervical discectomy/fusion at C4/5 and C5/6.

The Claimant relies upon oral arguments presented as well as the following submissions: the Demand for Arbitration with attached documents; an arbitration statement with exhibits received 08/13/2012 and the Patient’s testimony at the hearing.

The Respondent relies upon oral arguments presented as well as the following submissions: an arbitration statement with exhibits received 08/14/2012.

LAW

According to the AMA, the 9924x series of CPT codes are utilized to bill for consultation services. A consultation is a type of evaluation and management service provided by a physician at the request of another physician or appropriate source to either recommend care for a specific condition or problem or to determine whether to accept responsibility for ongoing management of the patient's entire care or for the care of a specific condition or problem.

A physician consultant may initiate diagnostic and/or therapeutic services at the same or subsequent visit.

A "consultation" initiated by a patient and/or family, and not requested by a physician or other appropriate source (e.g., physician assistant, nurse practitioner, doctor of chiropractic, physical therapist, occupational therapist, speech-language pathologist, psychologist, social worker, lawyer, or insurance
company), is not reported using the consultation codes but may be reported using the office visit, home service, or domiciliary/rest home care codes as appropriate.

The written or verbal request for consult may be made by a physician or other appropriate source and documented in the patient's medical record by either the consulting or requesting physician or appropriate source. The consultant's opinion and any services that were ordered or performed must also be documented in the patient's medical record and communicated by written report to the requesting physician or other appropriate source.

CPT 99245 is defined as an office consultation for a new or established patient, which requires these three components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problems and the patient’s and/or family’s needs. Usually, the presenting problems are of moderate to high severity. Physicians typically spend 80 minutes face-to-face with the patient and/or family.

CPT 99244 is defined by the AMA as an office consultation for a new or established patient, which requires these three components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problems and the patient’s and/or family’s needs. Usually, the presenting problems are of moderate severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

CPT 99243 is defined by the AMA as an office consultation for a new or established patient which requires these three components: a detailed history, a detailed examination and medical decision making of low complexity

For the above-referenced services the following definitions/criteria apply.

According to the CPT manual, the extent of the history is dependent upon clinical judgment and on the nature of the presenting problems. The levels of E/M services recognize four types of history that are defined as follows:

(1) **Problem focused**: chief complaint; brief history of present illness or problem.

(2) **Expanded**: chief complaint; brief history of present illness; problem pertinent system review.

(3) **Detailed**: chief complaint; extended history of present illness; problem pertinent system review extended to include a review of a limited number of additional systems; pertinent past, family, and/or social history directly related to the patient’s problems.

(4) **Comprehensive**: chief complaint; extended history of present illness; review of systems which is directly related to the problem(s) identified in the history of the present illness plus a review of all additional body systems; complete past, family, and social history.
According to the CPT manual, the extent of the examination performed is dependent on clinical judgment and on the nature of the presenting problem(s). The levels of E/M services recognize four types of examinations that are defined as follows:

1. **Problem focused**: a limited examination of the affected body area or organ system.

2. **Expanded problem focused**: a limited examination of the affected body area or organ system and other symptomatic or related organ systems.

3. **Detailed**: an extended examination of the affected body area and other symptomatic or related organ systems.

4. **Comprehensive**: a general multi-system examination or a complete examination of a single organ system.

For the purposes of these CPT definitions, the following body areas are recognized: head, including the face; neck; chest, including breasts and axilla; abdomen; genitalia, groin, buttocks; back; and each extremity. The following organ systems are recognized: eyes; ears, nose, mouth, and throat; cardiovascular; respiratory; gastrointestinal; genitourinary; musculoskeletal; skin; neurologic; psychiatric; and hematologic/lymphatic/immunologic.

According to the CPT manual, medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

1. The number of possible diagnoses and/or the number of management options that must be considered;

2. The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed; and

3. The risk of significant complications, morbidity and/or mortality, as well as comorbidities, associated with the patient’s presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

Four types of medical decision making are recognized: straightforward; low complexity; moderate complexity; and high complexity. To qualify for a given type of decision making, two of the three elements in the below Table must be met or exceeded:

<table>
<thead>
<tr>
<th>Complexity of Medical Decision Making</th>
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<tbody>
<tr>
<td><strong>Number of Diagnoses or Management Options</strong></td>
</tr>
<tr>
<td>Minimal</td>
</tr>
<tr>
<td>Limited</td>
</tr>
<tr>
<td>Multiple</td>
</tr>
<tr>
<td>Extensive</td>
</tr>
</tbody>
</table>
Co-morbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M services unless their presence significantly increases the complexity of the medical decision making.

According to the CPT manual, clinical examples of the codes for E/M services are provided to assist physicians in understanding the meaning of the descriptors and selecting the correct code. The clinical examples are listed in the Appendix with each example being developed by physicians in the specialties shown. The examples have been tested for validity and approved by the CPT Editorial Panel. Physicians were given the examples and asked to assign a code or assess the amount of time and work involved. Only examples that were rated consistently have been included in the Appendix.

The CPT manual also indicates that Any specifically identifiable procedure (ie, identified with a specific CPT code) performed on or subsequent to the date of initial or subsequent E/M services should be reported separately.

The actual performance and/or interpretation of diagnostic tests/studies ordered during a patient encounter are not included in the levels of E/M services. Physician performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately, in addition to the appropriate E/M code. The physician's interpretation of the results of diagnostic tests/studies (ie, professional component) with preparation of a separate distinctly identifiable signed written report may also be reported separately, using the appropriate CPT code with modifier 26 appended.

