In the Matter of the Arbitration between

Seaview Orthopaedics a/s/o E. C.
CLAIMANT(s),

v.

Forthright File No: NJ1909001860825
Proceeding Type: In-Person
Insurance Claim File No: 037447419
Claimant Counsel: Midlige Richter
Claimant Attorney File No: 350.1763
Respondent Counsel: Law Offices of Styliades and Jackson
Respondent Attorney File No: 253628100
Accident Date: 05/10/2018

Liberty Mutual Insurance Group
RESPONDENT(s).

Award of Dispute Resolution Professional

Dispute Resolution Professional: Matthew J. O'Brien 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: E.C.

In Person Proceeding Information

A proceeding was conducted on: 02/13/2020

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:

Claimant's counsel amended this matter to $88,991.63.

Findings of Fact and Conclusions of Law

E.C. (hereinafter patient/injured person) was injured in a motor vehicle accident that occurred on May 19, 2018. At the time of the accident E.C. was eligible to receive Personal Injury Protection (PIP) benefits from Liberty Mutual Insurance Company (hereinafter "respondent"). Accordingly, E.C. received medical services from Seaview Orthopaedics (hereinafter "claimant"). The claimant brings this arbitration under an assignment of benefits from the patient/insured with the contention that the respondent failed to fully issue payment to the provider for services rendered to E.C. as a result of this motor vehicle accident.

In rendering this award, I have considered the following documents:

1) Claimant's Demand for Arbitration and attachments,

2) Claimant's February 10, 2020 submissions with attachments,

3) Claimant's February 20, 2020 post-hearing submission with attachments, and

4) Respondent's February 6, 2020 submissions with attachments.

Issues:

In accordance with the prehearing submissions submitted by the parties as well as the arguments raised by counsel in this In-Person hearing, the following issue(s) are in dispute herein:

1. Medical Necessity,

Analysis:

Medical Necessity:

It is well established that the burden lies with the Claimant to establish that the services for which PIP benefits are sought were reasonable, medically necessary and causally related to an automobile accident. Miltner v. Safeco Ins. Co. of Am., 175 N.J. Super. 156, 158 (Law Div. 1980). That burden must be carried by the preponderance of the evidence. State v. Seven Thousand Dollars, 136 N.J. 223 (1994).

N.J.A.C. 11:3-4.2 defining the term "medical necessity" as "meaning that the medical treatment or diagnostic test is consistent with the clinically supported symptoms, diagnosis or indications of the injured person, and ; (i) 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; (ii) the treatment of the injury is not primarily for the convenience of the injured person or the provider; and (iii) Does not include unnecessary testing and treatment." N.J.A.C. 11:3-4.2 also defines "Clinically Supported" as meaning 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 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."

N.J.A.C. 11:3-29.4 Application of Medical Fee Schedules

Liberty Mutual issued payment to Claimant for CPT code 97810 on DOS 4/19/2019-6/17/2019 pursuant to N.J.S.A. 39:6A-4.6 and the Physicians' fee schedule.

Horizon PPO Reductions

Liberty Mutual applied PPO reductions to payment for DOS 4/19/2019-6/17/2019 pursuant to Claimant's PPO agreement with Horizon Casualty Services, Inc. It is Respondent's position that all payments were properly issued in accordance with the PPO agreement and no further payments are due. Attached please find as **Exhibit B** the contract and certification between Seaview Orthopaedics & Medical Associates, LLP and Horizon Casualty Services, Inc. Likewise, Respondent has a contract with Horizon Casualty Services, Inc. The contract between Liberty Mutual and Horizon Casualty Services, Inc., is attached at **Exhibit C.**

Lack of Medical Necessity

Liberty Mutual denied CPT code 97811 for DOS 4/19/2019-5/17/2019 pursuant to an MDR Determination Rationale (MDR) report rendered on 4/25/2019 by Dr. Brian Chang DAC LAC, who found:

"*MDR Rationale:*

Pertinent symptoms and diagnostic findings/critical management process:

Precert Nurse: Chi, Eric (Acupuncture) is requesting initial tx 3x/wk x 4 wks for this 39 year old female injured in MVA 5/10/18. Referral from Dr. Keiron Greaves. Initial exam 4/19/2019 pt c/o neck pain with pain scale 1/10. Exam revealed tongue with thin white coat, dusky purple and pulse slippery.

