In the Matter of the Arbitration between

Ridgewood Diagnostic Laboratory a/s/o K. A.

CLAIMANT(s),

v.

Progressive Insurance Company
RESPONDENT(s).

Forthright File No: NJ1812001819381
Proceeding Type: In-Person
Insurance Claim File No: 16-1152806
Claimant Counsel: Midlige Richter
Claimant Attorney File No: 401.0012
Respondent Counsel: Cooper Maren Nitsberg Voss & Decoursey
Respondent Attorney File No:
Accident Date: 10/02/2016

Award of Dispute Resolution Professional

Dispute Resolution Professional: Joseph J. Riva 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: 01/22/2020

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:

None

Findings of Fact and Conclusions of Law

This arbitration arises out of an automobile accident that occurred on 10/02/16. On that date, KA (patient) was an insured of Progressive Insurance Company (respondent) and eligible to receive personal injury protection (PIP) benefits when he suffered injuries because of the accident.

On 03/14/18, the patient underwent toxicology screening at Ridgewood Diagnostic Laboratory (claimant). Claimant took an assignment of patient's claim for PIP benefits. After a dispute arose regarding those benefits, claimant commenced this proceeding, seeking reimbursement from respondent of $4,786.20 with interest for unpaid medical expense benefits together with counsel fees and costs.

The reimbursement claim is laid out in the Arbitration Summary submitted by claimant.

The issues identified by the parties, confirmed by counsel at the arbitration hearing, and presented for my consideration are: (1) whether claimant lacks standing by failing to comply with the Internal Appeals Process (IAP) in respondent's Decision Point Review Plan (DPRP); (2) if not, whether the toxicology screening was medically necessary and causally related to the accident; (3) if so, whether claimant established its usual, customary and reasonable (UCR) rates for the screening; and (4) counsel fees and costs.

The parties did not present any other issues. They agreed that only the issues presented would be decided. For that reason, I have not considered nor decided any other issues.

The parties submitted a number of documents in support of their respective positions for my review, including:

- Claimant's *Demand for Arbitration* with attachments,
- Claimant's 12/04/18 corrected *Demand for Arbitration*,
- Claimant's response to request for MRO report with attachments,
- Claimant's 06/04/19 submission with attached Attorney Fee Certification and Exhibits A through E,
- Claimant's additional 06/04/19 submission with attachments,
- Respondent's *Statement of Response*,
- Respondent's request for MRO report,
- MRO report of Dr. Jennifer Yanow dated 03/15/19, and
- Respondent's 06/03/19 submission with attached Exhibits A through L.

I have carefully reviewed all of the parties' submissions and considered the arguments of counsel advanced at the hearing. Any issue previously raised but not identified at the hearing is deemed abandoned.

As a starting point, it suffices to note that this arbitration was consolidated with *Princeton Surgiplex LLC a/s/o KA v. Progressive Insurance Company*, NJ1753001 (Forthright, Feb. 18, 2020); *Accelerated Rehab and Pain Management a/s/o KA v. Progressive Insurance Company*, NJ1768716 (Forthright, Feb. 18, 2020); *Accelerated Surgical Center a/s/o KA v. Progressive Insurance Company*, NJ1844576 (Forthright, Feb. 18, 2020); and *Barnert Surgical Center a/s/o KA v. Progressive Insurance Company*, NJ1851651 (Forthright, Feb. 18, 2020).

IAP

An insurer's DPRP shall include "[a]n 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 . . . ." *N.J.A.C.* 11:3-4.7(c)(6). Furthermore, a DPRP shall include "[r]easonable restrictions on the assignment of benefits pursuant to *N.J.A.C.* 11:3-4.9(a) . . . ." *N.J.A.C.* 11:3-4.7(c)(7).

In *Coalition for Quality Health Care v. N.J. Dep't of Banking & Ins.*, 348 *N.J. Super.* 272, 314-17 (App. Div. 2002), the court upheld the approval by the Department of Banking and Insurance (DOBI) of insurers' policy provisions that imposed reasonable restrictions on the assignment of PIP benefits to providers. As to what constitutes reasonableness, the court relied on *N.J.A.C.* 11:3-4.9, which specifically states that "[i]nsurers 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." This regulatory provision provides:

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 as 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.