N.J.A.C. §11:3-29.4(g) provides:

“Artificially separating or partitioning what is inherently one total procedure into subparts that are integral to the whole for the purpose of increasing medical fees is prohibited. Such practice is commonly referred to as “unbundling” or “fragmented” billing. Providers and payors shall use the National Correct Coding Initiative Edits, incorporated herein by reference, as updated quarterly by CMS and available at http://www.cms.hhs.gov/NationalCorrectCodInitEd/.

“1. CPT 97010 (application of hot/cold packs) is bundled into the payment for other services and shall not be reimbursed separately.

“2. The eligible charge for an office visit includes reviewing the report of an imaging study when the provider of the imaging study has billed for the technical and professional component of the service. In these circumstances, it is not appropriate for the provider to bill for an office visit and CPT 76140 or for the physician component of the imaging study. CPT 76140 may only be billed where a provider in a different practice or facility reviews an imaging study and produces a written report.”

Pursuant to N.J.A.C. §11:3-4.2:

“Decision point means those junctures in the treatment of identified injuries indicated by hexagonal boxes on the Care Paths where a decision must be made about the continuation or choice of further treatment. The determination whether to administer one of the tests
listed in N.J.A.C. 11:3-4.5(b) is also a decision point for both identified and all other injuries.”

“‘Decision point review’ means the procedures in an insurer’s approved decision point review plan for the insurer to received notice and respond to request for proposed treatment or testing at decision points.”

Although often used interchangeably, pre-certification and decision point review are not synonymous. The latter is defined in the regulations set forth above and pertains to those junctures marked by hexagons in the Care Paths. Pre-certification, however, is permitted by N.J.A.C. §11:3-4.7(c)(2) which allows a carrier to submit a Decision Point Review Plan which includes “identification of any specific medical procedures, treatments, diagnoses, diagnostic tests, other services or durable medical equipment that are subject to precertification. The inclusion of precertification requirements in a decision point review plan is optional. The medical procedures, treatments, diagnoses, diagnostic tests or durable medical equipment required to be precertified shall be those that the insurer has determined may be subject to overutilization and that are not already subject to decision point review.”

N.J.A.C. §11:3-4.4(d) provides that the “Failure to request decision point review or precertification where required or failure to provide clinically supported findings that support the treatment, diagnostic test or durable medical equipment requested shall result in an additional co-payment not to exceed 50 percent of the eligible charge for medically necessary diagnostic tests, treatments or durable medical goods that were provided between the time notification to the insurer was required and the time that proper notification is made and the insurer has an opportunity to respond in accordance with its approved decision point review plan.”

N.J.A.C. §11:3-4.7(b) states that “No decision point or precertification requirements shall apply within 10 days of the insured event or to emergency care.”

N.J.A.C. §11:3-4.7(c)(4) provides a carrier three business days in which to review and respond to a precertification request.

When confronted with a dispute as to the services provided, the burden rests upon the claimant to establish that the medical expenses for which it seeks PIP benefits were reasonable, necessary and causally related to an automobile accident. See Milner v. Safeco Ins. Co. of Am., 175 N.J. Super. 156 (Law Div. 1980).

N.J.S.A. 39:6A-4(a) provides for the payment of medical expense benefits in accordance with a benefit plan provided in the policy and approved by the commissioner for reasonable, necessary and appropriate treatment. This statute also indicates that medical treatments, diagnostic tests and services provided by the policy shall be rendered in accordance with commonly accepted protocols and professional standards and practices. Protocols shall be deemed to establish guidelines as to standard appropriate treatment for injuries sustained in automobile accidents. Those guidelines are set forth in the Care Paths.

The Care Paths are recommended courses of care based on professional recognized standards. The Care Paths identify typical courses of intervention. That is, the Care Paths were created to establish the typical treatment protocols for neck and back injuries as a measuring stick to help determine whether treatment is medically necessary. There may be patients who require more or less treatment. However, cases that
deviate from the Care Paths may be subject to more careful scrutiny and may require documentation of special circumstances to justify the deviations. Deviations may be justified by individual circumstances, such as pre-existing conditions and/or comorbitides. The Care Paths encourage result oriented medical treatment practices. The guidelines established in the Care Paths are designed to avoid the continuation of treatment and therapy, week after week, over many months and years without any observable improvement. Such practice is not only wasteful, but may cause a patient to suffer unnecessarily before more effective and beneficial care might be available from a different type of treatment. The Care Paths, then, do not deprive the patient of the opportunity to seek the treatment of choice, but rather they encourage alternative choices if a treatment plan becomes unproductive. Comments of DOBI, December 21, 1998.

Pursuant to N.J.A.C. 11:3-4.6(c), treatments that vary from the Care Paths shall be reimbursable only when warranted by reason of medical necessity.

The necessity of medical treatment is a matter to be decided in the first instance by the claimant’s treating physicians, and an objectively reasonable belief in the utility of a treatment or diagnostic method based on the credible and reliable evidence of its medical value is enough to qualify the expense for PIP purposes. *Thermographic Diagnostics, Inc. v. Allstate Ins. Co.*, 125 N.J. 491 (1991).

