In the Matter of the Arbitration between

Professional Orthopaedic Associates a/s/o F. S.

CLAIMANT(s),

v.

Plymouth Rock Assurance of New Jersey
RESPONDENT(s).

Forthright File No: NJ1902001831664
Proceeding Type: In-Person
Insurance Claim File No: 663901509639
Claimant Counsel: Midlige Richter
Claimant Attorney File No: 200.0145
Respondent Counsel: Law Office of Patricia A. Palma
Respondent Attorney File No: 663901509639WAF
Accident Date: 05/04/2017

Award of Dispute Resolution Professional

Dispute Resolution Professional: Sylvia A Hebron 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: FS

In Person Proceeding Information

A proceeding was conducted on: 08/09/2019

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:

None

Findings of Fact and Conclusions of Law

In rendering this decision I have reviewed the pre-hearing submissions of the parties and I have considered the oral arguments of the parties on 8/9/19.

FACTS

FS was involved in an automobile accident on 5/4/17 from which she suffered bodily injuries. Subsequent to the accident, FS sought treatment with claimant and was eventually referred for cervical discectomy and fusion at C4 through T1. At the time of the accident she was eligible to receive personal injury protection benefits ("PIP") under a policy of insurance issued by High Point, respondent herein. Claimant now alleges improper denial of requested surgery and has instituted this action pursuant to a valid Assignment of Benefits.

ISSUES

1) Whether or not requested cervical surgery is medically necessary and for injury causally related to the subject accident.

No other issues were identified by the parties at hearing and no other issues will be addressed herein.

ANALYSIS

Claimant argues FS initially presented to Dr. Cohen on 6/15/17 due to neck pain with radiation down the right arm and low back pain which had been persistent for five weeks. Physical examination documented findings which included posterior cervical tenderness, pain with axial compression and positive Spurling's maneuver on the right. Dr. Cohen's assessment was of acute cervical and lumbar strains and adjacent level 1 degeneration above a previous fusion which was aggravated by the subject accident. A course of physical therapy was recommended.

Claimant notes FS' history of cervical discectomy and fusion at C5-6 and C6-7 in 2003 in addition to prior lumbar disc herniation.

Claimant argues FS presented for follow up evaluation on 8/3/17 at which time she reported only minimal improvement in her neck, right arm and low back pain with physical therapy. Claimant indicates positive objective findings on physical examination of 8/24/17 were consistent with those previously documented. Dr. Cohen's assessment was of adjacent level degeneration on the radiograph at C4-5 above the previous C5-7 fusion. Recommendation was for continued physical therapy.

Dr. Cohen interpreted cervical MRI to reveal a solid fusion at C5-6 with a clear lucency across the C6-7 level consistent with a pseudoarthrosis; interesting luxation loss of disc at C7-T1; severe collapse of C4-5 with discoloration central foraminal stenosis secondary to disc herniation as well as osteophyte. Claimant indicates Dr. Cohen discussed treatment options of injection therapy and surgical intervention and he opined FS was a surgical candidate due to the compression, neurologic symptoms and the severe collapse.

Respondent relies upon a review performed by Dr. Lazar on 8/30/17 and a review on appeal performed

by Dr. Weintraub on 9/20/17 in support of its denial of reimbursement. Dr. Lazar reviewed the medical record and indicated emergency room x-rays noted intact surgical fusion and pre-existing degenerative changes with no acute injury. Additionally, he indicated Dr. Cohen noted normal motor, sensory and reflex exam on 6/15/17 and the 8/24/17 exam documented new symptoms of bilateral arm paresthesia and deltoid weakness. He also noted FS rejected pain management injections and he opined, given extensive degenerative cervical disc disease, the progression of the changes and associated signs and symptoms was a more likely explanation for FS' current complaints. Dr. Weintraub agreed with this assessment adding emergency room x-rays were interpreted to reveal significant degenerative changes above and below the prior fusion which was not related to the subject accident. He also noted Dr. Cohen's initial diagnosis of cervical sprain and strain.

Respondent also argues Dr. Cohen's interpretation of the cervical x-rays and MRI differed from that of the emergency room radiologist. Claimant indicates the MRI, as originally interpreted, does not note disc herniation at C4-5 or severe collapse at C4-5 or any abnormality at C7-T1.

Claimant argues FS was asymptomatic prior to the subject accident and under Bowe v. NJ Manufacturer's Ins. Co., 367 N.J. Super. 128 (App. Div. 2004), an aggravation of a pre-existing condition is all that is required for an injury to be compensable through PIP.

Pursuant to N.J.S.A. 39:6A-4, PIP benefits are afforded, without regard to negligence, liability or fault of any kind, to the named insured and members in the family residing in the household who sustain 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. Legal causation for PIP purposes requires a substantial nexus between the injury and a qualifying automobile. See New Jersey Automobile Insurance Law, 2011 Edition, Craig & Pomeroy, sec. 6:2-3.

Where there is a dispute as to the services provided, the burden rests upon the claimant to establish that the medical expenses for which it seeks PIP benefits were reasonable, necessary and causally related to the automobile accident. See Miltner v. Safeco Ins. Co. of America, 175 N.J. Super. 156 (Law Div. 1980). Pursuant to N.J.S.A. 39:6A-2(e), "medical expenses" means reasonable and necessary expenses for treatment or services as provided by the policy. Additionally, pursuant to N.J.S.A. 39:6A-2(m), "medically necessary" means that the treatment is consistent with the symptoms or diagnosis, and treatment of the injury and is not 1) primarily for the convenience of the injured person or provider and 2) is the most appropriate standard or level of service which is in accordance with standards of good practice and standard professional treatment protocols and 3) does not involve unnecessary diagnostic testing.

