In the Matter of the Arbitration between

University Hospital - PE a/s/o D.G.
CLAIMANT(s),

v.

Progressive Insurance Company
RESPONDENT(s).

Forthright File No: NJ1811001815571
Proceeding Type: In-Person
Insurance Claim File No: 17-5926777
Claimant Counsel: Midlige Richter
Claimant Attorney File No: 297.0156
Respondent Counsel: Klinger & Farrell, LLP
Respondent Attorney File No:
Accident Date: 05/22/2017

Award of Dispute Resolution Professional

Dispute Resolution Professional: George C. Nardella 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

In Person Proceeding Information

A proceeding was conducted on: 07/01/2019

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

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

None

Findings of Fact and Conclusions of Law

This matter arises out of a motor vehicle accident that occurred on 5/22/17. Prior to rendering this decision, I have reviewed all of the documents submitted by the claimant and the respondent. Oral argument of counsel was heard on 7/1/19.

The claimant has submitted a Demand for Arbitration seeking $41,472.00 for emergency department services rendered to the patient from 5/22/17 to 5/25/17.

The only issues raised at the arbitration hearing were: are the policy PIP limits $15,000.00 or $250,000.00 in this case and is the claimant precluded from proceeding because of a failure to comply with the respondent's internal appeal requirements?

Issue #1: Are the policy PIP limits $15,000.00 or $250,000.00 for the services the claimant provided in this case?

Claimant's Argument:

The claimant notes that the patient was a 17 year old involved in an accident as an unrestrained back seat passenger. EMS responded to the scene, and noted the patient was ejected from the vehicle and lost consciousness at the accident scene. The patient reported head, neck, chest and back pain, and was seen in the claimant's Level I Trauma Center.

The claimant argues that the patient was seen by the trauma unit immediately upon arrival due to the high probability of imminent life-threatening deterioration. Initial considerations based on claimants presenting problems included closed head injury, cervical injury, spinal cord injury, intrathoracic injury and intra-abdominal injury.

The claimant notes that upon admission, the patient was cleared from cervical injuries via x-ray. During the triage the patient underwent various CT scans and an MRI, which revealed Left posterior 5th rib fracture with hemopneumothorax and Left greater than Right pulmonary parenchymal contusion/ hemorrhage.

The patient was admitted to Pediatric Intensive Care Unit for monitoring of respiratory status. The claimant notes that the patient was initially doing poorly on incentive spirometry due to pain however pain control improved. The patient was provided intravenous opioid pain medication during the admission, and received constant, 24 hour neurologic monitoring. The claimant argues that as the medical records note, during the inpatient stay the patient received continuous monitoring, pain control, pulmonary rehabilitation, DVT ppx, and daily nursing care and rehab services when ready.

The claimant argues that the patient sustained a severe, traumatic closed head injury and a severe pulmonary contusion and the patient required supervised pain control, including the intravenous opioid narcotic morphine which improved her pain. The patient's lungs had decreased inspiratory phase, and thus the patient required oxygen. The claimant argues that due to the sternal injury, and decreased lung capacity, the patient was at an increased risk for a deep vein thrombosis ("DVT" a life threatening blood clot), thus requiring DVT propholaxis. The claimant notes that the patient was treated for the DVT through the use of a Lovenox, an anticoagulant that helps prevent the formation of blood clots, which can result in serious and life-threatening complications if the patient experiences a bleed.

The claimant also argues that DRPs confronted with this issue have routinely looked at the suspected injury when making a "significant injury" determination. The claimant cites prior PIP Awards to support this position.

The claimant notes that the patient spent 2 days in the hospital before she was stabilized to the point where he could be safely discharged.

The claimant concludes that all of the foregoing had to be performed in an inpatient setting and as is discussed more fully below, this statutory exception was intended to address the precise situation presented by these facts: a patient selects a policy with limited coverage, and then sustains a catastrophic injury requiring life-saving treatment in a hospital.

The claimant argues that since the services rendered to the patient were for medically necessary treatment of permanent or significant injuries rendered at a trauma center or acute care hospital immediately following the accident pursuant to *N.J.S.A.* 39:6a-3.1, the claimant is entitled to be paid in full for its services.

The claimant notes that the issue in dispute in this matter, is the applicable limits of patient's PIP policy with respondent pursuant to *N.J.S.A.* 39:6A-3.1. The claimant argues that the plain language of this statute compels application of a $250,000.00 limit.

The claimant argues that the respondent's attempt to impose a PIP limit of $15,000.00 is contrary to clear statutory language as well as the policy purchased by the patient/insured.