Medical Director: E. C. is a 39 years female. Date of Loss is 5/10/18.

As of 4/25/19, 0 units of 97810 approved & 0 units of 97813 approved so far.

As of 4/25/19, 0 units of 97810 denied & 0 units of 97813 denied so far.

Pain levels 1/10

Pre-cert Nurse Comments:

Pt has had 1 month of PT on file and has treated with PM. Will pend to MDR to determine MN.

Pre-cert Nurse Rationale for MDR:

Outside generally accepted medical standards and standard professional treatment protocols

Clinical Citation:

Outside generally accepted medical standards and standard professional treatment protocols

Opinions/comments/conclusion/rationale based upon review of the submitted records:

Provider did not submit proper documentation up to medical standards showing the specific need for all requested modalities. Modalities which are not shown as needed or used will be denied. (ie.

Which acupuncture points used per code, which acupuncture point applied with e-stim)

Summary conclusion/resources/references:

Modified

Standard of care:

New Jersey Care Path Guidelines, IAMA Guidelines, Suwen, AMA (American Medical Association), AAC (American Acupuncture Council)"

Copies of Dr. Chang's MDR report and notice to the treating provider of denied services are attached as **Exhibit D**.

Liberty Mutual denied DOS 5/20/2019-6/17/2019 pursuant to an MDR Determination Rationale (MDR) report rendered on 5/23/2019 by Dr. Brian Chang DAC LAC, who found:

"*MDR Rationale:*

Pertinent symptoms and diagnostic findings/critical management process:

Precert Nurse: Clement, Ayuen (Acupuncture) is requesting a 2nd month of treatment3xwk/4wks with initial and f/u visits for this 39 year old female injured in a MVA 5/10/18. Initial office visit 4/19/19. DOE 5/10/19- pt is c/o NP into the L shoulder, L shoulder pain, pain in the LUE, and pain in the LLE. Tongue thin white

coat/dusky/purple and Pulse slippery. Pended to MDR. 99201-99203 denied ANA5 as this is an established pt.

Medical Director: EC is a 39 years female. Date of Loss is 5/10/18.

As of 5/23/19, 12 units of 97810 approved & 0 units of 97813 approved so far.

As of 5/23/19, 0 units of 97810 denied & 0 units of 97813 denied so far.

Pain levels 5/10

Pre-cert Nurse Comments:

Previous request was modified by MDR.

Pre-cert Nurse Rationale for MDR:

Unable to determine the MN for 24 units 97811 based on the documentation submitted and generally accepted medical standards and standard treatment protocols and previously denied by MDR.

Clinical Citation:

Unable to determine the MN for 24 units 97811 based on the documentation submitted and generally accepted medical standards and standard treatment protocols and previously denied by MDR.

Opinions/comments/conclusion/rationale based upon review of the submitted records:

Provider did not submit proper documentation up to medical standards showing the specific need for all requested modalities. Modalities which are not shown as needed or used will be denied. (ie. Which acupuncture points used per code, which acupuncture point applied with e-stim)

Summary conclusion/resources/references:

Standard of care:

New Jersey Care Path Guidelines, IAMA Guidelines, Suwen, AMA (American Medical Association), AAC (American Acupuncture Council)"

Copies of Dr. Chang's MDR report and notice to the treating provider of denied services are attached as **Exhibit E**.

