In the Matter of the Arbitration between

Sall Myers Medical Associates a/s/o M.V.

CLAIMANT(s),

v.

MetLife Auto & Home
RESPONDENT(s).

Forthright File No: NJ1912001876739
Proceeding Type: In-Person
Insurance Claim File No: SLL84823
Claimant Counsel: Midlige Richter
Claimant Attorney File No: 150.3865
Respondent Counsel: Chasan Lamparello Mallon & Cappuzzo, PC
Respondent Attorney File No: 13248-1838
Accident Date: 04/07/2019

Award of Dispute Resolution Professional

Dispute Resolution Professional: Vincenzo Stampone 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: M.V.

In Person Proceeding Information

A proceeding was conducted on: 04/14/2020

Claimant or claimant's counsel appeared by telephone . 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

M.V. was involved in a motor vehicle accident on April 7, 2019 from which this matter arises.

Issues in Dispute:

I. Is Claimant barred from proceeding based on alleged material misrepresentation and/or fraudulent conduct?
II. If Claimant can proceed, were the services rendered medically necessary?
III. If so, what is the proper rate of reimbursement?

The following documents were submitted for review and consideration by Claimant:

1. Demand with attachments;

2. Pre-hearing submission dated March 31, 2020;

3. Certification of Services.

The following documents were submitted for review and consideration by Respondent:

1. Pre-hearing submissions dated March 30, 2020.

I also heard the arguments of the parties.

As a result of the accident, M.V. sustained personal injuries and ultimately came under the care of Claimant Sall Myers Medical Associates who seeks $4,703.93. Claimant argues that the services were medically necessary, pre-certified and approved and that the Respondent's material misrepresentation argument is baseless. Respondent MetLife Auto & Home has denied payment stating that the treatment was denied because of material misrepresentation. It also raised medial necessity.

Material Misrepresentation

Respondent argues that the Examination Under Oath of M.V. was taken on August 20, 2019 with the aid of a Spanish-English translator and provided a copy of same as its Exhibit B. It argued that M.V. testified that she did not get examined at the hospital emergency room, that she testified she did experience pain in the neck, paid above her buttocks and sometimes right-hand numbness and that she began her therapy session prior to being seen by a physician. She noted the doctor did not speak Spanish and that she never told the doctor that her pain went down the buttocks to the hips, that there was numbness or tingling in the back of the arms/triceps, or that she had numbness and tingling into the right forearm. It argued that despite, same, there are allegedly subjective complaints of same in the treatment records and that those subjective complaints were utilized to justify treatment. It denied benefits via correspondence to Claimant and noted that the patient's sworn testimony corroborated that she did not have any radiating pain down her buttocks and denied numbness and tingling down her right arm.

Claimant counters that the Respondent's allegation is false. It argued that the transcript itself reveals that the patient indicated pain was to the right shoulder, back, arm and that the when questioned as to the pain the investigator indicated the patient pointed to the right shoulder down to the wrist. Additionally, that there was no definition of radiating pain, but the actions of the patient clearly indicted the pain was right above the buttocks at the lower back. Additionally, that the patient testified her hands falls asleep.

An insurer is justified in denying coverage when, during the investigation phase of a claim the insured

makes knowingly false statements concerning a subject that is relevant and germane to the insurer's investigation. *Longobardi v. Chubb Ins. Co.*, 121 *N.J.* 530 (1990). A misstatement is "material if when made a reasonable insurer would have considered the misrepresented fact relevant to its concerns and important in determining its course of action." *Id.* at page 542. A misrepresentation of prior accident and injury history is material in the investigation of a claim for medical benefits. Claimant's rights are no greater than those of his assignor. See *Allstate Ins. Co. v Lopez*, 325 *N.J. Super.* 268 (Law Div. 1999); *Tirgan v Mega Life & Health Ins.*, 304 *N.J. Super.* 385 (Law Div. 1970).

