In the Matter of the Arbitration between

Shore Orthopaedic Group a/s/o M.A.
CLAIMANT(s),

v.

State Farm Indemnity Company
RESPONDENT(s).

Forthright File No: NJ1901001827699
Proceeding Type: In-Person
Insurance Claim File No: 30-0471-S74
Claimant Counsel: Midlige Richter
Claimant Attorney File No: 190.1833
Respondent Counsel: Gregory P. Helfrich & Associates
Respondent Attorney File No: 16-19SUMM06695
Accident Date: 06/15/2017

Award of Dispute Resolution Professional

Dispute Resolution Professional: Lisa D. Mundy 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: MA

In Person Proceeding Information

A proceeding was conducted on: 07/15/2019

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:

Claimant amended its claim to reflect $155,152.00 for dates of service 7/6/18 to 5/8/19. Claimant stipulated it was paid for the office visit of 1/16/19.

Findings of Fact and Conclusions of Law

This matter stems from a motor vehicle accident that occurred on 6/15/17 in which the patient, MA is alleging injuries. On that date, MA was eligible to receive PIP benefits under an insurance policy issued by respondent. Claimant, Shore Orthopaedic Group, proceeds by way of assignment from MA.

Claimant has filed the within action seeking reimbursement of PIP medical benefits in the amount of $155,152.00 representing non-payment of medical expense benefits for dates of service 7/6/18 through 5/8/19.

At the hearing, respondent made an application for a postponement. It was noted that this case was initiated on 1/31/19 and was previously postponed by consent of the parties on or about 5/10/19. It was thus agreed that the standard for review, pursuant to Forthright Rule 41, was good cause. Respondent indicated counsel just returned from vacation. She was still waiting for UCR proofs as well as the CHN fee schedule. Also, claimant recently attempted to amend the claim to include 3 additional OVs. Respondent indicated it did not know what the defense would be for those dates. Claimant vehemently objected to this application. In an attempt to facilitate the moving forward with this case, claimant withdrew the amendment for the three office visits. Claimant argued the UCR/CHN proofs could be obtained post-hearing. Claimant also stated it would file another Demand for Arbitration to include the additional 3 dates of service. Claimant asserted respondent was aware it needed to obtain these proofs well before counsel's vacation. Claimant was not disputing the CHN contract and it had already submitted its UCR proofs. I agreed. The postponement was denied for lack of good cause. As the hearing when on, respondent's counsel indicated she would rather address amendment now as opposed to in a new arbitration. Thus, claimant re-asserted its request to amend the Arbitration Demand to include a claim for the office visits of 2/20/19, 4/3/19 and 5/8/19. Respondent requested additional time to brief its defense with regard to these additional dates. The request for post-hearing time was granted.

Further, at the hearing, claimant stipulated it received payment for the office visit and x-ray performed on 1/16/19.

In accordance with Forthright Rule 43, at the hearing, the parties raised four issues to be decided by this DRP. The parties understand that issues not raised at the time of the hearing, regardless as to whether they were raised in the parties' submissions, will not be addressed herein and are deemed waived.

Thus, the issues in dispute are as follows:

1. Compliance with Internal Appeals Process
2. Reimbursement of EMG/NCV codes
3. Reimbursement pursuant to the PPO agreement vs. UCR
4. Unbundling

Notably, in post-hearing, the issue of medical necessity for the office visits of 2/20/19 and 5/8/19 was raised and addressed by respondent.

Evidence Considered: In making my determination, I considered the following evidence submitted by the parties: claimant's Demand for Arbitration with attachments, respondent's pre-hearing submission of 4/2919 with attachments, claimant's pre-hearing submission of 5/7/19 with attachments, respondent's pre-hearing submission dated 7/2/19, respondent's post-hearing submission dated 8/8/19 with attachments and claimant's post-hearing submission dated 8/12/19 with attachments. I also considered the oral argument of the parties offered at the time of hearing.

Issue One: Compliance with Internal Appeals Process

As a threshold issue, respondent asserts claimant lacks standing to proceed with its claim for date of service 7/6/18 as it failed to comply with the carrier's mandatory Internal Appeals Process ("IAP"). Specifically, respondent argues claimant failed to file a post-service appeal for date of service 7/6/18. Respondent relies upon N.J.A.C. 11:3-4.7B in support of its position.

Claimant argues it submitted appeals for all dates of service at issue and thus, it should be afforded standing to proceed herein.