Pursuant to N.J.S.A. §39:6A-2(m), “Medically necessary” means that the treatment is consistent with the symptoms or diagnosis, and treatment of the injury (1) is not primarily for the convenience of the injured person or provider, (2) is the most appropriate standard or level of service which is in accordance with standards of good practice and standard professional treatment protocols.” *See also* N.J.A.C. 11:3-4.2 which states “Medically necessary” or “medical necessity” means that the medical treatment or diagnostic test is consistent with the clinically supported symptoms, diagnosis or indications of the injured person, and: the treatment is the most appropriate level of service that is in accordance with the standards of good practice and standard professional treatment protocols including the Care Paths in the Appendix, as applicable.

In addition, N.J.A.C. 11:3-4.2 Definitions, state in pertinent part: "Clinically supported" means that a health care provider prior to selecting, performing or ordering the administration of a treatment or diagnostic test has:

- Personally examined the patient to ensure that the proper medical indications exist to justify ordering the treatment or test;
- Physically examined the patient including making an assessment of any current and/or historical subjective complaints, observations, objective findings, neurologic indications, and physical tests;
- Considered any and all previously performed tests that relate to the injury and the results and which are relevant to the proposed treatment or test; and
- Recorded and documented these observations, positive and negative findings and conclusions on the patient's medical records.

physician’s opinion is not automatically accorded conclusive weight, *Black & Decker Disability Plan v. Nord*, 123 S. Ct. 1965 (2003), (relating to ERISA Plans), it is accorded an appropriate measure of deference.


Pursuant to N.J.A.C. 11:3-4.2, “Diagnostic test” means a medical service or procedure utilizing biomechanical, neurological, neurodiagnostic, radiological, vascular or any means, other than bioanalysis, intended to assist in establishing a medical, dental, physical therapy, chiropractic or psychological diagnosis, for the purpose of recommending or developing a course of treatment for the tested patient to be implemented by the treating practitioner or by the consultant.

**ANALYSIS and FINDINGS**

Having considered all the evidence and arguments presented in this case, my findings and conclusions are as follows. Foremost I note there is no dispute that the Patient was involved in a motor vehicle accident on 08/29/2010 in which she sustained bodily injuries; or that at said time she was eligible for PIP benefits pursuant to a policy issued by the Respondent.

**On the 10/28/2010 Downcode**

On this date the Patient presented to Dr. Gary Neil Goldstein for an initial consultation. The doctor billed CPT 99245 for this service – the highest level evaluation. The Respondent paid at the lower rate for the 99243-level service. Claimant now seeks payment of the difference ($54.12).

The required elements of the pertinent consultation levels are detailed *supra* and are summarized thusly:

<table>
<thead>
<tr>
<th></th>
<th>99245</th>
<th>99243</th>
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</thead>
<tbody>
<tr>
<td>History</td>
<td>Comprehensive</td>
<td>Detailed</td>
</tr>
<tr>
<td>Exam</td>
<td>Comprehensive</td>
<td>Detailed</td>
</tr>
<tr>
<td>Decision Making</td>
<td>High</td>
<td>Low</td>
</tr>
</tbody>
</table>

All the requirements of these two codes are different. . As previously noted, according to the AMA all of the key components, i.e., history, examination, and medical decision making, must meet or exceed the stated requirements to qualify for a particular level of E/M service. In this instance I find the Claimant has failed to document a high level of medical decision making.

As detailed *supra*, in order to meet a particular level of medical decision making, at least two of the three criteria must be met. The various criteria are shown in the following table.
Given the documentation before me I agree with the Respondent that this date of service does not rise to the 99245 level. In Dr. Goldstein’s report he records only three diagnoses:

(a) TMJ dysfunction,
(b) “cervical disc issue” with neck pain and left upper extremity radicular sensation, possible double crush” and
(c) low back pain with left lower extremity radicular sensation.

Dr. Golstein prescribed medications (Xanax and Vicodin). He indicated he wanted to see the Patient again after MRIs were performed and indicated that electrodiagnostic testing of all four extremities was warranted. He also recommended a TENS unit.

Given the foregoing I do not find that either the number of diagnoses or the management options were “extensive,” though they were clearly “multiple.”

With regard to the amount/complexity of data to be reviewed, the report does not indicate that any records were reviewed. Thus the only data reviewed would be Dr. Goldstein’s own examination. The report does document evaluation of the Patient’s TMJ, a problem-focused neurological examination and orthopedic examination of the lumbar and cervical spine. This element could well rise to the “extensive” level proffered by the Claimant.

However, I do not find that the risk of complications/morbidity/mortality was high given the Patient’s presenting complaints and the doctor’s diagnoses and treatment plan. As such the Claimant has not demonstrated two of the three criteria for “high complexity” medical decision making. Thus Claimant has also failed to demonstrate all three elements of a 99245-level consultation. Therefore I deny this portion of the claim.

On the Adequacy of Documentation for the 11/18/2010 Electrodiagnostic Testing

After the 10/28/2010 initial evaluation, the Patient returned on 11/18/2010 at which time Dr. Goldstein performed electrodiagnostic testing. Respondent denied payment for same. To be clear, the issue raised by Respondent is not the medical necessity of this testing, but rather whether the Claimant has submitted sufficient documentation to support the billing therefor. Respondent contends that it never received any records for this service until the Claimant submitted them as part of this arbitration.

