In the Matter of the Arbitration between

Seaview Orthopaedics a/s/o M.D.
CLAIMANT(s),

v.

Plymouth Rock Assurance of New Jersey
RESPONDENT(s).

Forthright File No: NJ1907001850683
Proceeding Type: In-Person
Insurance Claim File No: 683801579238-001
Claimant Counsel: Midlige Richter
Claimant Attorney File No: 350.1717
Respondent Counsel: Law Office of Patricia A. Palma
Respondent Attorney File No: 683801579238HCH
Accident Date: 06/02/2018

Award of Dispute Resolution Professional

Dispute Resolution Professional: Maureen M. Johnston 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: MD

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 by telephone .

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

None

Findings of Fact and Conclusions of Law

Petitioner seeks PIP reimbursement for services provided to patient MD. This patient was involved in an auto accident on June 2, 2018. As a result of the auto accident, the patient sought medical care and treated with this provider, Seaview **Orthopedics**.

The issue in the demand involves unpaid physical therapy, office visits and right shoulder arthroscopy. The issue for the carrier was medical necessity/causality.

Claimant position:

Claimant advises that this patient was involved in the subject accident on June 2, 2018. He was the restrained driver when rear ended by a distracted driver behind him. Claimant had immediate onset neck pain and presented to the hospital where he was treated and released. Claimant also noted that he struck his head on the headrest and felt dizziness as well as some difficulty with vision.

The patient consulted with Dr. Yalamanchili of Seaview Orthopedics and Medical Associates on June 18, 2018. The patient denied history of neck pain but noted he had been diagnosed with lower back disc problems in the past. The pain worsened since the MVA.

Claimant also advised he had struck his head on the headrest and had dizziness. Dr. Yalamanchili's examination of the neck was positive for loss of normal lordosis with tenderness and spasm. The lower back exam was also positive for tenderness and spasm and limited range of motion. The provider assessed that the claimant had suffered a new onset back pain and an aggravation of low back pain as a result of the MVA. He suggested the patient begin a program with physical therapy and massage for the neck and back. the patient was also referred to Dr. Chopra and diagnosed with a concussion. The treatment provided is not at issue herein. Claimant advises that the patient attended physical therapy regularly while being monitored by Dr. Yalamanchili. There was minimal improvement and the patient remained symptomatic. MRI studies were performed given the persistent pain.

Dr. Yalamanchili sought precertification for continued physical therapy but same was denied and the claimant's October 2018 physical therapy remains unpaid. Following the MRI, the provider noted that the cervical spine revealed disc herniation at C4-5 and C5-6 with lumbar herniation at L4-5. The provider recommended continued physical therapy and exercise. The patient returned in January 2019 for complains of neck and back pain as well as right shoulder pain. The patient was referred to pain management for consideration of injection therapy and evaluation of right shoulder pain.

The patient presented to Dr. Spagnuola for complaints of right shoulder pain on February 8, 2019. The claimant noted he had been worked up for his continued complaints of pain in the cervical spine radiating into the shoulder, but the shoulder pathology had increased. Dr. Spagnuola's examination indicated pain and weakness and testing of the supraspinatus tendon with tenderness at the AC joint positive adduction test. MRI of the right upper extremity was ordered. Claimant began therapy focusing on the right shoulder pathology as of February 2019 which was also denied by the carrier. The patient was referred to pain management specialist Meyers. Dr. Meyers concluded the patient had persistent pain which was not resolved through conservative measures. He recommended a lumbar epidural injection performed on March 19, 2019. Although the carrier had denied a conservative course of physical therapy, the epidural injection was approved.

In April 2019, the MRI of the right shoulder was reviewed and revealed significant partial thickness tear of the supraspinatus tendon approaching 50 percent consistent with bursitis and some degenerative change of the AC joint. Home exercise plan was prescribed

The claimant's symptoms continued into May 31, 2019. He recommended the claimant undergo a

diagnostic and operative arthroscopy of the right shoulder to alleviate ongoing pain symptoms. The precertification request was denied and appealed. In October 2019, there was a follow-up office visit that was denied, and the patient complained of continued worsening symptoms. He advised that the patient had a difficult time scheduling surgery because of work. On December 10, 2019, the claimant underwent the right shoulder diagnostic and operative arthroscopy with cuff tendon repair denied by the carrier.