Regarding the basic policy, the claimant notes that the New Jersey Legislature enacted *N.J.S.A.* 39:6A-3.1, which provides:

39:6A-3.1. Alternate coverage; minimum required coverages

Effective: November 2, 2009

> As an alternative to the mandatory coverages provided in sections 3 and 4 of P.L.1972, c. 70 (C.39:6A-3 and 39:6A-4), any owner or registered owner of an automobile registered or principally garaged in this State may elect a basic automobile insurance policy providing the following coverage:
>
> a. Personal injury protection coverage, for the payment of benefits without regard to negligence, liability or fault of any kind, to the named insured and members of his family residing in his household, who sustained bodily injury as a result of an accident while occupying, entering into, alighting from or using an automobile, or as a pedestrian, caused by an automobile or by an object propelled by or from an automobile, and to other persons sustaining bodily injury while occupying, entering into, alighting from or using the automobile of the named insured, with the permission of the named insured. "Personal injury protection coverage" issued pursuant to this section means and includes payment of medical expense benefits, as provided in the policy and approved by the commissioner, for the reasonable and necessary treatment of bodily injury in an amount not to exceed $15,000 per person per accident; **except that, medical expense benefits shall be paid in an amount not to exceed $250.000**: (1) for all medically necessary treatment of permanent or significant brain injury, spinal cord injury or disfigurement **or** (2) for medically **necessary treatment of other permanent or significant injuries rendered at a trauma center or acute care hospital immediately following the accident and until the patient is stable, no longer requires critical care and can be safely discharged or transferred to another facility in the judgment of the attending physician...** (emphasis supplied).

The claimant argues that this statute is clear that a limit of $250,000.00 applies, or is imbedded, in all "basic" policies for treatment of "significant injuries" immediately after an accident at trauma centers or acute care hospitals.

The claimant notes that the legislature's wording of this statute creates three classes of injuries which mandate application of the $250,000.00 policy limit: (1) permanent or significant brain, spinal cord injury or disfigurement; or (2) treatment of other permanent injury; or (3) treatment of other significant injuries. The claimant argues that the use of the disjunctive "or" clarifies the legislature's intent in this regard and further specifies the latter two categories must have treatment rendered at a Hospital immediately following the accident. The claimant also argues that furthermore, the statute makes clear that the carriers obligation continues until the patient "can be safely discharged or transferred to another facility in the judgment of the attending physician."

The claimant argues that the statute's plain language provides that the carriers obligation continues up to the time the patient is discharged from the hospital. Further, the statute mandates that the applicable medical opinion, or judgment, of the treating physician is dispositive as to the issue when the patient can be discharged, thus concluding the carrier’s obligation to apply a $250,000.00 limit.

The claimant notes that the arguments asserted by respondent generally fall into one or more of three categories. Namely, opposition to the $250,000.00 limits are: (1) the injuries are not permanent; (2) the injuries are not catastrophic or involving the brain or spinal cord; and/or (3) the patient could have been discharged earlier.

The claimant argues that all three arguments must fail.

The claimant argues that in New Jersey the paramount principle of legislative construction is to afford the legislatively chosen words of a statute their ordinary and well understood meaning. *State v Regis,* 208 N.J. 439(2011), *Nini v Mercer County Community College* 202 N.J. 98(2010). In other words, the guiding tenet of statutory construction is to determine if the words chosen by the legislature are in plain language, unambiguous, and yield only one meaning. *Liberty Lincoln-Mercury v Ford Motor Co*. 9 F.Supp.2d 450 (D.N.J. 1998).

The claimant argues that *N.J.S.A*. 39:6A-3.1 unequivocally provides a $250,000.00 PIP policy limit, in part, for treatment of a significant injury at a hospital immediately following an accident. The word catastrophic is not mentioned in the statute. The claimant also argues that further, the statute cannot in any credible way be limited to spine, brain, or only permanent injury.

Furthermore, the claimant argues that the language utilized in the statute provides that the treating physician is the individual responsible for determining when a patient can be discharged thus tolling the carrier's obligation to provide $250,000.00 in PIP benefits for hospitalizations following an accident.

The claimant also argues that it is not seeking an expansion but that all basic policies include $250,000.00 in PIP limits, as a matter of law, pursuant to the above statute. The claimant argues that no adjustment is needed because the statute mandates that all "basic" policies provide $250,000.00 in PIP coverage for the type of injuries at issue.

Lastly, it is anticipated Respondent may argue some of the treatment rendered during the admission to the hospital was related to underlying or pre-existing conditions. Similarly, this argument also fails to recognize controlling New Jersey Law. The claimant argues that our courts have consistently held that PIP is meant to compensate auto victims without regard to fault or other issues involved in the apportionment between prior injuries and aggravation of those injuries. See *Bowe v New Jersey Manufacturer's Ins. Co*. 367 N.J. Super. 128 (App. Div 2004).

In *Bowe*, the appellate division noted that if a condition or injury requires treatment as result of an accident, the PIP carrier is liable for the treatment even "if that treatment addresses, in whole or part, the pre-existing injury or condition."

The claimant argues, however, that in this matter, the subject accident alone was the precipitating factor resulting in the claimant's hospitalization immediately following the accident.

The claimant also argues that public policy of the No-Fault Act, namely prompt payment of personal injury protection ("pip") benefits for individuals injured in automobile accidents. And DOBI's specific intent to reimburse hospitals at UCR support petitioner's argument.