Additionally, *N.J.A.C.* 11:3-4.7(d)(8) requires that informational materials for policy holders, injured persons and providers shall include "[a]n explanation of the alternatives available to the provider if reimbursement for a proposed treatment, diagnostic test or durable medical requirement is denied or modified, including the insurer's internal appeals process and how to use it . . . ."

DOBI has recently clarified the use of the IAP. In *Bulletin* 10-30, the Commissioner reiterated that an insurer may require a provider to comply with its IAP prior to filing a *Demand for Arbitration*. Specifically, the Commissioner, among other things, stated:

> It is only reasonable and logical for insurers to require that, before using the expensive and lengthy external dispute process, an insured or a provider under assignment should first utilize the internal appeals process . . . . Thus, where a provider agrees in an Assignment of Benefits to follow the requirements of the Decision Point Review plan, 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.

Here, patient assigned to claimant his right to receive PIP benefits. By doing so, respondent argues that claimant agreed to be subject to the DPRP requirements and in failing to comply with the IAP in its DPRP prior to filing the *Demand for Arbitration*, the Assignment of Benefits (AOB) executed by patient was rendered null and void, thereby depriving claimant of standing.

That said, effective 04/17/17, new IAP requirements found at *N.J.A.C.* 11:3-4.7B provide:

> (a) The internal appeal procedure in an insurer's Decision Point Review Plan (DPR Plan) shall meet the requirements in this section.
>
> (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:
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> 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.

As a result of the new IAP requirements, respondent amended its DPRP and provided claimant with a copy of it on 11/03/17. The amended DPRP, in relevant part, states:

Post-Service Appeals

As a condition precedent to filing an 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-and-eighty (180) days of service of the adverse decision and at least forty-five (45) days prior to initiating arbitration or litigation. A response to the post-service appeal request shall be made not later than thirty (30) days after receipt of the appeal and all supporting documentation. In addition, all requests for post-service appeal must include, as the cover page, a fully completed PIP Post-Service Appeal form, which is available at http://www.state.nj.us/dobi/pipinfo/aicrapg.htm#protocol. The PIP Post-Service Appeal form must be faxed to **us** at **877-213-7258**. **We** shall neither accept nor respond to post-service appeals that are sent to any other physical address, fax number, or email address. Only requests for post-service appeals under this paragraph will be accepted at this fax number. Do not submit any other type of correspondence or request to this fax number.

In accordance with and subject to the requirements of N.J.A.C. 11:3-4.7(B)(b), **we** will require only one appeal for each issue appealed.

Per the IAP effective November 2017, post-service appeals are required to be filed within 90 days of the adverse decision. This change was highlighted in the notice to claimant, which states:

November 3, 2017

Effective 11/8/2017, there is a change to Progressive Medical Protocols Decision Point Review Plan that will affect how claims are handled under Part II – Personal Injury Protection (PIP) Coverage of our policy. The enclosed Decision Point Review/Precertification Plan replaces any prior plans that your facility is currently following for patients being treated under Progressive's Decision Point Review Plan.

Decision point review does not apply to emergency care or to care occurring within the first 10 days of the accident. For your convenience, we have included a copy of the Decision Point Review/Precertification Plan. We recommend you review Progressive's Decision Point Review Plan in detail. The following outlines the material changes to the new DPR.

. . .

- Post-service appeals must be submitted within 90 days of service of the adverse decision to be valid.

Additionally, claimant was provided notification of the IAP within the Explanation of Benefits (EOB), which states:

Appeal Language:

Any provider with an assignment of benefits must comply with the Internal Appeal Process in our Decision Point 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.

Here, respondent denied reimbursement for the toxicology screening, as evidenced by an EOB dated 04/19/18. Respondent argues that claimant's post-service appeal should have been submitted within 90 days of the EOB. Although 90 days from this date was 07/18/18, the post-service appeal was not submitted until 09/27/18 – 161 days after the requisite time for DPR compliance.

My difficulty with respondent's argument is that claimant submitted a post-service appeal on 09/27/18 in

response to respondent's 07/30/18 (EOB). As such, this appeal was within 90 days. While it is true that claimant's post-service appeal was not submitted within 90 days from the prior 04/19/18 EOB, the proofs do not show that claimant received that specific EOB – only the 07/30/18 EOB.