In *Longobardi v. Chubb Insurance Co.*, the Supreme Court held that "[f]or an insurer to void a policy because of a post-loss misrepresentation, the misrepresentation must be knowing and material." 121 *N.J.* 530, 540 (1990). The Court further held that "[a]n insured's misstatement is material if when made a reasonable insurer would have considered the misrepresented fact relevant to its concerns and important in determining its course of action." 121 *N.J.* at 542.

In *Palisades Safety & Insurance v. Bastien*, 175 *N.J.* 144 (2003), the insurer issued a policy that would have been more costly but for certain misrepresentations made by the applicant, Leonel. The misrepresentations involved an additional driver, type of driving and mileage driven. The court wrote:

> "There is no question but that Leonel made material misrepresentations to the insurer commencing with his application and continuing throughout the insurer/insured relationship. Applying the standard we announced in *Longobardi*, Leonel's misrepresentations indisputably affected assessment of the risk and the premium charged. Because Leonel shielded Paule's existence from Palisades, the insurer was unable to assess generally the underwriting costs of a second driver in the household, as well as the risks associated with the type of driving in which Paule would engage (i.e., commutation or pleasure) and usage (average miles per driver). Moreover, the company was prevented from considering specifically Paule's driving record and any relevant claims history. Thus, by denying Palisades essential information relevant to its concerns and important to its course of action, Leonel made material misrepresentations in the procurement of his automobile policy. Accordingly, Palisades was entitled to an order declaring the policy void." *Id*, at page 149.

The court concluded that denial of PIP benefits was appropriate because the fraud was intentional and resulted in a reduced premium paid for the deceptively represented risk.

A misrepresentation is material if it "naturally and reasonably influences[s] the judgment of the underwriter in making the contract at all, or in estimating the degree or character of the risk, or in fixing the rate of premiums." *Mass. Mut. v. Manzo*, 122 *N.J.* 104, 115 (1991).

Notwithstanding the indulgent view ordinarily accorded to an injured party's claim for PIP benefits, such coverage is unavailable when it is sought as part of an insured's first-party claim for benefits under his or her own policy of insurance declared void because of material misrepresentations made to the insurer. See *Palisades Safety & Insurance v. Bastien, supra*, 175 *N.J.*, at page 148.

I have reviewed the entire submissions of the parties. I find that in this matter the issue is not whether the patient forwarded a material misrepresentation in the procurement of the policy, but rather whether the patient actually provided the complaints, Respondent alleges the Claimant's services are premised upon. The Respondent arguments are based on the EUO of M.V. and it argues that same is not supported. Claimant counters that it performed all services, that the patient's testimony was supportive of the services and that three were neither material misrepresentation, nor a fraud perpetrated on the Respondent. I reviewed the EUO transcript several times. I believe the patient was answering the questions to the best of her ability, but it is also clear to me she did not recall all the specifics and it is clear to me that any inconsistencies certainly do not rise to the level to support an arguments of fraud or material misrepresentation. It was also clear to me that that there may have been some issues with either

the translator or the speed of the translation. I note the interpreter was identified as Raymond Randa, Spanish interpreter. I was not provided the credentials of the interpreter, or who provided the interpreter. Almost immediately, the interpreter was advising thatch investigator was going too fast with his questions. I note that there was no question regarding the patient's level of education. While the patient did not use words of art like radiating pain and tingling, clearly, the descriptions of the patient, as described by the Respondent's own investigator support the complaints and there is no substantiated proof of any material misrepresentation. Moreover, Respondent failed to cite to case law in support of its position. I find no proofs whatever of any material misrepresentation and find the denial based on the purported material misrepresentation unsupported and I reject same.

Medical Necessity

Respondent argued the services were not medically necessary.

Claimant argues that there is no medical necessity defense raised in support of Respondent's position and that Respondent is not relying on any report and that some services were paid. Moreover, that all services were actually pre-certified and approved. It provided a detailed recitation of the complaints, services and diagnostic tests and argues that the continued re-evaluations make it clear that the patient was improving and therefore, the treatment was medically necessary.