The claimant cites: *Gambino v. Royal Globe Ins. Companies*, 86 N.J. 100, 105 (1981). The claimant notes that the Supreme Court first reviewed the "true purpose of the enactment" of the No Fault act in *Gambino*, supra. In doing so, the *Gambino* Court considered the Joint Commission's finding, which concluded there were four (4) concerns the Legislature sought to address through the implementation of the No-Fault Act:

1. The prompt and efficient provision of benefits for all accident injury victims (the

"Reparation" objective);

2. The reduction or stabilization of the prices charged for automobile insurance (the

"Cost" objective);

3. The ready availability of insurance coverage necessary to the provision of

accident benefits (the "Availability" objective); and

4. The streamlining of the judicial procedures involved in third-party claims (the

"Judicial" objective).

Id. at 105-106.

The claimant notes that the *Gambino* court noted the Joint Commission concluded the reparation objective was to be viewed as the "primary purpose" of the No Fault Act, and was to be given "priority". The claimant also notes that the *Gambino* court reiterated previous findings that "the Act be liberally construed so as to effectuate its purposes."

The claimant also argues that hospitals generally, and Emergency Departments specifically, were afforded special protection from the "cost saving" provisions of AICRA upon which it relies. The claimant argues that specifically, the legislature provided for $15,000.00 of "Emergency Personal Injury Protection coverage" for the special policy and for coverage of up to $250,000.00 for accidents involving treatment of "permanent or significant injuries" following the accident.

Respondent's Argument:

With regard to coverage, the respondent argues that the policy under which the claim is made was issued with a $2,500 deductible. The policy had commenced earlier that month of the accident. The entire $15,000 policy limit was paid to the claimant, University Hospital (UMDNJ).

The respondent notes that the claimant has the burden of proof as to all elements of the claim. The respondent also notes that where there is a dispute as to medical necessity, the burden rests on the claimant to establish that the services for which PIP benefits are being sought were reasonable, necessary and casually related to an automobile accident. *Miltner v Safeco*, 175 N. J. Super. 156 (Law Div. 1980).

The respondent also argues that the burden of proof as to permanency or significance of claimant's injuries rests with the claimant. *Jersey City Medical Center/H C V. Progressive* (1643336) and that medical proofs prepared after the filing of arbitration must be ignored. The respondent argues that to the extent claimant seeks to rely upon medical proofs, reports or certifications prepared in conjunction with the arbitration, which were not submitted as part of the precertification request or appeal of the payment for treatment, such proof must be barred.

The respondent notes that in *Therapeutic Devices/JC v. GEICO* (NAF # 797590), DRP Sacco rejected the use of such documentation to support the medical necessity of medical services. The purposes of No Fault require that..."the medical necessity and the clinical support for that medical necessity should be proven at the time treatment/medical services are rendered and not after the fact." Claimant's proofs, which well postdated the precertification request (and were apparently prepared in conjunction with the arbitration demand) were "too little and too late. See, also: *Open MRI/ SS v. Allstate* (NAF# 560538) and *Therapeutic Devices/ SP v. Mercury* (NAF# 886334). And see: *Garden State MRI/DS v USAA* (NAF# 1372356) indicating that one must examine the proofs submitted as part of the decision point review process and not those subsequently presented.

The respondent also argues that the policy limits are exhausted. The respondent notes that the rights of the provider, under an alleged assignment, can rise no higher than that of the patient. *Tirgan v. Mega Life*, 304 N.J. Super. 385 (Law Div. 1997). The entire $15,000 policy has been exhausted.

The respondent also notes that in *Sanfilippo/ DP v. GEICO* (NAF 636419) the DPR concluded that the exhaustion of the policy limits also exhausts coverage. No further benefits may be sought. Moreover, claimant's counsel is not a successful claimant and is not entitled to fees and costs. The $15,000 limit must be enforced by the DRP. *Open MRI a/ s/ o Carmen Hernandez v Mercury Insurance*, 421 N.J. Super. 160 (N.J. Super.A.D.2011).

Analysis and Decision:

With regard to the provisions of *N.J.S.A.* 39:6A-3.1a, which in pertinent part states:

> ... for the reasonable and necessary treatment of bodily injury in an amount not to exceed $15,000 per person per accident: except that, medical expense benefits shall be paid in an amount not to exceed $250.000: (1) for all medically necessary treatment of permanent or significant brain injury, spinal cord injury or disfigurement or (2) for medically necessary treatment of other permanent or significant injuries rendered at a trauma center or acute care hospital immediately following the accident and until the patient is stable, no longer requires critical care and can be safely discharged or transferred to another facility in the judgment of the attending physician...

It is not disputed that the claimant qualifies as a trauma center or acute care hospital and that treatment commenced immediately following the accident.

The portions of the above statute that are of significance in determining the available coverage in this case are “significant injuries” and “until the patient is stable, no longer requires critical care and can be safely discharged or transferred to another facility in the judgment of the attending physician”.

The hospital discharge summary indicates that the patient was a 17 year old female who presented as trauma code activation. The record also indicates that the patient was in a motor vehicle accident and was an unrestrained rear seat passenger and was ejected from the back seat. The record also indicates a loss of consciousness, neck pain, back pain and left hip pain. The trauma evaluation identified left posterior 5th rib fracture with small hemopneumothorax and Left greater than right pulmonary parenchymal contusion/hemorrhage.