Respondent position:

Respondent's first submission addresses the original arbitration demand of $735.00 for physical therapy to the right shoulder and re-evaluations of the neck and low back as well as for future right shoulder arthroscopy. Dr. Weintraub denied physical therapy to the shoulder based on significant amount of physical therapy that had already been undergone. The patient noted no sustained relief. Dr. Lazar denied treatment on February 1, 2019 as causally unrelated. He advises the first document to complain of shoulder pain was on January 28, 2019 more than 7 months post-accident which was inconsistent with current complaints. The provider appealed to Dr. Bowen upheld the denial considering that the shoulder complaint was remote to the accident and inconsistent with acute trauma. Dr. Strackler in February 2019 denied further therapy. This was appealed, and Dr. Dunn upheld the appeal. The denial was based on the patient being 7 months post-accident and having presented with symptoms inconsistent with an injury following acute traumatic event.

Respondent also relies on the PIP application dated July 18, 2018 revealing head, neck and back pain without mentioning the shoulder. The carrier also considers the shoulder MRI which noted fraying tendons and partial undersurface tear with degenerative changes and bursitis. Respondent denied the precertification request for the right shoulder surgery based on a lack of causality as treatment to the shoulder was already denied.

Respondent relies further on *Bowe v. New Jersey Manufacturers Insurance Company*, 367 NJ Super 128 (App. Div. 2004) advising that a claimant must prove to a preponderance of the evidence that injuries for which treatment is rendered and for which reimbursement is sought were approximately caused by the particular MVA which triggers coverage under the policy of insurance at issue.

The provider's initial evaluation indicates that the patient has new onset neck pain and aggravation of prior low back pain. In September 2018, the patient had continued complaints of improved front of the neck pain but still having pain in the back of the neck especially left sided and trapezial area. MD complained of increasing right shoulder pain in January 2019 when he was referred for shoulder consultation. In the report of February 2019, the provider advises that the patient initially noticed significant pain in his neck radiating to the shoulders and low back. He had been worked up for continuing complaints of pain in the cervical spine radiating into the shoulder but over time in multiple evaluations was advised that increasing shoulder pathology existed in addition to cervical pain. The provider's assessment was impingement syndrome of the right shoulder. The patient then went on to be treated and to have the shoulder surgery in dispute.

The adverse determination letter of February 1, 2019 advised that the documentation submitted did not substantiate the causal relationship for the shoulder surgery. It advised no examination was documented and that due to the gap in time, there is no consistent proof that the current complaints are related to the subject accident.

Law and Analysis:

The burden to establish "medical necessity" by a preponderance of the evidence lies with claimant. When the parties disagree, claimant has the burden to establish that the services for which payment is

sought were reasonable, necessary and causally related to the subject automobile accident. *Miltner v. Safeco Ins. Co. of America*, 175 N.J. Super. 156, 158 (Law Div. 1980). The medical necessity of the treatment is a subject to first be decided by the injured party's treating physician. *Id.*

Medical expenses must be both reasonable and necessary and are defined by *N.J.S.A. 39:6A-2(m)* as follows:

> 'Medically necessary' means that the treatment is consistent with the symptoms or diagnosis, and treatment of the injury (1) is not primarily for the convenience of the injured person or provider, (2) is the most appropriate standard or level of service which is in accordance with standards of good practice and standard professional treatment protocols, as such protocols may be recognized or designated by the Commissioner of Health and Senior Services or with a professional licensing or certifying board in the Division of Consumer Affairs in the Department of Law and Public Safety, or by a nationally recognized professional organization, and (3) does not involve unnecessary diagnostic testing.

"Medical necessity" is further explained 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 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.