Among the records received from Claimant on 08/13/2012 are Dr. Goldstein’s report and the raw data for this testing. Although the photocopy of the raw data is of somewhat poor quality, I am able to ascertain that the data shows results for upper and lower, motor and sensory NCV testing (including F-wave testing) and also upper and lower extremity EMG testing. Dr. Goldstein’s report interprets this data as showing left carpal tunnel syndrome (CTS) and “C4-5/C5-6 cervical nerve root irritation/low-grade radiculopathy” and also left-sided L5 radiculopathy.

Given the limited argument against payment and the sufficiency of the documentation presented, I am satisfied that Claimant has proven her case on this issue. The documentation does support the billing of electrodiagnostic testing on this date.
Additional issues are raised, however, as to the proper calculation of the payment for this date. I address those now.

**On the Unbundling of CPT 76140**

As noted *supra*, N.J.A.C. §11:3-29.4(g) provides that CPT 76140 may only be billed “where a provider in a different practice or facility reviews an imaging study and produces a written report.” This is consistent with the AMA’s definition from the *CPT Manual* which defines CPT 76140 as “Consultation on x-ray examination made elsewhere, written report.”

In the report of the 11/18/2010 visit the only reference to any imaging studies is as follows:

“I have reviewed the patient's MRI studies and shown her the abnormalities on the view box in the lumbar spine at the L4-5 level as well as in the cervical spine. I told her quite directly that I will try to calm her down non-operatively. I think that we are ultimately going to have to deal with interventional treatment, either pain control injections or surgery.”

The report does not document a “consultation” on the imaging report, but rather merely notes that Dr. Goldstein reviewed same with the Patient. I do not believe that either the regulation or the AMA definition contemplated that such a brief and passing reference to review of an MRI would constitute a written report sufficient to support separate billing for this service. Accordingly I deny payment for same.

**On the Unbundling/Improper Coding of CPT 95861 on 11/18/2010**

As discussed *supra* the Claimant has adequately documented EMG testing of the upper and lower extremities. For this service Dr. Goldstein billed two units of CPT 95861. This code appears on the NJ PIP Fee Schedule as a needle EMG of two extremities. The Fee Schedule rate for this service is $250.92; therefore two units would be $501.84.

However, Respondent points out that there is another CPT code (also on the Fee Schedule) for a needle EMG of *four* extremities. The Fee Schedule rate for that code (CPT 95864) is $398.42. Thus, Respondent argues, the doctor has effectively overbilled by $103.42.

On this issue I agree with the Respondent. Claimant has provided no persuasive argument why it was proper to bill two units of two extremities instead of one unit of four extremities. Because this date of service has not yet been paid (see *supra*) I enter this Award in favor of Claimant expressly noting that neither unit of 95861 should be paid, but one unit of 95864 should.

This concludes the resolution of the issues pertaining to the 11/18/2010 date of service. Given my resolution of these issues I award $2,157.93 for the services rendered on this date, calculated as follows:

<table>
<thead>
<tr>
<th>CPT</th>
<th>Lesser of amount billed or Fee Schedule</th>
<th># of units billed</th>
<th>Amount Awarded</th>
</tr>
</thead>
<tbody>
<tr>
<td>76140</td>
<td>75.00 (not on FS)</td>
<td>2</td>
<td>0.00</td>
</tr>
<tr>
<td>95900</td>
<td>143.02</td>
<td>6</td>
<td>858.12</td>
</tr>
</tbody>
</table>
On the Pre-Certification Penalty for 01/31/2011

There is no dispute that on/about 12/06/2010 Dr. Goldstein submitted a pre-certification request seeking approval of CPT 62311, *inter alia*. This code is defined by the AMA as a lumbar “injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid.” There is no dispute that the Respondent approved that procedure.

On that date, however, the Claimant billed CPT 64483; defined by the AMA as a lumbar “injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT).”

Respondent applied a 50% penalty to the payment on the grounds that this the doctor did not request pre-certification of this procedure. Respondent thus paid $414.60. Claimant argues, in sum and substance, that these codes are essentially the same; that the Respondent had its chance to review the medical necessity thereof and therefore no penalty should be imposed. Claimant therefore seeks payment of the remaining $414.60.

My determination of this issue is complicated by the fact that neither party has submitted a report for the procedure on this date. Dr. Goldstein’s latest report prior to the pre-certification request was dated 11/18/2010 and indicates that he would request pre-certification for a “lumbar epidural via caudal root.” The 12/21/2010 report makes no mention of the type of injection to be performed; only that it had been approved.

Both of the codes apply to injection of anesthetic or steroid. As relevant to the facts herein, it appears the only difference is that 62311 applies to epidural or subarachnoid injection whereas 64483 applies to transforaminal epidural.

The records submitted for my consideration do not provide sufficient information upon which I can determine whether these two codes are sufficiently similar such that I can conclude the Respondent had an opportunity to consider the medical necessity of the procedure actually billed/performed. Nor can I ascertain which code more closely represents which service was actually performed. Therefore I cannot conclude that the Respondent had an opportunity to review the procedure which was actually performed. Thus I am compelled to rely solely upon the technicality that the code performed was not the code requested. Applying that standard, the application of a pre-certification penalty was appropriate. Therefore **I deny this portion of the claim.**
On the Medical Necessity of the 03/28/2011 and 06/30/2011 Office Visits

For both of these dates the doctor billed CPT 99214 (for which the Fee Schedule amount is $89.00 each). At this point it is necessary to discuss the prior treatment dates in greater detail than was required for the previous issues.