Liberty Mutual denied DOS 7/24/2019 pursuant to an MDR Determination Rationale (MDR) report rendered on 6/24/2019 by Dr. Brian Chang DACL LAC, who found:

"*MDR Rationale:*

Pertinent symptoms and diagnostic findings/critical management process:

Precert Nurse: LAc Clement, Ayuen (Acupuncture) is requesting 3rd month of acupuncture treatment @3x/wk for this 39 years old female injured in MVA 5/10/18. IOV: 4/19/2019. Re-eval 6/14/2019 pt c/o neck pain into the shoulders 6/10, left shoulder pain 6/10, left arm pain 6/10, left finger pain 3/10, left leg pain 6/10, left toe pain 6/10.

Pt states pain HAS WORSENED. Tongue and pulse on exam.

Medical Director: E. C. is a 39 years female. Date of Loss is 5/10/18.

As of 6/24/19, 24 units of 97810 approved & 0 units of 97813 approved so far.

As of 6/24/19, 0 units of 97810 denied & 0 units of 97813 denied so far.

Pain levels 3-6/10

Pre-cert Nurse Comments:

Pending tx plan to MDR for MN determination as pt previously approved for 24 sessions and is now c/o WORSENED PAIN.

Pre-cert Nurse Rationale for MDR:

Previously approved for 24 sessions and is now c/o WORSENED PAIN.

Clinical Citation:

Request exceeds Care Path Guidelines.

Opinions/comments/conclusion/rationale based upon review of the submitted records:

The patient is beyond Standard Of Care with 24 units of 97810 approved & 0 units of 97813 approved.

Summary conclusion/resources/references:

Denied

Standard of care:

New Jersey Care Path Guidelines, IAMA Guidelines, Suwen, AMA (American Medical Association), AAC (American Acupuncture Council)"

Copies of Dr. Chang's MDR report and notice to the treating provider of denied services are attached as **Exhibit F.**

Liberty Mutual denied DOS 8/15/2019-10/10/2019 pursuant to an Independent Medical Exam (IME) rendered on 7/10/2019 by Dr. Lawrence I. Barr, D.O., F.A.O.A.O., who found:

"**IMPRESSION:**

1. Cervical sprain with degenerative disc disease.

COMMENTS: The examinee had a cervical sprain. She has left arm pain. She has

degenerative disc disease. MRI report of the cervical spine dated May 16, 2018 from

Atlantic Medical Imaging reports central herniation at C4-5, C6-7 and herniation centrally to the right at C5-6. MRI report of the cervical spine dated April 51 2019 from Atlantic Medical Imaging reports somewhat limited study) mild multilevel spondylosis, most pronounced at C5~6 and C6-7, small disc protrusions contributing to mild stenosis, mild left foraminal stenosis at C3-4. CAT scan report of the cervical spine from University Radiology dated April 5, 2019 reported no acute fracture or subluxatian, mild multilevel spondylosis, most pronounced at C5-6 and C6-7. At this point, I question the need for a cervical disc replacement. She does have left arm pain. Clinically, I could not detect any radiculopathy, It my opinion, her MRI findings have actually improved from 2018 to 2019. Codes 22856, 22858, 97161, 97162 as well as 63481, 062370 and 00140000601 are not certified.

With regard to causal relationship, she had a cervical sprain. In my opinion, the MRI

findings most likely predated this occurrence. If additional records are provided, I would be happy to review those and that may alter my opinion. My opinion is held within a reasonable degree of medical probability."

A copy of Dr. Barr's IME report is attached as **Exhibit G**.

Liberty Mutual sent notice to the patient's attorney, with copy to the patient and Claimant, advising them of the IME findings and stating:

"Ms. EC had an Orthopedic surgery Independent Medical

Examination with Dr. Lawrence Barr on 07/10/2019. As a result of this

examination, the physician has determined that the cervical disc replacement

surgery is not reasonable, related or necessary."

A copy of this notice is attached as **Exhibit H**.

Thereafter, the treating provider submitted additional medical records and appeal for review. In response, Dr. Lawrence I. Barr, D.O., F.A.O.A. rendered an IME Addendum report on 8/26/2019 and found:

"I previously evaluated the examinee on July 10, 2019. I have been asked to review additional medical records and provide an addendum. This review was performed in my Cherry Hill, New Jersey, office. Additional records were personally reviewed as follows:

I reviewed an appeal by Haan Nguyen, M.D., Seaview Orthopedics, dated August 6, 2019.