Medical Necessity/Causality

The burden of establishing entitlement to PIP benefits is on the claimant. *Langley v. Allstate Insurance Company*, 206 *N.J. Super.* 365, 368 (App. Div. 1985). In order for medical expenses resulting from injuries sustained in an automobile accident to be compensable, claimant must prove by a preponderance of the credible evidence that they are both reasonable and medically necessary. *Paul v. Ohio Casualty Company*, 196 *N.J. Super.* 286, 295 (App. Div. 1984) *certif. denied* 99 *N.J.* 228 (1985). In addition, claimant has the burden of proving by a preponderance of the credible evidence that the treatment was proximately caused by the particular accident. *Bowe v. New Jersey Manufacturers Insurance Company*, 367 *N.J. Super.* 128, 138-139 (App. Div. 2004).

The applicable medical necessity regulatory provisions and legal principles are well known. The regulatory definition of the phrase "medical necessity" is set forth in *N.J.A.C.* 11:3-4.2 as follows:

> '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:
>
> 1. 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;
>
> 2. The treatment of the injury is not primarily for the convenience of the injured person or provider; and
>
> 3. Does not include unnecessary testing or treatment.

The phrase "clinically supported" is defined in *N.J.A.C.* 11:3-4.2 as follows:

> 'Clinically supported' means that a health care provider prior to selecting, performing or ordering the administration of a treatment or diagnostic has:

1. Personally examined the patient to ensure that the proper medical indications exist to justify ordering the treatment or test;

2. Physically examined the patient including making an assessment of any current and/or historical subjective complaints, observations, objective findings, neurological indications and physical tests;

3. 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

4. Recorded and documented these observations, positive and negative findings and conclusions on the patient's medical records.

The question of whether medical treatment is necessary is initially decided by the patient's treating physician, and an objectively reasonable belief in the utility of a treatment or diagnostic method based on credible and reliable evidence of its medical value is enough to qualify the expense for PIP purposes. *Thermographic Diagnostics v. Allstate*, 125 *N.J.* 491, 512 (1991). The treating physician enjoys wide discretionary latitude in determining the extent of treatment needed for a particular patient in that it is not unusual to witness a genuine dichotomy of medical opinion as to the type and extent of treatment needed for a particular injury. *Elkins v. New Jersey Mfrs. Ins. Co.*, 244 *N.J. Super.* 695, 701 (1990); *Miskofsky v. Ohio Cas. Ins. Co.*, 203 *N.J. Super.* 400, 410 (Law Div. 1984). As a result, when there is a conflict in the opinions of the medical experts regarding a patient's treatment or condition, the treating physician's objectively reasonable belief should be accorded greater weight. *Mewes v. Union Building & Construction Company*, 45 *N.J. Super.* 88, 94 (App. Div. 1957).

Guided by these regulatory provisions and legal principles, respondent relies on the 03/15/18 MRO report of Dr. Jennifer Yanow who found the toxicology screening performed on 03/14/18 – the day before her MRO report – to be casually related to the accident only if the medication being prescribed was different than the medication prescribed prior to the injury. Dr. Yanow also found the patient to have reached maximum medical improvement from a pain management standpoint noting there is "absolutely" no further treatment beyond June of 2017 required for this injury other than office visits if the patient is receiving medication as a result of the accident.).

In response, claimant notes the patient was involved in the 10/02/16 accident wherein he was the restrained driver of an automobile, which was struck by another vehicle. He sought emergency room care following the accident and subsequently developed neck and low back pain. He underwent conservative treatment, as well as multiple injections, in an effort to obtain pain relief.