The Patient initially presented to Dr. Goldstein on 10/28/2010. At that time she was noted to be wearing an oral appliance to treat her TMJ dysfunction. Reflexes were described as 2+ and symmetrical except for the left brachioradialis and Achilles which were 1+. Cervical ROM was noted at 75-80% of normal with tenderness to palpation. Thoracolumbar ROM was 85% of normal. SLR and Lasegue’s produced “some positivity” on the left.

As noted supra the Patient underwent electrodiagnostic testing on 11/18/2010. This revealed left L5 radiculopathy, left carpal tunnel syndrome and left-sided radiculopathy at C4/5 – C5/6.

When the Patient returned to Dr. Goldstein on 11/18/2010 she complained of neck pain and left shoulder pain radiating into the left upper extremity. Low back pain was also noted and “left lower extremity radicular sensation strongly to the knee.” On examination the doctor noted pain and weakness raising her left arm overhead. He noted there was “so much general inflammation about the shoulder, it is difficult to separate intrinsic shoulder pathology from radicular sensation or both.” Lasegue’s remained positive on the left and great toe dorsiflexion had “some weakness” on the left.

At her 12/21/2010 follow-up examination the Patient “complains bitterly about neck pain and pain radiating into the left arm, with numbness in hand.” She also reported back pain. The doctor injected the Patient’s wrist with Marcaine and dispensed a Futuro wrist splint to address wrist complaints.

Dr. Goldstein noted that he would see the Patient again in three weeks and “at that point, it may be necessary to proceed with EMG’s to make sure we are targeting the correct level.” It is unclear what the doctor meant by this seeing as he had performed the EMG just one month prior.

On 02/02/2011 the Patient was examined by Dr. Wayne Kerness, an orthopedic surgeon, at the Respondent’s request. This is discussed infra.

The Patient returned on 02/21/2011. The report of that date indicates that Dr. Goldstein had performed an epidural on 01/31/2011. He reported that this produced “some improvement, but it was relatively transient, perhaps a week or less.” He therefore recommended a lumbar discogram “with an eye toward planning definitive surgery.”

On examination Dr. Goldstein noted decreased sensation in the median innervated area of the left hand with “some spillover into the C5 and C6 distribution.” He reported “an overtly positive Tinel’s.” He also noted L5 and S1 numbness in the left leg. Lasegue’s remained positive and there was “some weakness noted in heel and toe calf raising.”

The Patient returned to Dr. Goldstein again on 03/28/2011. She complained of “issues with her low back” such as radiation to the left buttocock and posterior thigh. She also reported neck pain with radiating pain into the left hand. Cervical compression testing produced neck pain with radiation into the left arm. Dr. Goldstein noted that the Patient’s benefits had been terminated by Respondent, and
indicated that she required a left carpal tunnel release, a lumbar discogram and CT scan “to plan more definitive surgery.” He also referenced possible cervical transforaminal epidural for the Patient’s neck or “minimally invasive neck surgery.”

The Patient returned again on 06/30/2011 complaining of neck pain and low back pain radiating into the left arm and leg. There was “a great deal of specific numbness in the left hand.” On examination the doctor again noted weakness on great toe dorsiflexion and positive SLR. For the first time Dr. Goldstein referenced the lumbar MRI as showing a herniation at L4/5. He noted that she had not responded well to the lumbar epidural and opined “it is reasonable to proceed with some version of discectomy, either minimally invasive or open.”

He again opined that she required a carpal tunnel release, pointing out she had decreased sensation along the median nerve distribution. Tinel’s positive. Reverse Phalen’s and median nerve compression tests were positive on the left; negative on the left.

He indicated that “her left arm problem is partially carpal tunnel, partially cervical radiculopathy.” He indicated that “realistically, she has failed conservative management. Cervical discectomy and fusion would be the appropriate treatment there.” He noted his intention to request precertification for left carpal tunnel release, lumbar discogram and cervical discectomy and/or fusion at C4-5 and C5-6.”

Dr. Goldstein saw the Patient again on 08/18/2011. He noted that her “physical examination today is essentially unchanged from previous office visit.” He noted sensory abnormalities in the left leg; numbness and tingling in the median nerve distribution in the left hand; positive Tinel’s. He noted that the Respondent had not approved any surgeries.

As referenced above, the Respondent’s denial of treatment was initially based upon an examination by Dr. Wayne Kurness. He examined the Patient on 02/02/2011 – two days after she received the lumbar epidural. By way of record review he noted that a cervical MRI performed on 11/03/2010 was “suggestive of disc herniations at the C3-C4, C5-C6 and C6-C7 levels.” He noted that a lumbar MRI on the same date “did not reveal any disc herniations.”

Dr. Kurness reported that according to the Patient her left wrist discomfort began two weeks prior. On physical examination he reported that she had normal ROM in all cervical planes. He reported finding no paravertebral muscle spasm in the cervical spine. Muscle strength testing was reported at +5 throughout. He reported negative Tinel’s. Wrist ROM was reported as full bilaterally. Lumbar ROM was normal and – with flexion – exceeded normal measurement.