The discharge records also indicate that the patient was evaluated by the trauma team and underwent pan-CT scan with a significant finding of left posterior 5th rib fracture with small hemopneumothorax and Left greater than Right pulmonary parenchymal contusion/hemorrhage. The patient was admitted to the pediatric intensive care unit for monitoring of her respiratory status. The patient initially did poorly on incentive spirometry due to pain, however pain control improved and the patient was downgraded from the pediatric intensive care unit to peds floor on hospital day 2, and by hospital day 3 the patient's pain was controlled with no respiratory distress, tolerating regular diet and ambulating. The patient was discharged home on hospital day 3 in stable condition.

It is undisputed that the patient suffered a left posterior 5th rib fracture with small hemopneumothorax and Left greater than right pulmonary parenchymal contusion/hemorrhage. It is also undisputed that initially the patient did poorly on incentive spirometry due to pain and was admitted to the pediatric intensive care unit for monitoring.

Based on the evidence, the claimant has established that the patient suffered significant injuries in the accident and treatment was rendered at a trauma center or acute care hospital immediately following the accident in accordance with the requirements of *N.J.S.A.* 39:6A-3.1a.

Based on the above, the PIP limits of the respondent's policy for the hospital services at issue is $250,000.00.

Issue #2: Is the claimant precluded from proceeding because of a failure to comply with the respondent's internal appeal requirements?

Claimant's Argument:

The claimant argues that the respondent failed to satisfy its burden of proof with respect to the untimely appeal defense. The claimant notes that the underlying theme in the respondent's defense is that the argument of non-compliance is reserved to insurers and unavailable to providers. The claimant also argues that the respondent's argument lacks fundamental elements of due process and notice.

The claimant argues that the respondent's arguments relating to its Decision Point Review Plan ("DPRP") are an affirmative defense, and therefore the respondent bears the burden of satisfying each of the elements necessary to enjoy the preclusive effects.

The claimant argues that notice must be affirmatively proven. The claimant argues that in addition to proving the existence and applicability of the DPRP, a party asserting a failure to appeal or untimely appeal affirmative defense must also show actual notice of the DPRP appeal requirements by the party seeking to be paid. Specifically, *N.J.A.C.* 11:3-4.7, titled "Decision point review plans", requires an insurer to supply "providers" with a copy of the DPRP "upon notice of a claim". *N.J.A.C.* 11:3-4.7(c)(3).

The claimant argues that this regulation requires the carriers to "distribute" the information in its DPRP and this rule is not permissive and specifically excludes the carrier's right to impose penalties when not in compliance with the regulation terms.

The claimant argues that simply stated, without actual notice of ALL of the DPRP appeal requirements, a provider, such as the claimant in the instant matter, simply cannot know the proverbial "rules of the game" for the appeal requirements as set forth in the DPRP. See *Jersey Shore Ambulatory Surgery Center a/s/o NJM*, #1324143, wherein DRP Tamburino held reference on EOB to DPRP was insufficient, and insurer was required to actually supply DPRP for preclusive effect to apply.

The claimant argues that it is axiomatic, wide variances exist among the various insurers in the State of

New Jersey regarding the appeal requirements. Accordingly, before an insurer such as the respondent can enjoy the preclusive effects of a deficient appeal affirmative defense, they must show that the insurer actually knew of those requirements.

The claimant argues that it is disturbing that the carrier seeks to impose a technical non-compliance defense in the appeal process, without ever establishing its basic requirement of Due Process or Notice in compliance with a DOBI regulation directly on point.

It is not disputed that DOBI amended the appeal process effective 4/17/17. See *N.J.A.C.* 11:3-4.7B. This streamlined appeal process requires only one appeal per issue. Further, in the post service context the regulation only requires service of an appeal 45 days prior to initiating arbitration. *N.J.A.C.* 11:3-4.7B(g).

The claimant argues that therefore, the respondent's only basis for arguing an untimely appeal which otherwise complies with the regulation arises from a perceived requirement which only exists in its DPRP.

The claimant argues again that it is the carrier's mandated requirement to affirmatively "distribute" the plan information if it seeks to enforce any associated penalties.

The claimant argues that since the respondent has failed to comply with DOBI's requirements, and has failed to establish actual notice, its argument regarding the untimely appeal should be rejected.

The claimant also argues in the alternative that it substantially complied with the respondent's DPRP and appealed the subject services prior to initiating the instant arbitration demand.

There is no dispute that the claimant actually appealed the services at issue.

The claimant argues that in the event the DRP determines there is some technical non-compliance with the respondent's DPRP, it is submitted that this technical non-compliance is not fatal to the instant claim. Specifically, under the doctrine of "Substantial Compliance" the appeal should be deemed compliant with the respondent's DPRP.

The claimant argues that any argument by the respondent regarding technical non-compliance asks the DRP to ignore their non-compliance and equates to a "form over substance" argument. This concept which has been rejected by the courts when applying equitable concepts when dealing with technical non-compliance in the PIP reimbursement context. See a *PruPac v. Greenberg*, 2002 WL 32829046.

The claimant argues that consistent with Judge Villanueva's holding that substance should trump form when dealing with technical non-compliance, the Appellate Division enunciated the doctrine of "substantial compliance" in *Medeiros v. O'Donnell & Naccarato*, 347 N.J. Super. 536 (App. Div. 2002).