With regard specifically to the medical necessity of the toxicology screening, claimant argues that before prescribing pain medication or performing pain management sedation/anesthesia, it is necessary to have the patient undergo toxicology screening. In support of this argument, claimant relies on Dr. Irfan Alladin's 03/14/18 Letter of Medical Necessity for Toxicology Screening, which states:

Initial toxicology testing will establish a baseline for the individual patient and identify any recent ingestion of prescription medication as well as potential adverse drug interactions. It is important that a new patient that requires a prescription for medication isn't taking other prescriptions in conjunction with what the doctor could potentially recommend. Toxicology screening is an essential tool in arriving at correct diagnosis and formulating treatment plans for pain management patients as well as those undergoing anesthesia and sedation. It is my medical opinion that these toxicology screenings are medically necessary and are consistent with the recently passed legislation by Governor Christie expanding the NJ Prescription Monitoring Program (NJPMP) which sets forth mandatory look up requirements for new and current patients under certain circumstances including access to NJPMP on a quarterly basis during the time a patient continues to receive a prescription for a Schedule II CDS.

Also, as noted by claimant, in 2016, the United States Department of Health and Human Services Centers for Disease Control and Prevention (CDC) issued "Guidelines for Prescribing Opioids for Chronic Pain." According to claimant, these guidelines provide:

> Experts agreed that prior to starting opioids for chronic pain and periodically during opioid therapy, clinicians should use urine drug testing to assess for prescribed opioids as well as other controlled substances and illicit drugs that increase risk for overdose when combined with opioids, including nonprescribed opioids, benzodiazepines, and heroin. There was some difference of opinion among experts as to whether this recommendation should apply to all patients, or whether this recommendation should entail individual decision making with different choices for different patients based on values, preferences, and clinical situations. While experts agreed that clinicians should use urine drug testing before initiating opioid therapy for chronic pain, they disagreed on how frequently urine drug testing should be conducted during long-term opioid therapy. Most experts agreed that urine drug testing at least annually for all patients was reasonable. Some experts noted that this interval might be too long in some cases and too short in others, and that the followup interval should be left to the discretion of the clinician. Previous guidelines have recommended more frequent urine drug testing in patients thought to be at higher risk for substance use disorder (30). However, experts thought that predicting risk prior to urine drug testing is challenging and that currently available tools do not allow clinicians to reliably identify patients who are at low risk for substance use disorder

Similarly, The American Association for Clinical Chemistry (AACC) has published "Laboratory Medicine Practice Guidelines-Using Clinical Laboratory Tests to Monitor Drug Therapy in Pain Management Patients."

According to claimant, the AACC stated the scope and purpose of the guideline was to compile an evidence based recommendations for the use of Laboratory and Point-of-Care (POC) urine drug tests for relevant over the counter medications, prescribed and non-prescribed drugs, and illicit substances in pain management patients.

The AACC created three "Tiers" of drug testing for pain management patients. Tier one testing was for routine monitoring of patients. Tier two testing was appropriate for high risk patients with a known history of abuse, risky poly-pharmacies, multiple providers, or if the patient shows lack of efficacy or toxicity. Tier three testing was a clinically indicated.

Initially, the AACC noted "Laboratory testing is more effective than other physician tools for the detection of relevant over-the-counter, prescribed, and non-prescribed drugs, and illicit substances in pain management patient and should be used routinely to monitor compliance." Accordingly, the AACC's consensus based expert opinion number 1 is that baseline drug testing should be performed prior to initiation of acute or chronic controlled substance therapy a minimum of one to two times per year even for low risk (Tier one) patients!

The AACC noted POC testing can provide immediate results for the provider. However, POC immunoassays have lower sensitivity and specificity than definitive assays performed in a laboratory. Specifically, the AACC noted "false negative results remain problematic" with point of care assays.

As such, the AACC considers laboratory mass-spectrometry testing the "gold standard." Regarding definitive testing, the AACC stated these tests significantly reduce the risk of false negative results due to their higher quality. As such, definitive testing was recommended by the AACC.

Furthermore, in its expert opinion number 1, the AACC concluded in addition to baseline testing, random drug testing should be performed at a minimum of at least one to two times a year even for low risk (Tier one) pain management patients.

Where there is a dispute as to PIP benefits, the burden rests on the claimant to establish by a preponderance of the evidence; that is, the greater weight of the credible evidence, that the services for which PIP payment is sought were reasonable, medically necessary and causally related to an automobile accident. *Miltner v. Safeco Ins. Co. of America*, 175 *N.J. Super.* 156 (Law Div. 1980). While it is true the treating 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.