Dr. Kurness opined that the Patient had sustained cervical and lumbar sprain and causally related these to the accident. He noted “no positive objective findings whatsoever on physical examination” and concluded that she had reached maximum medical improvement in orthopedic surgery and no further diagnostic testing was indicated. He also noted that given the delayed onset and the fact that his

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1 A date now shown on Dr. Goldstein’s billing ledger and therefore not a part of this arbitration.
2 Neither party has submitted the MRI reports. I therefore rely on the other physicians’ references thereto.
3 I must question the Patient’s time perception in this history as it not only contradicts Dr. Goldstein’s records, but also those of Dr. Brody who noted – on 09/28/2010 – the Patient to complain of left wrist/hand pain, numbness and tingling. He also noted a positive Tinel’s at that time.
examination “did not elicit any clinical findings suggestive of carpal tunnel syndrome” it was not causally related to the accident.

Curiously, he also noted that there “do not appear to be any relevant pre-existing conditions,” yet he did not causally relate the cervical herniations to the accident; raising an unanswered question: if they were not pre-existing, but not caused by the accident either, when did they develop?

On 03/11/2011 Dr. Kurness issued a supplemental report addressing Dr. Goldstein’s appeal. At that time Dr. Kurness had reviewed Dr. Goldstein’s 02/21/2011 office note and his 03/07/2011 appeal letter. Dr. Kurness maintained his earlier opinion that no further treatment was necessary.

As noted above, at this time I address only the medical necessity of the two office visits. I am convinced that the Claimant has indeed established same.

Respondent’s denial was entirely based upon the examination by and opinion of Dr. Kurness. That opinion was largely premised upon the Patient’s indication that the difficulty began two weeks prior. The evidence submitted clearly shows otherwise. As indicated in footnote 3, supra, Dr. Brody began noting hand/wrist complaints within a month of the accident.

However, Dr. Brody’s records were not among the list of those reviewed by Dr. Kurness. They – coupled with Dr. Goldstein’s notes – contradict the Patient’s obviously incorrect statement that the wrist symptoms began two weeks prior to the IME. It appears clear that Dr. Kurness’s opinion on causation (or lack thereof) was largely based upon the “delayed onset” of symptoms. Seeing as that premise was incorrect, it must call into question the validity of his conclusion.

His opinion was also based upon his lack of any findings consistent with CTS. Again, his findings are inconsistent with the other evidence I have been supplied. Not only did Dr. Goldstein report finding a positive Tinel’s on several dates, so too did Dr. Brody – again beginning on 09/28/2010.

I am convinced of the causal relationship between the Patient’s CTS and this accident. Completely aside from the cervical and lumbar issues (which are discussed more thoroughly in the next point), this supports the medical necessity of these two office visits. Accordingly I award payment of these two visits in the amount of $89.00 each ($178.00 in total).

On the Medical Necessity of Future Treatment

Claimant seeks approval of the following treatments: a left carpal tunnel release, a lumbar discogram; post-discogram CT scan and cervical discectomy/fusion at C4/5 and C5/6. Respondent maintains its denial of same based upon the findings and report of Dr. Kurness.

I am satisfied that the Claimant has demonstrated the medical necessity of the carpal tunnel release. I am persuaded that the release is the most appropriate level of service/treatment. Dr. Goldstein had previously tried a wrist splint and injection. Neither proved effective. The Patient’s symptoms continued unabated. For the same reasons set forth above I am not persuaded by Dr. Kurness’s refutation of causation; or – stated differently – I am satisfied that the Claimant has demonstrated a causal relationship. Therefore the carpal tunnel release should be covered by Respondent.

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4 I have reviewed the 03/07/2011 appeal letter but do not discuss same herein as it adds nothing patient-specific. It appears to be a form letter asking the Respondent to “consider all documentation previously submitted…”
With respect to the lumbar discogram and post-discogram CT scan I am persuaded that same are medically necessary. The Patient continually voiced lower-extremity radicular symptoms. Dr. Brody noted decreased sensation in the left lower extremity in the L5/S1 dermatome on 09/28/2010 and the electrodiagnostic testing confirmed L5 radiculopathy; yet the MRI showed no herniations.\(^5\) I am not persuaded by Dr. Kurness’s reportedly normal lumbar examination for mostly two reasons: (a) his examination was conducted just days after the lumbar epidural; and (b) it is contradicted by repeated findings by both Drs. Brody and Goldstein. Recognizing that Dr. Kurness’s evaluation was conducted just days after the lumbar epidural which could certainly have changed the Patient’s condition/symptoms\(^6\) and giving deference to the treating physicians (see Elkins, supra). I am convinced that this further test is medically necessary.

I would be remiss if I did not note at this point that I am convinced of the medical necessity only of the testing. As for what treatment is recommended as a result thereof, the issue is not put before me in this arbitration and cannot be ascertained without knowing the results of the tests. Moreover, I note that among the documents submitted by Respondent is a 12/19/2011 report by Dr. Goldstein wherein he addresses a subsequent motor vehicle accident on 11/25/2011 which he reported as causing “alteration and extension of preexisting symptomatology initiated by the August 2010 accident.” What effect – if any – that accident might have had on any proposed treatment is not before me at this time. In this arbitration I have determined based upon the evidence as it existed prior to the 2011 accident that the lumbar discogram and CT were medically necessary.

Regarding the Claimant’s demand for “cervical discectomy and/or fusion at C4-5 and C5-6” I find that Claimant has failed to establish the medical necessity of same. Weighing most heavily in my determination is the 03/28/2011 report wherein Dr. Goldstein wrote “With regard to the neck, we could consider pain control injections to the neck, in terms of a cervical transforaminal epidural or minimally invasive neck surgery.”