In *Medeiros*, the Appellate Division was confronted with a technical non-compliance with a preclusive statute, in that case the Affidavit of Merit statute. The *Medeiros* court held the following factors should be considered when evaluating the applicability of the doctrine of Substantial Compliance:

> (1) the lack of prejudice to the defending party; (2) a series of steps taken to comply with the statute involved; (3) a general compliance with the purpose of the statute; (4) a reasonable notice of petitioner's claim, and (5) a reasonable explanation why there was not a strict compliance with the statute. Id. at 543.

The claimant argues that as to the first factor, the respondent cannot credibly claim any prejudice by the delay in the appeal. The fact remains that despite the fact the claimant was not provided actual notice of the DPRP, the claimant nevertheless still provided the respondent notice of the claim and an opportunity

to cure prior to initiating the instant matter.

The claimant also argues that the second factor was satisfied since the claimant undertook steps to comply with the requirement by submitting a written appeal forty five (45) days prior to initiating arbitration, which is consistent with the actual mandate of the regulation.

The claimant proffers that the purpose of the policy requiring appeal, as embodied in the third factor, is to provide a carrier notice of a potential claim and a period to cure prior to incurring the additional penalties associated with the arbitration process. The claimant argues that this purpose was met, since the respondent was afforded an opportunity to review the claim before the arbitration was filed.

The claimant again notes that the respondent has had reasonable notice of the claim, since it received the appeal and chose not to respond. The claimant submits that it should not be penalized for the respondent's inability to understand and apply the law to these facts correctly.

Finally, the claimant argues that perhaps most importantly, the fifth factor involves a reasonable explanation for the technical non-compliance. The simple fact is that the non-compliance was a direct result of the respondent's failure to provide its DPRP to the claimant.

Respondent’s Argument:

The respondent argues that the claimant’s untimely appeal bars this action. The respondent notes that assignments in PIP are governed by *N.J.S.A*. 39:6A-4, which provides: "Benefits under this section shall (2) [n]ot be assignable, except to a provider of service benefits under this section in accordance with policy terms approved by the commissioner."

The respondent notes that University Hospital was sent the revised Progressive Decision Point Review Plans on 4/14/17 and 11/3/17. On 9/7/17 University Hospital was sent the Explanation of Benefits. The post service appeal was submitted on 9/6/18, one year after the "adverse decision."

The respondent notes the DOBI Order A17-103, pursuant to *N.J.A.C.* 11:3-4.7, indicates that all internal appeals shall be initiated using the forms developed by the DOBI. Insurers were required to submit new DPRPs to conform to the order. The order directs that additional information and guidance can be found in the FAQ's on the DOBI website:

> Q: How will the April 17, 2017 operative date of the new internal appeals rule be implemented?
>
> A: The Department believes that the rule should apply to new pre-service and post-service appeals that are submitted on or after April 17, 2017. Appeals that are already in progress, including second level appeals, would continue under the insurer's old system. This would result in all appeals being handled consistently in accordance with the regulation from 04/17/2017 going forward. This will be less confusing for providers and insurers and is consistent with how the effective date of other changes to DPR plans have been handled by the Department.

The respondent argues that the appeal of 9/6/18, as a post service appeal was not timely under the approved DPRP and a failure to comply with the DPRP voids any assignment.

The respondent notes that any and all assignments of benefits shall become void and unenforceable under the following conditions:

> 5. a health care provider does not comply with the "Dispute Resolution" provision in Part II of the policy and in [Progressive's] approved Decision Point review Plan, including utilization of the Internal Appeal Process.

Post-Service Appeals

> As a condition precedent to filing arbitration or litigation, a provider who has accepted an assignment, or any insured person, must submit a PIP Post-Service Appeal form to appeal any and all disputes subsequent to the performance or issuance of services, including, but not limited to, any claims for unpaid medical bills for medical expenses and for unpaid services not authorized and/or denied in the decision point review and precertification process. The request must specify the issue(s) contested and provide supporting documentation. In order to be considered valid, a post-service appeal under this section must be submitted within one hundred eighty (180) days of service of the adverse decision and at least forty-five (45) days prior to initiating arbitration or litigation.

The respondent argues that a failure to comply with the internal appeals time requirement bars recovery. The respondent cited a prior PIP award to support this position.

The respondent again proffers that the post service appeal was non-compliant with the DPRP and Forthright Decisions must comply with the Policy/DPRP Plan Assignments in PIP are governed by *N.J.S.A*. 39:6A-4, which provides: "Benefits under this section shall (2) [n]ot be assignable, except to a provider of service benefits under this section in accordance with policy terms approved by the commissioner."

Progressive's Decision Point Review plan was revised in accordance with the DOBI requirements as set forth in Order A17-103. The internal procedure was designed to have a "rapid review" of the insurer's decision. See: Department of Banking and Insurance comments to *N.J.A.C.* 11:4.7 (at page 26): "It is reasonable that users of the system be encouraged to attempt to resolve disputes directly with the insurer before initiating costly ADR or court proceedings."