> "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 test 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, 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.

N.J.S.A. 39:6A-4(a) provides for the payment of medical expenses in accordance with a benefit plan provided in the policy and approved by the commissioner of insurance for reasonable, necessary and appropriate treatment. According to the statute, medical treatment, diagnostic tests and services "shall be rendered in accordance with commonly accepted protocols and professional standards and practices…" *Id.* The statute goes on to state that:

> Protocols and professional standards and practices and lists of valid diagnostic tests which are deemed to be commonly accepted pursuant to this section shall be those recognized by national standard setting organizations, national or state professional organizations of the same discipline as the treating provider, or those designated or approved by the commissioner in consultation with the professional licensing boards in the Division of Consumer Affairs in the Department of Law and

> Public Safety. The commissioner, in consultation with the Commissioner of the Department of Health and Senior Services and the applicable licensing boards, may reject the use of protocols, standards and practices or lists of diagnostic tests set by any organization deemed not to have standing or general recognition by the provider community or the applicable licensing boards. Protocols shall be deemed to establish guidelines as to standard appropriate treatment and diagnostic tests for injuries sustained in automobile accidents, but the establishment of standard treatment protocols or protocols for the administration of diagnostic tests shall not be interpreted in such a manner as to preclude variance from the standard when warranted by reason of medical necessity."…

Pursuant to *N.J.A.C. 11:3-4.6(c)*, "[t]reatments that vary from the care paths shall be reimbursable only when warranted by reason of medical necessity."

The patient did have a course of care treating the neck and back primarily. Once the patient complaints were resolving to the neck, the pain appears to have continued into the shoulder. The symptoms led the provider to address the patient shoulder as there had been continued spasm and pain. MRI testing was positive for tears. There is no intervening accident or incident provided. The basis of the denial of the services was the gap in time. However, I find it reasonable based on the assessment of the provider's opinion, diagnostic results and the patient's symptomology to conclude that the shoulder services were medically necessary and reasonable. This would include the physical therapy provided.

I note that the billing submitted by the claimant was audited by the carrier and find that the surgery for the primary provider is properly billed at $11,338.37. The assistant is entitled to 17 percent of that amount or $1,927.52. In addition, patient is to be reimbursed for seven office visits at the $105.00 daily cap and two evaluations billed at $120.35 for a total of $14,241.59.

The prevailing claimant is entitled to an award of attorney fees, costs and interest to be calculated by the respondent. Fee shifting cases address the appropriate calculation and consideration of the "lodestar" - the number of hours reasonably or unreasonably 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. Depending on the evaluation of factors set forth in R.P.C. 1.5 as well as fee shifting cases, the fact finder is given discretion to adjust the fees upward or downward. *Enright v. Lubow,* 215 N.J. Super. 306 (App. Div. 1987); *Scullion v. State Farm Ins. Co.,* 345 N.J. Super. 431, 437-38 (App. Div. 2001).

I have reviewed the affidavit of services and considered the respondent's position. I award $1,300 in fees and $225 filing costs. This represents a reduction in the hourly rate and hours billed based on respondent's arguments. The fees awarded herein conform to guidelines/factors set forth in R.P.C. 1.5 as well as fee shifting guidelines expressed in case law and the DOBI regulations. Consideration has been given to the novelty and difficulty of the questions involved, the skill requisite to perform the legal services properly, the bona fides of the defenses, 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. The hourly fee must be considered reasonable based on a review of these factors. The total fee award must also be considered reasonable.

Therefore, the DRP ORDERS:

Disposition of Claims Submitted

1. Medical Expense Benefits: Awarded

Medical Provider	Amount Claimed	Amount Awarded	Payable To
Seaview Orthopaedics	$20,000.00	$14,241.59	Seaview Orthopaedics

The awarded amounts are subject to:
Deductibles
Co-payments
Payments made
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:$ 1,300

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

Entered in the State of New Jersey

Maureen M. Johnston, Esq.
Dispute Resolution Professional

Date:03/30/20