When the Patient returned three months later – with no documented treatment in the interim – the proposed course of care had escalated to cervical discectomy and fusion. I am aware that the less invasive procedures which Dr. Goldstein sought were denied by the Respondent. However, that does not establish the medical necessity of even more aggressive treatment.\(^7\) I cannot agree with Dr. Goldstein’s statement that “she has failed conservative management.” The Patient has received relatively little treatment for her neck. I cannot conclude that the discectomy and/or fusion is clinically supported at this time.

**ATTORNEY’S FEES and COSTS**

Claimant’s counsel has submitted a fee certification which itemizes 5.25 hours of work at the sought-rate of $300.00 per hour (totaling $1,575.00). Claimant also seeks reimbursement of $232.00 in costs.

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\(5\) As reported by Dr. Kurness. I do not overlook the fact that the absence of herniations is not the same as a normal MRI. As noted previously, I do not have the benefit of reviewing the MRI reports.

\(6\) This is not merely speculation on my part. The Patient did report to Dr. Kurness that “the low back pain is much improved.”

\(7\) The question of whether the denied cervical epidural or some other pain management has not been put before me in this matter as such it would be improper for me to comment on same.
Respondent argues that the number of hours and the hourly rate are excessive given the putative lack of complexity in the issues presented.

One of the most recent state supreme court cases addressing counsel fees is *Litton Indus., Inc. v. IMO Indus., Inc.*, 200 N.J. 372 (2009). In that case the Court stated:

“We have applied the same test for reasonable attorneys' fees in contract cases that we use in other attorneys' fee award cases in New Jersey. See *N. Bergen*, supra, 158 N.J. at 570, 730A.2d 843. In determining the reasonableness of an attorneys' fee award, the threshold issue "is whether the party seeking the fee prevailed in the litigation." *Ibid.* In that regard, the party must establish that the "lawsuit was causally related to securing the relief obtained; a fee award is justified if [the party's] efforts are a necessary and important factor in obtaining the relief." *Ibid.* (quoting *Singer v. State*, 95 N.J. 487, 494, 472 A.2d 138, *cert. denied*, 469 U.S. 832, 105 S.Ct. 121, 83 L.Ed.2d 64 (1984)).

[* * * ]

The next step in determining the amount of the award is to calculate the "lodestar," which is that number of hours reasonably expended by the successful party's counsel in the litigation, multiplied by a reasonable hourly rate. *Furst v. Einstein Moomjy, Inc.*, 182 N.J. 1, 21, 860 A.2d 435 (2004). Rule of Professional Conduct 1.5(a) "commands that `[a] lawyer's fee shall be reasonable' in all cases, not just fee-shifting cases," *id.* at 21-22, 860 A.2d 435 (quoting RPC 1.5(a)), and requires courts to consider:

(1) the time and labor required, the novelty and difficulty of the questions involved, and the skill requisite to perform the legal service properly;
(2) the likelihood, if apparent to the client, that the acceptance of the particular employment will preclude other employment by the lawyer;
(3) the fee customarily charged in the locality for similar legal services;
(4) the amount involved and the results obtained;
(5) the time limitations imposed by the client or by the circumstances;
(6) the nature and length of the professional relationship with the client;
(7) the experience, reputation, and ability of the lawyer or lawyers performing the services;
(8) whether the fee is fixed or contingent.

[RPC 1.5(a).]

“The computation of the lodestar mandates that the trial court determine the reasonableness of the hourly rate of "the prevailing attorney in comparison to rates `for similar services by lawyers of reasonably comparable skill, experience, and reputation' in the community." *Furst, supra*, 182 N.J. at 22, 860 A.2d 435 (quoting *Rendine, supra*, 141 N.J. at 337, 661 A.2d 1202). Further, the court must consider the degree of success in determining the reasonableness of the time expended. *Furst, supra*, 182 N.J. at 23, 860 A.2d 435. Thus, when a party has succeeded on only some of its claims for relief, the trial court should reduce the lodestar to account for the limited success. *Ibid.* Moreover, if the same evidence adduced to support a successful claim was also offered on an unsuccessful claim, the court should consider whether it is nevertheless reasonable to award legal fees for the time expended on the unsuccessful claim.
“Beyond the lodestar amount, in cases in which the fee requested far exceeds the damages recovered, "the trial court should consider the damages sought and the damages actually recovered." Packard-Bamberger & Co., supra, 167 N.J. at 446, 771 A.2d 1194. In addition to that proportionality analysis, the court must evaluate the reasonableness of the total fee requested as compared to the amount of the jury award. That is, when the amount actually recovered is less than the attorney's fee request, the court must consider that fact in determining the overall reasonableness of the attorney's fee award. Ibid. To be sure, there is no precise formula for that portion of the reasonableness analysis. The ultimate goal is to approve a reasonable attorney's fee that is not excessive.”

Although the Court cautioned about the proportionality of an attorneys' fee and the amount in dispute, it also recognized that in Litton it was dealing with a contract case. The Court acknowledged the difference in contract cases when it wrote:

“Unlike the traditional fee-shifting case in which enhancement has some relevancy as a type of encouragement to represent a party, see Rendine, supra, 141 N.J. at 339, 661 A.2d 1202 (1995), the opposite applies in a contract case. That is, although enhancement is not a concern, the relationship between the fee requested and the damages recovered is a factor to be considered by the trial court because the notion of proportionality is integral to contract fee-shifting to meet the reasonable expectation of the parties.”