The respondent also notes that Rule 20 of the Forthright rules of arbitration provides that the award "shall be in accordance with New Jersey law and the applicable policy provisions." The insurance policy must be enforced by the DRP. The respondent cites *Open MRI a/s/o Carmen Hernandez v Mercury Insurance*, 421 N.J. Super. 160 (N.J.Super.A.D.2011).

The respondent also notes that the language in the DPRP as to the conditions of assignment (requiring compliance with the DPRP and appeals provisions) comes directly from and duplicates the policy of insurance approved by DOBI and issued by Progressive. Likewise, the Assignment of Benefits provision of the DPRP comes directly from and duplicates that of the Progressive policy. The respondent notes that Decision Point Review letters were sent to University Hospital on 4/14/17 and 11/3/17.

The respondent also notes that deference is to be given to DOBI's actions in approving the policy and plan. The respondent notes that the claimant challenges the approved DPRP requirements (and by extension the approved policy conditions). We accord "great deference" to an agency's interpretation of the statutes within the scope of its authority, and the agency's adoption of rules that implement those statutes. *N.J. Soc'y for the Prevention of Cruelty to Animals v. N.J. Dep't of Agric*., 196 N.J. 366, 385 (2008). *New Jersey State League of Municipalities v Dept of Community Affairs*, 158 N.J. 211 (1999).

The respondent notes that in the field of insurance, the expertise and judgement of DOBI is to be given great weight for the purpose of determining whether DOBI's actions are valid and reasonable. The burden is on the party challenging an administrative agency's action to overcome the presumption that the actions by the agency are valid and reasonable. *N.J. Coalition v DOBI*, 323 N.J. Super. 207 (1999). The place to do that is not in Forthright arbitration.

The respondent also argues that the claimant has failed to present any explanation as to why there was no timely compliance with the appeal provisions of the plan. Rather, the appeal was profoundly

untimely. The delay wholly fails to promote timely resolution of claims, which is a key component in No Fault (See: *N.J.S.A*. 39:6A-1). In *DiFrancisco v. Chubb*, 283 N.J. Super 601 (App. Div. 1995), the court notes how delays result in a material dilution of the insurer's rights."

The respondent also argues that claimant's counsel has inaccurately relies upon *N.J.A.C.* 11:3-4.7. A full reading of the section indicates that it defines the elements of a Decision Point Review Plan. The full plan, submitted to DOBI for approval, is to include numerous items, including copies of the informational letter and information as to how it is to be distributed to providers and policyholders.

The regulation addresses the materials to be submitted to DOBI in order to have the plan approved.

The respondent argues that here, the amended DPRP informational letter was submitted to the provider, who was put on notice of the amended internal appeals requirements. Additionally, the EOB sent to claimant cites the appeal requirement and provides access to the Decision Point Review Plan informational letter.

The respondent concludes that as a result of the above, the claimant has failed to comply with the conditions of assignment and therefore lacks standing to bring this action.

Analysis and Decision:

N.J.A.C. 11:3-4.7(c) provides in pertinent part:

A decision point review plan filing shall include the following information:

…

> 3. copies of the informational materials described in (d) below and an explanation of how the insurer will distribute information to policyholders, injured persons and providers at policy issuance, renewal and upon notification of claim.
>
> …
>
> 6 An internal appeals procedure that permits the provider to provide additional information and have a rapid review of a decision to modify or deny reimbursement for a treatment or the administration of a test;
>
> …
>
> 7 Reasonable restrictions on the assignment of benefits pursuant to *N.J.A.C.* 11:3-4.9(a)"

N.J.A.C. 11:3-4.7provides:

> (d) the Informational materials for policyholders, injured persons and providers shall be on forms approved by the Commissioner and shall include at a minimum the information in (d) 1 through 9 below…
>
> 8. An explanation of the alternatives available to the provider if reimbursement for a proposed treatment, diagnostic test or durable medical equipment is denied or modified, including insurer internal appeal procedures and how to use it;…

N.J.A.C. 11:3-4.9 provides in pertinent part:

> "…insurers may file for approval policy forms that include reasonable procedures for restrictions

on the assignment of personal injury protection benefits, consistent with the efficient administration of the coverage. Insurers may not prohibit the assignment of benefits to providers. Reasonable restrictions may include, but are not limited to:

1. A requirement that as a condition of assignment, the provider agrees to follow the requirements of the insurer's decision point review plan for making decision point review and precertification requests;

2. A requirement that a condition of assignment, the provider shall hold the insured harmless for penalty co-payments imposed by the insurer based on the provider's failure to follow the requirements of the insurer's Decision Point Review Plan; and/or

3. A requirement as a condition of assignment, the provider agrees to submit disputes to alternate dispute resolution pursuant to *N.J.A.C.* 11:3-5.