Law & Analysis

Pursuant to N.J.A.C. 11:3-4.7(c)6, a PIP 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."

Further, N.J.A.C. 11:3-4.7(c)(7) likewise provides that a DPRP shall include "[r]easonable restrictions on the assignment of benefits pursuant to N.J.A.C. 11:3-4.9(a)."

Effective 4/17/17, N.J.A.C. 11:3-4.7B. Requirements for insurer internal appeals procedures.

> (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:
>
> > 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.

Based upon the weight of the credible evidence submitted before me, the oral argument of the parties and the applicable law, I ultimately find claimant failed to comply with the internal appeal requirements as set forth in respondent's DPRP with regard to date of service 7/6/18. Here, I find respondent's argument persuasive. I have reviewed the submitted records and find the following appeals were provided for my review:

- Appeal dated 8/24/18 for DOS 7/11/18 for CPT code 99213;
- Appeal dated 10/8/18 for DOS 8/29/18 for CPT code 99213;
- Appeal dated 11/13/18 for DOS 10/4/18 for multiple CPT codes for the spinal surgery;
- Appeal dated 11/13/18 for DOS 10/4/18 for multiple CPT codes for internal spinal monitoring;
- Appeal dated 2/12/19 for DOS 1/16/19 for CPT codes 72040 and 99213; and
- Appeal dated 5/1/19 for DOS 4/3/19 for CPT code 99213.

Notably, there was no appeal provided that included date of service 7/6/18 or the EMG/NCV codes billed on that date. I therefore find claimant lacks standing to proceed with date of service 7/6/18 and is claim associated with that date are denied.

<u>Issue Two</u>: Cross-Walking EMG/NCV codes

Based upon the above findings, the issue of reimbursement of the EMG/NCV testing performed on 7/6/18 has been rendered moot and will not be addressed further herein.

<u>Issue Three</u>: Reimbursement Pursuant to PPO vs. UCR

As indicated above, the parties agree to the applicability of the PPO agreement with CHN.

Respondent submits that the CHN Fee Schedule, contained in Exhibit 2.8 of the PPO contract, calls for the lesser of the following:

1. The current Fee Schedule of CHN, samples of which are provided to Provider from time to time;
2. Any applicable state, federal, or other mandated fee schedule; or
3. The actual fees of charges of Provider.

Respondent further asserts that any award be subject to payment at the lesser of the applicable fee schedule or a discounted amount off the usual, customary and reasonable fee as stated in N.J.A.C. 11:3-29.4(a) and as required under Section 5.2 Provider Services and Obligations of the PPO contract. In particular, subsection 5.2.5 states in pertinent part that the provider shall:

> 5.2.5 submit all claims for covered Services as provided in the Provider Manual and pursuant to the Standard Terms. Provider shall accept as full payment from each Payor for the Covered Services deemed Medically Appropriate pursuant to the Utilization management Program the lesser of charges customarily charged to other patients or the consideration provided in the Fee Schedule. Provider hereby waives any amounts from any Payor and any Eligible person (i) in excess of the fees customarily charged to other patients or the amounts provided in the Fee Schedule; and (ii) any amount from any Payor or Eligible Person for services performed which

have been deemed not to be Medically Appropriate by the Utilization Management Program....

Respondent also notes that Exhibit 2.8 of the CHN PPO fee schedule made part of the amendment dated 8/14/01 states the following:

> The schedule of maximum reimbursement amounts pursuant to which Payors shall pay Provider to provide Medically Appropriate Covered Services shall be the lesser of:
>
> 1. 65% of Providers actual fees; or
>
> 2. Any applicable state, federal or other mandated fee schedule.

Thus, respondent maintains its liability is limited to 65% of the fee schedule allowance for dates of service 7/11/18 and 8/29/18. However for date of service 10/4/18, respondent argues CPT codes 22551, 22552, 22853, 20936 and 20930 are still subject to a UCR analysis. Respondent relies upon N.J.A.C. 11:3-29.4(a) in support of its position. Respondent argues that since payment under the PPO is subject to the state fee schedule and the New Jersey regulations state that a PIP carrier cannot be compelled to pay higher than the fee schedule rate or the UCR, the subject codes are still subject to a UCR analysis.

With regard to UCR, respondent argues claimant has not met its burden in establishing it billed its usual and customary rate of reimbursement for CPT codes 22551, 22552, 22853, 20936 and 20930. Respondent relies upon the Fair Health database to support its position that claimant's charges are unreasonable.