Having considered the arguments of counsel in light of the record and applicable regulatory provisions and legal principles, I conclude that claimant has proven by a preponderance of the credible evidence

that the 03/14/18 toxicology screening was medically necessary and causally related to the accident. In reaching this conclusion, I find persuasive Dr. Alladin's 03/14/18 Letter of Medical Necessity for Toxicology Screening, as well as the national authorities cited by claimant.

Regarding causality, I note that Dr. Yanow's 03/15/18 MRO report states that "[t]he toxicology screening performed on 3/14/2018 would only be related if the medications being prescribed were different than the medications prescribed prior to the injury." In fact, there is no evidence that the patient was prescribed medications prior to the 10/02/16 accident. It, therefore, follows that the prescribed medications were causally related to the accident.

UCR

The charges at issue are not codes for which a fee is established by the New Jersey PIP Medical Fee Schedules. Where a CPT code does not appear on the fee schedules, the limit of what an insurer must pay is set forth in *N.J.A.C.* 11:3-29.4(e), which provides that "the insurer's limit of liability for any medical expense benefit for any service or equipment not set forth in or not covered by the fee schedules shall be a reasonable amount considering the fee schedule amount for similar services or equipment in the region where the service or equipment was provided. . . ." *N.J.A.C.* 11:3-29.4(e) further provides that "[w]here the fee schedule does not contain a reference to similar services or equipment. . . , the insurer's limit of liability for any medical expense benefit for any service or equipment not set forth in the fee schedules shall not exceed the usual, customary and reasonable fee."

That said, the Department of Banking and Insurance (DOBI) has not defined a UCR fee, even though referenced in public comments. Accordingly, what is considered a UCR fee is often, as here, disputed between a provider and PIP insurer.

It is well settled that when the code is not contained in the medical fee schedules, the claimant bears the burden of presenting evidence that it billed in accordance with UCR charges in the geographical region. In *Cobo v. Market Transition Facility*, 293 *N.J. Super.* 374, 386 (App. Div. 1996), citing 24 *NJR* 1348 (April 6, 1992), the court instructed:

> The provider, in submitting the billings, makes the initial determination as to what his or her usual, customary and reasonable fee is. It is incumbent on the insurer, based on his experience with the particular provider or other providers in the region, to determine whether, in fact, the usual, customary and reasonable fee has been billed.
>
> . . .

> Thus, the scheme envisions that the health care provider will set its own customary fee, not the insurer or insurer's auditor. But, at the same time, the insurer has a mandate to review the provider's bills to ensure that it has billed at its customary and reasonable rate.

Cobo defines the standard of reasonableness. In determining the reasonableness of a medical provider's fee, *Cobo* instructed us to consider such factors as (1) the subject provider's billing history, (2) disparity in charges to different insurance carriers and (3) what other providers are charging for the service. *Id.* at 387.

Following *Cobo,* through amendments to the fee schedule, DOBI spelled out the process for how a UCR fee is to be calculated. As DOBI pointed out in *Bulletin No. 10-30,* dated 10/28/10, *N.J.A.C.* 11:3-29.4(e)(1) "clearly states that the provider is to submit his or her usual and customary fee for the service and it is the insurer, not the provider, that is to determine reasonableness." Such a procedure conforms to *Cobo. See In Re Adoption of N.J.A.C. 11:3-29 by the State of New Jersey, Department of Banking and Insurance,* 410 *N.J. Super.* 6, 43 (App. Div. 2009).

Beyond its determination that *N.J.A.C.* 11:3-29.4(e)(1) conformed to *Cobo,* the court observed:

> The new provision allows the insurer to consult with a national database for help in determining the reasonableness of the fee. Such a procedure will provide more protection against arbitrary determinations to the providers. Nevertheless, if a provider disagrees with the insurer's determination, the provider has the option of filing for arbitration. *N.J.S.A.* 39:6A-5.1. There is accountability and meaningful review.
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> [*Id.* at 43.]

Even though *N.J.A.C.* 11:3-29.4(e)(1) states that '[the] insurer may use national databases of fees, such as those published by Ingenix . . . or Wasserman . . . to determine the reasonableness of fees for the provider's geographic region or zip code," the reliability of the Ingenix database (not the Wasserman database) was confronted with a legal challenge. In response, the court enjoined the use of the Ingenix database in determining UCR pending further review by DOBI. *Ibid.*

Subsequently, DOBI undertook a review of the Ingenix database and concluded in *Order A10-113* dated 08/26/10 that the Ingenix MDR database can be used by insurers to determine the reasonableness of fees that are not on the fee schedule.