On 10/28/2010 DOBI Commissioner Thomas Considine issued Bulletin 10-30. Addressed to all New Jersey private passenger automobile insurers and motorbus insurers and the National Arbitration Forum, this document reads in pertinent part:

> "Use of Insurer's Internal Appeals Process prior to filing for arbitration: A number of DRPs have stated that there is no authority in statute, the Administrative Code or in case law that would permit the insurer to bar providers from access to the statutorily created dispute resolution process based upon the failure of the provider to comport with what one DRP described as, "the unexplained terms and conditions of an internal appeals process established by, shaped by, managed by and governed by the respondent carrier." These DRPs have described the internal appeal process as an "arbitrarily determined procedure." Other DRPs have opined that the only "penalty" permitted by the Decision Point Review plan is a penalty deductible, not denial of a payment for a claim. Still other DRPs have decided that it is "unreasonable" to dismiss a provider's demand for arbitration for failure to submit an internal appeal within the required time frames in the insurer's Decision Point Review Plan.
>
> "These arguments are contrary to the whole purpose of the appeals process and the Department's rules. In N.J.A.C. 11:3-4.9(a)1, the Department permits insurers, as part of an insureds' assignments of benefits to providers, to require the providers to comply with all requirements of the Decision Point Review plans. Moreover, N.J.A.C. 11:3-4.7(c)6 requires insurers' Decision Point Review plans to contain an internal appeals process and such plans may require that the internal appeals process be exhausted prior to the initiation of PIP arbitration. These limited restrictions on the assignment of benefits do not deny payment of a claim or prohibit a provider from accessing the statutorily mandated external dispute resolution process. They merely establish a prerequisite for doing so. It is only reasonable and logical for insurers to require that, before using the expensive and lengthy external dispute resolution process, an insured or a provider under assignment should first utilize the insurer's internal appeals process. The internal and external appeal processes established by the Department for health care follow this pattern. Thus, where a provider agrees in an Assignment of Benefits to follow the requirements of the Decision Point Review plans, the provider also agrees to comply with the insurer's internal appeals process contained therein, and with any penalties imposed in the plan for failure to comply with the internal appeals process."

In addition, effective 4/17/17, N.J.A.C. 11:3-4.7B sets forth certain standards to which all internal appeal procedures must abide. In pertinent parts, that regulation indicates:

> (b) Insurers shall only require a one-level appeal procedure for each appealed issue before making a request for alternate dispute resolution in accordance with N.J.A.C. 11:3-5. That is, each issue shall

only be required to receive one internal appeal review by the insurer prior to making a request for alternate dispute resolution. An appeal of the denial of a medical procedure, treatment, diagnostic test, other service, and/or durable medical equipment on the grounds of medical necessity is a different issue than an appeal of what the insurer should reimburse the provider for that same service.

(c) All appeals shall be initiated using the forms established by the Department by Order in accordance with N.J.A.C. 11:3-4.7(d) and posted on the Department's website.

(d) The appeal forms and any supporting documentation shall be submitted by the provider to the address and/or fax number designated for appeals in the insurer's DPR Plan. Pursuant to N.J.A.C. 11:1-47, insurers may permit electronic filing of appeals by providing the process for electronic filing in its DPR Plan.

(e) There shall be two types of internal appeals:

1. Pre-service: Appeals of decision point review and/or precertification denials or modifications prior to the performance or issuance of the requested medical procedure, treatment, diagnostic test, other service and/or durable medical equipment (collectively known as "services"); and

2. Post-service: Appeals subsequent to the performance or issuance of the services.

…

(f) A pre-service appeal shall be submitted no later than 30 days after receipt of a written denial or modification of requested services.

(g) A post-service appeal shall be submitted at least 45 days prior to initiating alternate dispute resolution pursuant to N.J.A.C. 11:3-5 or filing an action in Superior Court.

(h) Decisions on pre-service appeals shall be issued by the insurer to the provider who submitted the appeal no later than 14 days after receipt of the pre-service appeal form and any supporting documentation.

(i) Decisions on post-service appeals shall be issued by the insurer to the provider who submitted the appeal no later than 30 days after receipt of the appeal form and any supporting documentation."

In applying the above, it is first noted that the respondent is permitted to have an appeal procedure and place reasonable restrictions on an assignment of benefits. It is also noted that the provisions of *N.J.A.C.* 11:3-4.7(c) include the requirements that:

A decision point review plan filing shall include the following information:

…

3. copies of the informational materials described in (d) below and an explanation of how the insurer will distribute information to policyholders, injured persons and providers at policy issuance, renewal and upon notification of claim.

In reviewing the evidence submitted, it is noted that the respondent's DPRP was not placed into evidence.

It is also noted that specifically, the DPRP's provisions regarding how the informational materials described in *N.J.A.C.* 11:3-4.7 (d) will distribute information to policyholders, injured persons and providers at policy issuance, renewal and upon notification of claim has not been submitted.

However, it is also noted that there is no evidence that the respondent's DPRP was not approved.

Based on the above, the question remains, were the respondent's notices of the DPRP appeal requirement sufficient.

Firstly, there is no evidence that the patient was notified of the DPRP appeal requirements upon notification of the claim.

Secondly, the respondent's first 2 notices to the claimant of its new DPRP were sent to the claimant, not in relation to any claim, but as a general notice that the provisions of the DPRP requirements had changed. The letters to the claimant hospital were generic letters and were not sent in regard to this patient or in relation to any specific claim. It is hard to imagine how the claimant would identify which patients are affected by this notice and there is no evidence that the hospital had an identification process in place to identify all claims to a certain carrier.

It is additionally noted that neither of these letters were sent at policy issuance, renewal or upon notification of claim.