Additional note dated July 26, 2019.

MRI of the cervical spine from University Radiology dated April 5, 2019 was reviewed which shows only small protrusions at C5-6 and C6-7.

MRI of the cervical spine from AMI dated May 16, 2018.

COMMENTS: When I evaluated the examinee, she had normal strength) reflexes and sensation. She did report radiating pain into her left arm, but there were no clinical signs of radiculopathy on examination. After reviewing these records, my opinion is unaltered that she is not in need of cervical spine fusion. Degenerative disc disease in itself with herniations or protrusions, or however you want to term them, is not an indication for cervical spine surgery. My opinion is held within a reasonable degree of medical probability."

A copy of Dr. Barr's IME Addendum report is attached as **Exhibit I**.

N.J.A.C. 11:3-29.4 Application of Medical Fee Schedules

Liberty Mutual would issue payment to Claimant for DOS 4/19/2019-7/24/2019 pursuant to N.J.S.A. 39:6A-4.6 and the Physicians' fee schedule.

Usual, Customary and Reasonable Rate

Liberty Mutual would issue payment for CPT codes 22856 and 22858 on DOS 10/10/2019 in accordance with the usual, customary and reasonable (UCR) rate of payment for Claimant's geographical area pursuant to N.J.A.C. 11:3-29.4(e), which provides:

> "Except as noted in (e)1 through 3 below, 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 or, in the case of elective services or equipment provided outside the State, the region in which the insured resides. When a CPT, CDT or HCPCS code for the service performed has been changed since the fee schedule rule was last amended, the provider shall always bill the actual and correct code found in the most recent version

of the American Medical Association's Current Procedural Terminology or the American Dental Association's Current Dental Terminology. The amount that the insurer pays for the service shall be in accordance with this subsection. Where the fee schedule does not contain a reference to similar services or equipment as set forth in the preceding sentence, 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.

1. 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 explanations 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.medfees.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.

2. All applicable provisions of this section concerning billing and payment apply to fees for services provided outside of New Jersey and to fees that are not on the fee schedule.

3. Codes in Appendix, Exhibit 1 that do not have an amount in the ASC facility fee column are not reimbursable if performed in an ASC and are not subject to the provision in (e) above concerning services not set forth in or covered by the fee schedules."

In Cobo v. Mkt. Transition Facility, 293 N.J. Super. 374 (App. Div. 1996), the issue of establishing a usual, customary and reasonable charge was specifically addressed. The Court held that, "it is the medical provider, not the insurance carrier, who establishes the provider's usual and customary rate." Id. at 389. An insurance carrier is to review the medical provider's fee to ensure that the charge reflects a usual and customary rate; however, the provider is entitled to its billing rate so long as it is reasonable. Id. at 386. The Cobo Court further identified factors to be utilized in determining the reasonableness of the provider's fee, including:

1. the fees charged by other providers for the subject service;
2. the provider's billing history, and
3. any disparity in billing submitted to different insurance carriers.

Id. at 387.

Respondent also references *DOBI* Bulletin No. 10-30, attached as **Exhibit J**, which specifically directs DRPs to permit insurers to determine the reasonableness of a provider's UCR rate with the use of national databases such as Ingenix consistent with Order No.: A10-113. The FAIR Health Database information showing the UCR rate for these codes for this type of provider in this region is attached as **Exhibit K**. Claimant billed well above this range, and Respondent would reimburse Claimant in accordance with the UCR rates. Respondent submits that Claimant has not met their burden of proof in establishing that the billed amounts are in accordance with the UCR rates, and thus the correct UCR amounts are those listed on the EOR attached as **Exhibit A**.