What's more, *N.J.A.C.* 11:3-29.4(e)1, effective 01/04/13, provides:

> For the purposes of this subchapter, determination of the usual, reasonable and customary fee means that the provider submits to the insurer his or her usual and customary fee by means of explanation of benefits from payors showing the provider's billed and paid fee(s). The insurer determines the reasonableness of the provider's fee by comparison of its experience with that provider and with other providers in the region. National databases of fees, such as those published by Ingenix (www.ingenixonline.com), FAIR Health (www.fairhealthus.org) or Wasserman (http://www.medfess.com/), for example, are evidence of the reasonableness of fees for the provider's geographic region or zip code. The use of national databases of fees is not limited to the above examples. When using a database as evidence of the reasonableness of a fee, the insurer shall identify the database used, the edition date, the geozip and the percentile.

Considering claimant's burden of proof, I conclude by a preponderance of the credible evidence that the amounts set forth in respondent's Arbitration Summary are sufficiently supported by the record evidence and, in particular, the FAIR Health database.

Accordingly, I award claimant reimbursement of $4,044.20 rather than the $4,786.20 sought by claimant.

Counsel Fees and Costs

Claimant's counsel seeks counsel fees in the amount of $2,437.50 together with costs of $228.90. Respondent objects to such an award with particular opposition to both the total number of hours billed (7.5) and the hourly billing rate ($325.00). It is respondent's position that the counsel fee requested is excessive and not consonant with the amount at issue.

In *New Jersey Coalition for Healthcare v. DOBI*, 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." The courts have construed *Rule* 4:42-9(a)(6), which allows for an award of counsel fees "in an action upon a liability or indemnity policy of insurance in favor of a successful claimant," to permit an award of attorney's fees and judicial actions brought under the PIP statute.

I find the claimant was successful and is entitled to an award of counsel fees.

In *Enright v. Lubow*, 215 *N.J. Super.* 306 (App. Div.), *cert. denied*, 108 *N.J.* 193 (1987), the court identified the factors to be considered in deciding whether to award attorney's fees, including 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 insurer's conduct as it contributes substantially to the need for litigation, the general conduct of the parties, and the totality of the circumstances. As the court pointed out in *Scullion v. State Farm*, 345 *N.J. Super.* 431 (App. Div. 2001), while the *Enright* factors are to be considered in making the threshold determination as to whether to award counsel fees, many of those factors are equally applicable in determining the amount of counsel fees to be awarded. The court in *Scullion* clearly suggests that the proper determination of the amount of counsel fees to be awarded requires a line by line analysis of the various certifications of services to determine whether hours expended by counsel or excessive for what appeared to be routine efforts.

I have carefully reviewed the line item entries in the PIP Arbitration Attorney Fee Certification submitted by claimant's counsel. In doing so, I have applied the principles set forth in *Litton Industries, Inc. v. IMO Industries, Inc.*, 200 *N.J.* 372 (2009) for determining the lodestar for legal fees as well as for determining whether it should be enhanced or reduced. I have also carefully considered the arguments advanced by counsel. I am mindful of the fact that any amount awarded as counsel fees must be consonant with the amount at issue. I find that an award of counsel fees in the amount of $1,100 is consonant with the amount at issue and consistent with the requisites of *R.P.C.* 1.5 as well as with the degree of effort, expertise and experience required for a successful prosecution of this claim. I also award costs in an amount of $225.00, representing the filing fee, the only costs for which evidence has been presented.

Therefore, the DRP ORDERS:

Disposition of Claims Submitted

1. Medical Expense Benefits: Awarded

Medical Provider	Amount Claimed	Amount Awarded	Payable To
Ridgewood Diagnostic Laboratory	$4,786.20	$4,044.20	Ridgewood Diagnostic Laboratory

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:$ 225.00 Attorney's fees:$ 1,100

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

Entered in the State of New Jersey

Joseph J. Riva, Esq.
Dispute Resolution Professional

Date:02/18/20