It has been well established by New Jersey’s Courts that Rule 4:42-9(a)(6) allows for an award of counsel fees “in an action upon a liability or indemnity policy of insurance, in favor of a successful claimant” in judicial actions brought under the PIP statute. Craig & Pomeroy, New Jersey Auto Insurance Law (GANN LAW BOOKS) (case citations omitted). In N.J. Coalition of Health Care Professionals, Inc. v. N.J. Dep’t of Banking & Ins., 323 N.J. Super. 207 (App. Div. 1999), the Court noted that “an award of counsel fees to an insured who successfully obtains an arbitration award against an insurance carrier for payment of PIP benefits has been the statutory and historical jurisprudence of our State.”

Pursuant to N.J.A.C. 11:3-5.6(d)(3), a DRP’s award may include attorney’s fees for a successful claimant in an amount consonant with the award and with Rule 1.5 of the Supreme Court’s Rules of Professional Conduct as quoted in Litton, supra.


In Olewinski, supra, the PIP claim was settled during a conference prior to the trial. On the issue of whether the claimant was successful for the purposes of an award of counsel fees, the Court concluded “that attorneys’ fees should be allowed when a case is settled at any time after the commencement of suit...” Id. at 432.

In Enright v. Lubow, 215 N.J. Super. 306 (App. Div. 1987) the Court indicated the factors to be considered in deciding whether to award attorney’s fees include the insurer’s good faith in refusing to pay the claim, the excessiveness of plaintiff’s demands, the bona fides of the parties, the insurer’s
justification in litigating the issues, the insured’s conduct as it contributes substantially to the need for litigation, the general conduct of the parties and the totality of the circumstances.

In *Rendine v. Pantzer*, 141 N.J. 292 (1995), our state supreme court stated: “both as a matter of economic reality and simple fairness, we have concluded that a counsel fee awarded under a fee shifting statute cannot be “reasonable” unless the lodestar, calculated as if the attorney’s compensation were guaranteed irrespective of result, is adjusted to reflect the actual risk that the attorney will not receive payment if the suit does not succeed.” *Id.* at 338.

As a general principle I find the hourly rate sought by Claimant’s attorney is not unreasonable given the experience possessed by counsel and the degree of work/skill required to prosecute the present matter. However, an attorney’s fee is also a product of the complexity of the service being rendered. For example, an experienced attorney might be worth $X per hour in the provision of legal fees, but that same rate might not be reasonable for time spent by that attorney making photocopies as s/he is not utilizing that degree of knowledge/skill. I have considered the criteria and standards set forth herein. I find that an award of counsel fees in the amount of $1,275.00 is consonant with the amount awarded and consistent with the requisites of RPC 1.5 and the criteria set forth in *Enright v. Lubow*, 215 N.J. Super. 306 (App. Div. 1987), as well as, *Scullion v. State Farm Ins. Co.*, 345 N.J. Super. 431 (App. Div. 2001).

Pursuant to N.J.A.C. 11:3-5.6(d)(2), the award shall apportion the costs of the proceedings in a reasonable and equitable manner consistent with the resolution of the issues in dispute. I therefore award costs in the amount of $232.00.

**Therefore, the DRP ORDERS:**

**Disposition of Claims Submitted**

1. Medical Expense Benefits: Awarded:

<table>
<thead>
<tr>
<th>Medical Provider</th>
<th>Amount Claimed</th>
<th>Amount Awarded</th>
<th>Payable To</th>
</tr>
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<tbody>
<tr>
<td>Dr. Gary Goldstein</td>
<td>$4,045.04⁸</td>
<td>$2,335.19</td>
<td>Dr. Gary Goldstein</td>
</tr>
<tr>
<td>Left carpal tunnel</td>
<td>Future treatment</td>
<td>Granted</td>
<td>Provider</td>
</tr>
<tr>
<td>release</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lumbar discogram &amp; CT</td>
<td>Future treatment</td>
<td>Granted</td>
<td>Provider</td>
</tr>
<tr>
<td>scan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cervical surgery</td>
<td>Future treatment</td>
<td>Denied</td>
<td>n/a</td>
</tr>
</tbody>
</table>

Subject to co-pay, deductible and NJ PIP Fee Schedule.


4. Death or Funeral Expense Benefits: Not in issue.

⁸ Claimant has not submitted a Rule 16 summary. This figure is shown as the “insurance pending” balance on the doctor’s billing ledger and matches the amount shown on the Demand for Arbitration.
5. Interest: I find that the Claimant did prevail. Interest is awarded pursuant to N.J.S.A. 39:6A-5h.: in an amount to be calculated by the Respondent at the interest rates and from the dates of accrual as set forth in the statute.

**Attorney's Fees and Costs**

☐ I find that the Claimant did not prevail and I award no costs and fees.

☒ I find that the Claimant prevailed and I award the following costs and fees (payable to Claimant's attorney unless otherwise indicated) pursuant to N.J.S.A. 39:6A-5.2g:

Costs: $232.00

Attorney's Fees: $1,275.00

THIS AWARD is rendered in full satisfaction of all claims and issues presented in the arbitration proceeding.

Entered in the State of New Jersey

[Signature]

Christopher M. Cannell, Esq.
Dispute Resolution Professional

Date: 10/14/2012