Based on the above, it is determined that the notice of the DPRP changes contained in the above cited letters is not sufficient notice to the claimant regarding the appeal requirements.

The only other notice to the claimant is on the EOB. It is noted that the notice on the EOB states:

> *Appeal Language:*
>
> Any provider with an assignment of benefits must comply with the Internal Appeal process in our Decision Paint Review Plan before seeking alternate dispute resolution (which includes filing a Demand for Arbitration with Forthright). This applies to any determination of decision point review, precertification of treatment, or any reduction applied in connection with the payment of medical expenses. Details are set forth in our Decision Point Review Plan. If you need a copy of the Decision Point Review plan, please contact Progressive at 1-855-243-1331.

The respondent argues that upon receipt of the above notice the clock starts on the right to appeal, which right expires in 90 days.

With regard to post service appeals, the Administrative Code does not contain a deadline that starts on receipt of an adverse determination. The only time limit for post service appeals in the Administrative Code is that appeals are to be submitted at least 45 days prior to initiating alternate dispute resolution pursuant to *N.J.A.C.* 11:3-5 or filing an action in Superior Court.

The 45 day requirement was complied with in this case.

The 90 day requirement is solely derived from the respondent's DPRP.

In reviewing the EOB notice, it is determined that this reference to the appeal process i.e. that a provider must comply with the DPRP before filing a Demand with Forthright, does not place the provider on notice that a time limitation had begun to run.

The gist of the notice is that the provider must comply with the DPRP before filing. This notice does not

place the provider on alert that, in addition to the 45 day requirement in the Administrative Code, there is another shorter deadline which must be adhered to or the right to file an arbitration or court case will be waived.

Additionally, the respondent has not established that this notice was approved by DOBI as being sufficient notice, when DOBI approved the DPRP.

It is also noted that with regard to the claimant's substantial compliance argument, this respondent was given sufficient time to address the appeal prior to the claimant filing this arbitration and the respondent has not established that it was prejudiced.

Based on the above, it is determined that the claimant's Assignment of Benefits is upheld and the claimant is entitled to proceed in this matter.

It is also noted that both counsel in this case have presented their clients' positions effectively and argument of both counsel was persuasive, making this a difficult decision. The completeness and professionalism displayed by both counsel is appreciated.

Award:

For the reasons set forth above, the claimant is awarded: $41,471.08

(Bill of $59,472.00 minus the respondent's EOB payment and co-pay deductible credit)

Attorney Fee and Costs:

I find the claimant to be the prevailing party and award attorney fees and costs. The claimant has submitted a Certification of Services and respondent argued that the hourly rate and number of hours listed were excessive and that any award of fees and costs is subject to applicable case law and regulations.

The Certification of Services submitted by claimant's counsel has been reviewed and Respondent's argument that the fees sought by claimant's counsel are excessive has been taken into consideration, as well. *N.J.A.C.* 11:3-5.6 provides that "an 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." This is also in accordance with Forthright Rule 22.

Further, in determining the amount of the attorney fee I have also considered the relevant factors in *Enright v. Lubow*, 215 N.J. Super. 306 (App. Div.), certif. den. 108 N.J. 193 (1987) and *Scullion v. State Farm Insurance Company*, 345 N.J. Super 431 (App. Div. 2001) and RPC 1.5. Consideration has been given, but not limited to, the novelty and difficulty of the questions involved, the skill requisite to perform the legal services properly, the fees customarily charged in the locality for similar legal services, the amount involved and the results obtained, as well as the experience, reputation and ability of the lawyer performing the service. In applying these factors, I conclude that an attorney's fee of $1,550.00 is consonant with the Amount Awarded; reflects a "lodestar" calculation as required in N.J.A.C. 11:3-5.6(e); and, is generally in keeping with the guidelines of RPC 1.5 and the Appellate Division's decisions in *Enright v. Lubow*, 215 N.J. Super. 306, 313 (App. Div.), certif. den. 108 N.J. 198 (1987) and *Scullion v. State Farm*, 345 N.J. Super. 431 (App. Div. 2001); and, therefore, appropriate and reasonable in this case. Costs of $228.90 are also awarded.

Therefore, the DRP ORDERS:

Disposition of Claims Submitted

1. Medical Expense Benefits: Awarded

Medical Provider	Amount Claimed	Amount Awarded	Payable To
University Hospital	$41,472.00	$41,471.08	University Hospital

The awarded amounts are subject to:
Deductibles
Co-payments
Policy limits

2 . Income Continuation Benefits	Not in Issue	
3 . Essential Services Benefits	Not in Issue	
4 . Death Funeral Expense Benefits	Not in Issue	
5 . Award of Interest	Awarded	Amount to be calculated by Respondent pursuant to N.J.S.A. 39:6A-5.2g

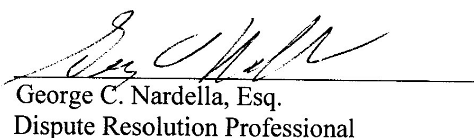
Attorney's Fees and Costs

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

Cost:$ 228.90 Attorney's fees:$ 1,550.00

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

Entered in the State of New Jersey



George C. Nardella, Esq.
Dispute Resolution Professional

Date:08/14/19