Assistant Surgeon reductions

Liberty Mutual would apply reductions to payment for CPT code 22856-80 for DOS 10/10/2019 pursuant to N.J.A.C. 11:3-29.4(f). N.J.A.C. 11:3-29.4(f) provides:

> "(f) Except as specifically stated to the contrary, the following shall apply to physician charges for multiple and bilateral surgeries (CPT 10000 through 69999), co-surgeries and assistant surgeons:

5. The eligible charge for medically necessary assistant surgeon expenses shall be 20 percent of the primary physician's allowable fee determined pursuant to the fee schedule and rules. Assistant surgeon expenses shall be reported using modifier -80, -81 or -82 as designated in CPT. When the assistant surgeon is someone other than a physician surgeon, the reimbursement shall not exceed 85 percent of the amount that would have been reimbursed had a physician surgeon provided the service. Non-physician assistant surgeon services shall be reported using modifier-AS."

Thus, Liberty Mutual would issue payment for CPT code 22856-80 at 20% of the primary physician's allowable rate.

Multiple Procedure Reduction Formula

Liberty Mutual would apply the multiple procedure reduction formula to payment for DOS 10/10/2019 pursuant to N.J.A.C. 11:3-29.4(f). N.J.A.C. 11:3-29.4(f) provides:

> "(f) Except as specifically stated to the contrary, the following shall apply to physician charges for multiple and bilateral surgeries (CPT 10000 through 69999), co-surgeries and assistant surgeons:
>
> 1. For multiple surgeries, rank the surgical procedures in descending order by the fee amount, using the fee schedule or UCR amount, as appropriate. The highest valued procedure is reimbursed at 100 percent of the eligible charge. Additional procedures are reported with the modifier "-51" and are reimbursed at 50 percent of the eligible charge. If any of the multiple surgeries are bilateral surgeries using the modifier "-50," consider the bilateral procedure at 150 percent as one payment amount, rank this with the remaining procedures, and apply the appropriate multiple surgery reductions.
>
> 2. There are two types of procedures that are exempt from the multiple procedure reduction. Codes in CPT that have the note, "Modifier -51 exempt" shall be reimbursed at 100 percent of the eligible charge. In addition, some related procedures are commonly carried out in addition to the primary procedure. These procedure codes contain a specific descriptor that includes the words, "each additional" or "list separately in addition to the primary procedure." These add-on codes cannot be reported as stand-alone codes but when reported with the primary procedure are not subject to the 50 percent multiple procedure reduction.
>
> 3. The terminology for some procedure codes includes the terms "bilateral" or "unilateral or bilateral." The payment adjustment rules for bilateral surgeries do not apply to procedures identified by CPT as "bilateral" or "unilateral or bilateral" since the fee schedule reflects any additional work required for bilateral surgeries. If a procedure is not identified by its terminology as a bilateral procedure (or unilateral or bilateral) and is performed bilaterally, providers must report the procedure with modifier "-50" as a single line item. Reimbursement for bilateral surgeries reported with the modifier "-50" shall be 150 percent of the eligible charge."

Additionally, attached please find as **Exhibit J** *DOBI* Bulletin No. 10-30 which specifically cites N.J.A.C. 11:3-29(f) in support of fact that surgical codes are subject to the multiple procedure reduction formula and that the only codes not subject to the multiple procedure reduction formula are those CPTs: 1.) that have a modifier -51 exempt; or 2.) that contain a specific descriptor that includes the words "each additional" or "list separately in addition to the primary procedure."

Thus, Liberty Mutual would issue payment for CPT code 22856 at 100% and for CPT code 22858 at

50% of the usual, customary and reasonable rates.

Claimant's counsel argued that the patient first presented to the claimant o May 15, 2018 for complaints of ion-going neck pain with radiating pain down both arms and radiating pain to both hands, Patient also had numbness and tingling diffusely in the arms and hands, Claimant's examination of claimant's cervical spine was positive for tenderness, spasming bilaterally, limited range of motion. He requested an MRI. MRI was positive for herniations at C4-5, C5-5 and C6-7. PT was recommended.

Claimant was referred to pain management specialist Dr.. Greaves for ongoing complaints. Dr. Greaves recommended cervical epidurals to decrease pain.