Respondent also asserts that "any award for date of service 10/4/18 should be made with a 65% of the billed charges for CPT 22551, 22552, 22853, 20936 and 20930 as follows" for date of service 10/4/18:

CPT Code	Amount Billed	65% PPO Discount Applied
22551	$68,000.00	$44,200.00
22552	$25,000.00	$16,250.00
22853	$25,000.00	$16,250.00
22853-59	$25,000.00	$16,250.00
20936	$4000.00	$2600.00
20930	$1700.00	$1105.00

Claimant does not dispute the applicability of the PPO agreement and argues that pursuant to the PPO contract, claimant is entitled to reimbursement at the rate of 65% of its billed amount. Claimant submits respondent's assertion that a UCR analysis applies to the charges for date of service 10/4/18 is both factually and legally incorrect.

Claimant asserts the PPO contract calls for payment at 65% of the billed charges, unless the CPT code is on the Horizon proprietary "fee schedule." Claimant notes this fee schedule has not been supplied. Claimant maintains that the PPO does not state that late payments should be paid at UCR rates as determined by the carrier. It is claimant's position respondent inappropriately seeks to insert PIP contextual UCR into a contract that was negotiated and agreed upon without such terms and meanings. Claimant submits that to interpret this provision as respondent suggests would be to reward respondent for breaching its agreement.

Claimant notes that DOBI has contemplated this exact issue and has stated the following:

> If providers contract to be part of a network for a certain fee, that is their usual and customary fee for that service and is the appropriate level of reimbursement.

In light of the above, claimant asserts that if a provider agrees to a network and the rates provided therein, the provider is agreeing that those rates constitute its UCR.

Notwithstanding the above, claimant also argues it has submitted sufficient evidence of its usual and customary rate of reimbursement by virtue of exemplar EOBS. Claimant further argues respondent's UCR are deficient and should be rejected. In this regard, claimant questions the reliability of Mitchell and asserts this alone is insufficient proof of a reasonable rate of reimbursement.

Law & Analysis

The validity of PPO agreements in PIP cases was expressly upheld by the Appellate Division in the case of *Seaview Orthopaedics v. N.H.R.*, 348 N.J. Super. 272 (App. Div. 2004). The court in *Seaview*, held that PPO agreements are entirely compatible with the No-Fault scheme because such contracts do not increase, but rather tend to lessen the monetary obligations of insurers and insureds and fit within the cost containment intentions of the AICRA legislation.

The Court further held that the parties were free to contract as they deemed appropriate for medical service fees that are lower than those listed in the PIP fee schedule. The Court specifically provided that Courts will not rewrite contracts to make "better deals" for the parties which they freely bargained for and voluntarily chose to make for themselves.

Based upon the weight of the credible evidence submitted before me, I find that pursuant to the contract terms, respondent is liable for reimbursement at 65% of the fee schedule allowance for codes contained in the New Jersey PIP fee schedule and 65% of the provider's billed amount for those codes not listed on the fee schedule. Here, I agree with claimant's argument and find that that a UCR analysis does not apply. The PPO contract is clear on its face and specifically contemplates a reduction in the provider's billed fees. The contract does not indicate payment is to be made with a further reduction for UCR. I find that the contract is clear on its fact and there is no ambiguity in this regard.

Issue Four: Unbundling

Respondent next argues that relative to date of service 10/4/18, clamant is not entitled to separate reimbursement for CPT code 22845 as this procedure is an inclusive component of CPT code 22853. Respondent relies upon N.J.A.C. 11:3-29.4(g) and the NCCI edits in support of its position.

Specifically, respondent argues CPT 22845 may not be reported with CPT 22853 unless the proper modifier is used. In the current matter, Claimant billed CPT 22845 with a modifier 59. Respondent argues that this modifier is not the proper modifier since the surgery at issue was performed on the cervical spine and therefore was performed on the same anatomical site during the same surgical session.

Respondent relies upon the Modifier 59 Article, which identifies correct usage as follows:

> **Distinct Procedural Service:** Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation

must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

> **Note:** Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25."

> Modifier 59 and other NCCI-associated modifiers should NOT be used to bypass a PTP edit unless the proper criteria for use of the modifier are met. Documentation in the medical record must satisfy the criteria required by any NCCI-associated modifier that is used.