Further, the applicable regulations define "medically necessary" or "medical necessity" at N.J.A.C. 11:3-4.2 as the medical treatment or diagnostic test which is consistent with the clinically supported symptoms, diagnosis or indications of the injured person which is 1) the most appropriate level of service that is in accordance with the standards of good practice and standard professional treatment protocols and 2) not primarily for the convenience of the injured person or provider and 3) does not include any unnecessary testing or treatment. Finally, "clinically supported" is also explained at N.J.A.C. 11:3-4.2 as a health care provider who has, prior to selecting, performing or ordering the administration of a treatment or diagnostic test 1) personally examined the patient to ensure that the proper medical indications exist to justify ordering the treatment or test and 2) physically examined the patient. . .and 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.

Bowe v. NJ Manufacturers, 367 N.J. Super 128 (App. Div. 2004) stands for the proposition that a plaintiff seeking PIP benefits must prove, by a preponderance of the evidence, that the treatment for which she seeks reimbursement was proximately caused by the particular automobile accident triggering coverage under her policy. In reviewing the Bowe decision, I note that the Court opined that a carrier may assert as a defense to a PIP claim that the treatment for which the insured is seeking benefits is exclusively related to a pre-existing injury or condition. When this defense is raised, the insured has the burden of proving that the treatment at issue is causally linked to either (1) an aggravation of that injury or condition, or (2) a new injury independent of that pre-existing injury or condition. In either case, the treatment must have resulted from the particular automobile accident triggering coverage.

After reviewing the medical evidence and the arguments of the parties as well as the standard of medical necessity as outlined above, I find that claimant has proven by a preponderance of the evidence that the treatment at issue is for injury causally related to the subject motor vehicle accident and is medically necessary. The clinical examinations revealed clinically supported symptoms, indications and diagnoses that support the requested treatment including upper extremity motor strength and trace weakness in the deltoids. To the extent the physical examination findings of respondent's doctors conflict with the treating physician's examination findings, I afford deference to the treating provider.

My review of the medical record gives me no reason to believe FS was symptomatic with cervical complaints prior to the subject accident. I note in Bowe, the record demonstrated the patient, Ms. Bowe, had been treating with chiropractic for injuries sustained in an automobile accident which had occurred two years prior to the automobile accident which was the subject of the Bowe case. Further, she told the treating orthopedic surgeon the onset of her lower back pain began only two weeks prior to her initial visit in November 1997 which she attributed to the accident that occurred in February 1997 (the subject accident). When he testified at trial, the treating orthopedist revealed he had not reviewed a MRI taken in connection with the 1995 motor vehicle accident and it was also revealed he had not reviewed any of the medical records in relation to that accident which showed Ms. Bowe had been treating with a chiropractor for head, neck, back and chest pain, with pins and needles in the arms and numbness in the fingers. Bowe, 367 N.J. Super. 128. In the present matter, Dr. Cohen was aware of the prior cervical surgery. Additionally, there is no evidence of cervical complaints and/or treatment after the previous cervical surgery and prior to the time of the subject accident. Dr. Cohen described the relevant finding set forth on the 8/11/17 MRI as "severe collapse of C4-5 discoloration central foraminal stenosis secondary to disc herniation as well as osteophyte". There is no evidence that the natural progression of FS' degenerative condition would have occurred so precipitously had the subject accident not occurred. I am persuaded by the arguments and a preponderance of the evidence set forth that FS' cervical injury was either a new injury or an exacerbation of her degenerative condition which was asymptomatic prior to the subject accident. Pursuant to Bowe, an insured need only establish an exacerbation of a pre-existing injury or condition to prove causality. Accordingly, the requested treatment is awarded.

CONCLUSION

Claimant is awarded its request for cervical decompression surgery and fusion at C4 through T1. **Any issues regarding billing, coding, treatment frequency or other administration of claimant's bills are not the subject of the instant arbitration and shall be addressed at a later date if they should arise.**

Based upon a review of the arguments of the parties and the evidence submitted, I find claimant a successful claimant entitled to attorney's fees. Therefore, attorney's fees are awarded as outlined pursuant to Rule 22 of the New Jersey No-Fault PIP Arbitration Rules, effective April 1, 2011, administered by Forthright and the PIP Alternate Dispute Resolution Rules as amended on May 1, 2017;

N.J.S.A. 39:6A-5.2(g) and N.J.A.C. 11-3-5.6(e).

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 claimant 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 above.

Pursuant to RPC Rule 1.5(a), a lawyer's fee shall be reasonable. The factors to be considered in determining 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.

I have reviewed claimant counsel's certification of services which requests attorney's fees of $2,502.50 and costs of $228.90. Counsel requests fees based on 7.70 hours of legal work at the rate of $325.00 per hour. Respondent argues that the hourly rate and amount of hours billed are excessive.

In determining the amount of the attorney fee, I have also considered the principles set forth in Enright v. Lubow, 215 N.J. Super. 306 (App. Div.), certif. den. 108 N.J. 193 (1987); Litton Industries v. IMO Industries, 200 N.J. 372 (2009); Scullion v. State Farm Ins. Co., 345 N.J. Super. 431 (App. Div. 2001) and Rendince v. Pantzer, 141 N.J. 292 (1995) in determining the "lodestar" for legal fees as well as determining whether they should be enhanced or reduced. I have also considered respondent's objection to the amount of fees sought. Applying these factors, I find that an attorney's fee of $1,800.00 is consonant with the award. 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
Professional Orthopaedic Associates	$0.00	$0.00	Professional Orthopaedic Associates

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 Not in Issue

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:$ 1,800.00

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

Entered in the State of New Jersey

Sylvia A. Hebron

Sylvia Hebron, Esq.
Dispute Resolution Professional

Date:09/23/19