I have reviewed the submissions. In the interest of brevity, I will not merely recite the Claimant's submission, as it is important to note there is no defense raised by Respondent, no physician's review view and it approved the serviced in response to a pre-certification request. I have reviewed the records and Claimant has satisfied me that treatment rendered was medically necessary and Respondent has raised essentially no medical necessity defense whatsoever. I reviewed the submissions of the parties, which I note were quite voluminous and find that Claimant has failed to satisfy its burden, by a preponderance of the evidence that strapping was medically necessary. Therefore, I deny same.

I find that the Claimant has satisfied their burden in this matter with regard to the above. I award the fee schedule amount of $4,703.93 subject co co-payment and deductible.

Claimant has prevailed in this matter. *N.J.A.C. 11:3-5.6(g)* provides that "the award may include reasonable attorney's fees for a successful claimant in an amount consonant with the award." The amount of such fees, if any, is determined by multiplying only that time which was reasonably expended by a reasonable hourly rate in accordance with R.P.C. 1.5, which in turn provides for the following factors for consideration: (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. *See N.J.A.C. 11:3-5.6(e)1; R.P.C. 1.5.* Time not reasonably expended, and/or which exceeds that which competent counsel would have expended to achieve a comparable result, in consideration of damages prospectively recoverable, interest vindicated and underlying statutory objectives, shall be excluded from the calculation. *See N.J.A.C. 11:3-5.6(e).* Partial/limited success may result in a reduction of the lodestar calculation total if it is therefore deemed excessive. *See N.J.A.C. 11:3-5.6(e).* Where the requested attorney's fee exceeds the amount actually recovered, the determination as to whether the attorney's fee is consonant with the award "will focus on whether the attorney's fee request is compatible and/or consistent with the amount of the arbitration award." *See N.J.A.C. 11:3-5.6(e)2.* Attorney's fee requests grossly disproportionate with the amount of the award require a heightened lodestar calculation. *See id.*

Additionally, the Appellate Division has held that factors for consideration in awarding whether and how much, if any, attorney's fees are to be awarded "include: (1) the insurer's good faith in refusing to pay the demands; (2) excessiveness of plaintiff's demands; (3) bona fides of one or both of the parties, (4) the insurer's justification in litigating the issue; (5) the insured's conduct in contributing substantially to the necessity for the litigation on the policies, (6) the general conduct of the parties, and (7) the totality of the circumstances." *See Enright v. Lubow*, 215 N.J. Super. 306, 316 (App. Div. 1987); *see also Scullion v. State Farm Ins. Co.*, 345 N.J. Super. 431 (App. Div. 2001). Moreover, and particularly in instances in which a fee disproportionate to the amount awarded is contended to be sought, the attorney's fee certification should be carefully considered for reasonable expenditure of attorney time. *See Scullion*, 345 N.J. Super. at 442.

In light of the above considerations, including but not limited to the amount in issue, the nature of the issue and defense involved, the reasonably necessary efforts to address same, by hearing attendance, in writing, and the obtaining of proofs, and in light of *N.J.A.C. 11:3-5.6(e)*, R.P.C. 1.5, applicable case law, the above award, and the parties' positions, $1,050.00 in attorney's fees is awarded, and is consonant with the award rendered herein. Claimant is awarded $225.00 in costs. Interest is awarded.

Therefore, the DRP ORDERS:

Disposition of Claims Submitted

1. Medical Expense Benefits: Awarded

Medical Provider	Amount Claimed	Amount Awarded	Payable To
Sall Myers Medical Associates	$4,734.84	$4,703.93	Sall Myers Medical Associates

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

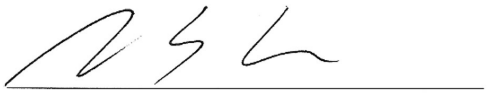
Attorney's Fees and Costs

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:$ 1,050.00

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

Entered in the State of New Jersey



Vincenzo Stampone, Esq.
Dispute Resolution Professional

Date:04/17/20