It is respondent's position that in accordance with the NCCI edits, the primary purpose of the -59 modifier is to indicate that two or more procedures are performed at different anatomic sites or different patient encounters. It should only be used if no other modifier more appropriately describes the relationships of the two or more procedure codes. Modifier -59 and other NCCI associated modifiers should not be used to bypass an NCCI edit unless the proper criteria for use of the modifier is met.

Claimant argues it is entitled to separate reimbursement of CPT 22845 as it was performed to a different cervical level.

Law & Analysis

N.J.A.C. 11:3-29.4(g)1 provides as follows:

> 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/. Modifier 59 and other NCCI-associated modifiers should not be used to bypass an NCCI edit unless the proper criteria for use of the modifier are met. Documentation in the medical record must satisfy the criteria required by any NCCI-associated modifier used. Form more information on the criteria for the use of modifiers, see the NCCI Policy Manual and Modifier 59 Article referenced in (g) above.

NCCI code pair edits are automated prepayment edits that prevent improper payment when certain codes are submitted together for Part B-covered services. The NCCI edits provide that if a provider submits two codes of an edit pair together, the Column 1 code is eligible for payment and the Column 2 code is not. However, the edits also provide that if both codes are clinically appropriate and the NCCI-associated modifier is used, both codes are eligible for payment.

In this matter, I find respondent's argument persuasive and agree that CPT 22845 was inappropriately billed with the -59 modifier. The submitted evidence supports respondent's contention that this procedure was performed by the same physician, at the same patient encounter on the same anatomical region (cervical spine). I am not persuaded by claimant's position that a different cervical level constitutes a different anatomical region for modifier purposes.

Accordingly this portion of claimant's Demand is denied.

Issue Five: Medical Necessity

It is respondent's position that the office visits of 2/20/19 and 5/8/19 were not medically necessary.

Respondent asserts that office exam date of service 2/20/19 was properly denied as not medically necessary pursuant to an MDR dated 3/29/19 by Dr. Sean Lager.

Likewise, respondent further asserts that the office exam of 5/8/19 was not medically necessary pursuant to the orthopedic IME of Dr. Wayne Kerness dated 3/15/19. Dr. Kerness found normal ranges of motion and negative orthopedic testing. Dr. Kerness diagnosed the patient with cervical radiculopathy despite being post cervical decompression surgery and with a lumbar sprain.

Claimant argues all treatment was clinically supported as medically necessary. Claimant relies upon the submitted records and provides a detailed analysis regarding MA's care up through the cervical surgery of 10/4/18, which was approved by respondent.

Claimant submits MA reported some stiffness in the weeks immediately following surgery but felt there was overall improvement. Dr. Glastein recommended physical therapy. MA continued to see Dr. Glastein monthly for post-surgical re-evaluation as well as treatment of the lumbar spine.

<u>Law & Analysis</u>

Where there is a dispute as to medical necessity, the burden rests on the claimant to establish that the services for which he seeks PIP payments were reasonable, necessary and causally related to an automobile accident. See *Miltner v. Safeco Ins. Co. of Am.,*175 N.J. Super. 156. The claimant has the burden of proof to a preponderance of the evidence. See *State v. Seven Thousand Dollars*, 136 N.J. 223 (1994).

Pursuant to N.J.A.C. 11:3-4.2, "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 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 and treatment.

Pursuant to N.J.A.C. 11:3-4.2, "clinically supported" means that a health care provider prior to selecting or ordering the administration of a treatment or diagnostic test has: (1) Personally examined the patient to insure 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, neurologic 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 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 reimbursement. See*Thermographic Diagnostics, Inc. v. Allstate Ins. Co.*, 125 N.J. 491 (1991).

The Care Paths identify typical courses of intervention. 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. Treatments must be based on patient need and professional judgment. Deviations may be justified by individual circumstances, such as pre-existing conditions and/or comorbidities. N.J.A.C. 11:3-4.10. 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 because 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.

Based upon the evidence presented, the oral argument of the parties and applicable law, I find that claimant has overcome its burden of establishing the medical necessity of the three office visits of 2/20/19, 4/3/19 and 5/8/19. I have reviewed the submitted medical records and find Dr. Glastein sufficiently documented the patient's persistent lower back pain with correlating positive clinical findings upon examination. It appears this patient was undergoing periodic follow-up visits pending insurance approval for lumbar surgery. I find these visits clinically supported as medically necessary.

Conclusion

Based on the above findings, claimant is awarded **$96,980.24**. This Award is made subject to the New Jersey fee schedule as well as any remaining patient co-pay/deductible if applicable.