After the series of three epidurals, the patient returned to Dr. Nguyen for surgical consultation, Dr. Nguyen determined that the patient was a candidate for surgical consultation of an anterior cervical discectomy.

Conclusion:

In accordance with the holdings of Miltner and State, I find that the claimant has provided sufficient medical documentation to establish, beyond a preponderance of the evidence that the established that the services performed in this matter were clinically supported s medically necessary. Although the respondent issued numerous denials, I find that the claimant has walked this patient history from initial complaints of pain, physical therapy, epidural injection s and ultimately the discectomy as the patient was not improving. As such, I find that the claimant has established, beyond a burden of proof that the treatment was medically necessary. Claimant is entitled to the amended amount sought; MRI testing provided in this matter was clinically supported as medically necessary. As the claimant supported that the patient had complaints of radicular pain after multipole epidural injections and medial branch blocks were performed in the cervical and lumbar spine, and as the MRI was used to adjust claimant's treatment plan, I find the thoracic MRI to be medically necessary. I find this sin comparison the respondents denial and appeal denial. Initially although Dr. Patel finds records devoid of med back pain, it is unclear if is looking at the patient's initial chiropractic records which documented those issues. Secondly, Dr,. Patel fails to mention the epidural injections or the medical branch blocks which once performed allowed the pain in the cervical spine to present itself. As such, I find the respondent's reports to be an insufficient for denial of treatment. I find that the patient's medical records established that the cervical MRI was clinically supported as medically necessary and therefore the claimant is entitled to reimbursement in the amount sought.

Attorney's Fees and Costs:

An award of attorney's fees and costs for a successful claimant is not mandatory but lies within the discretion of the Dispute Resolution Professional in accordance with N.J.A.C. 11:3-5.6. In determining the proper amount of fees, "the most useful starting point … is the number of hours reasonably expended on the litigation multiplied by a reasonable hourly rate. HIP v. Hovnanian at Mahwah, 291 N.J. Super. 144, 157 (App. Div. 1996). The fact finder is given discretion to adjust the fees upward or downward in its discretion. Id. at 158, 160. See Enright v. Lubow, 215 N.J. Super. 306 (App. Div. 1987), cert. denied, 108 N.J. 93 (1987); Scullion v. State Farm Ins. Co., 345 N.J. Super 431, 437-438 (App. Div. 2001); Rendine v. Pantzer, 141 N.J. 292, 335-36 (1995); Scezpanski v. Newcomb Medical Center, Inc., 141 N.J. 346, 354 (1995). Fee shifting cases addresses 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 Rules of Professional Conduct.

Claimant's counsel has submitted a Certification of Services in the amount of $2,100.00 for attorney's

fees and $248.06 for filing fees and costs. The respondent disputes the amount sought by the claimant for attorney's fees, challenging the number of hours charged as well as the hourly rate billed. Based upon my review of the Certification of Services, the factors set forth in R.P.C. 1.5, the respondent's arguments as well as the fee shifting guidance provided in the case law and the new regulation, I award $1,300.00 in attorney's fees and $248.06 in costs. This award represents a reduction in the hourly rate and the hours billed. Pursuant to R.P.C. 1.5 special consideration was given to the novelty and difficulty of the question involved, the skill requisite to perform the legal services, the fees customarily charged in the locality for similar services, the amount involved, and the results obtained.

Therefore, the DRP ORDERS:

Disposition of Claims Submitted

1. Medical Expense Benefits: Awarded

Medical Provider	Amount Claimed	Amount Awarded	Payable To
Seaview Orthopaedics	$150,000.00	$88,991.63	Seaview Orthopaedics

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

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

Attorney's Fees and Costs

I find that the Claimant prevailed and I award the following costs and fees (payable to Claimant's attorney unless otherwise indicated) pursuant to N.J.S.A. 39:6A-5.2g

Cost:$ 228.90 Attorney's fees:$ 1,900.00

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

Entered in the State of New Jersey

Matthew J. OBrien, Esq.
Dispute Resolution Professional

Date:04/20/20