I find that Claimant was successful and is entitled to an award of counsel fees and costs.

Rule 22 of the New Jersey No-Fault PIP Arbitration Rules provides that the costs of the proceedings shall be apportioned by the DRP and the Award may include attorney's fees for a successful claimant in accordance with N.J.A.C. 11:3-5.6(e). N.J.A.C. 11:3-5.6(e) provides as follows:

(e) Pursuant to N.J.S.A. 39:6A-5.2(g), the costs of the proceedings shall be apportioned by the DRP and the award may include reasonable attorney's fees for a successful claimant in an amount consonant with the award. Where attorney's fees for a successful claimant are requested, the DRP shall make the following analysis consistent with the jurisprudence of this State to determine reasonable attorney's fees, and shall address each item below in the award:

1. Calculate the "lodestar," which is the number of hours reasonably expended by the successful claimant's counsel in the arbitration multiplied by a reasonable hourly rate in accordance with the standards in Rule 1.5 of the Supreme Court's Rules of Professional Conduct.

i. The "lodestar" calculation shall exclude hours not reasonably expended;

ii. If the DRP determines that the hours expended exceed those that competent counsel reasonably would have expended to achieve a comparable result, in the context of the damages prospectively recoverable, the interests vindicated, and the underlying statutory objectives, then the DRP shall reduce the hours expended in the "lodestar" calculation accordingly; and

iii. The "lodestar" total calculation may also be reduced if the claimant has only achieved partial or limited success and the DRP determines that the "lodestar" total calculation is therefore an excessive amount. If the same evidence adduced to support a successful claim was also offered on an unsuccessful claim, the DRP should consider whether it is nevertheless reasonable to award legal fees for the time expended on the unsuccessful claim.

2. DRPs, in cases when the amount actually recovered is less than the attorney's fee request, shall also analyze whether the attorney's fees are consonant with the amount of the award. This analysis will focus on whether the amount of the attorney's fee request is compatible and/or consistent with the amount of the arbitration award. Additionally, where a request for attorney's fees is grossly disproportionate to the amount of the award, the DRP's review must make a heightened review of the "lodestar" calculation

described in (e)1 above.

Supreme Court's Rules of Professional Conduct.

Further, Rule 1.5 of the Supreme Court's Rules of Professional Conduct provides that a lawyer's fee shall be reasonable. The factors to be considered in determining the reasonableness of a fee include the following: (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.

In *Enright v. Lubow*, 215 N.J. Super. 306 (App. Div. 1987), the court set out seven basic factors to be included in the determination to award attorney's fees: (1) the insurer's good faith in refusing to pay the claim; (2) the excessiveness of plaintiff's demands; (3) the bona fides of the parties; (4) the insurer's justification in litigating the issues; (5) the insured's conduct as it contributes substantially to the need for litigation; (6) the general conduct of the parties; and (7) the totality of the circumstances. Id at 313. See also *Scullion v. State Farm Ins. Co.,*345 N.J. Super. 431 (App. Div. 2001). More specifically, the factors I considered in determining the reasonableness of the attorney fee were the time and labor required, the skill requisite to perform the legal service properly, the fee customarily charged in the locality for similar legal services, the amount involved and the results obtained.

Counsel for claimant has submitted a Certification of Services seeking a counsel fee of $2991.40 representing 8.5 hours at $325.00 per hour and costs of $228.90. Counsel for Respondent has objected to the number of hours billed and the hourly billing rate. I have reviewed the Certification of Services and find that an award of $1400.00 is consonant with the award, Rule 1.5 and the applicable case law. This amount reflects a reduction in both hourly rate and time spent. I also award costs of $228.90 representing costs associated with filing the Demand for Arbitration.

Therefore, the DRP ORDERS:

Disposition of Claims Submitted

1. Medical Expense Benefits: Awarded

Medical Provider	Amount Claimed	Amount Awarded	Payable To
Shore Orthopaedic Group	$155,152.00	$96,980.24	Shore Orthopaedic Group

The awarded amounts are subject to:
Deductibles
Co-payments
Medical fee schedule

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

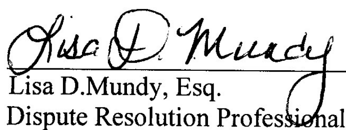
Attorney's Fees and Costs

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:$ 1400.00

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

Entered in the State of New Jersey



Lisa D.Mundy, Esq.
Dispute Resolution Professional

Date:09/13/19