A M E R I C A N A R B I T R A T I O N A S S O C I A T I O N
NO-FAULT/ACCIDENT CLAIMS

In the Matter of the Arbitration between

(Claimant)

v.

ALLSTATE
INSURANCE COMPANY

(Respondent)

AAA CASE NO.: 18 Z 600 16950 02
INS. CO. CLAIMS NO.: 41236608072GS
DRP NAME: John J. Fannan
NATURE OF DISPUTE: MEDICAL NECESSITY, CERTIFICATION, NON-COOPERATION

AWARD OF DISPUTE RESOLUTION PROFESSIONAL

I, THE UNDERSIGNED DISPUTE RESOLUTION PROFESSIONAL (DRP), designated by the American Arbitration Association under the Rules for the Arbitration of No-Fault Disputes in the State of New Jersey, adopted pursuant to the 1998 New Jersey "Automobile Insurance Cost Reduction Act" as governed by *N.J.S.A. 39:6A-5, et. seq.*, and, I have been duly sworn and have considered such proofs and allegations as were submitted by the Parties. The Award is **DETERMINED** as follows:

Injured Person(s) hereinafter referred to as: The Patient

1. Oral Hearings were held on: August 5, 2003

2. ALL PARTIES APPEARED at the oral hearing(s).

COUNSEL FOR THE CLAIMANT appeared telephonically.

3. Claims in the Demand for Arbitration WERE NOT amended at the oral hearing as permitted by the DRP (Amendments, if any, set forth below). STIPULATIONS were not made by the parties regarding the issues to be determined (Stipulations, if any, set forth below).

4. FINDINGS OF FACTS AND CONCLUSIONS OF LAW:

This is a claim which arises out of an automobile accident which occurred on July 26, 2001 in which the patient was injured. I find that the Patient was eligible to make claim for PIP benefits pursuant to the terms and conditions of a policy of automobile insurance issued by the respondent to him.

The patient came under the care of Dr. Wesley. On August 10, 2001, Dr. Wesley prescribed the issuance of a dual channel multimode EMS unit and supplies "as needed".

The prescription was forwarded to the claimant herein, Electrical Medical Systems to be filled. Electrical Medical Systems submitted a Request for Pre-Certification of same on August 11, 2001, a request which was sent both by fax and certified mail. In a letter dated August 26, 2001, the claimant confirmed to the respondent that it had issued the durable medical equipment to the patient on August 16, 2001. It is the open and unpaid bill for this equipment as well as the supplies issued by the claimant over the course of six months ($1,214.14) which is the subject of this arbitration.

The respondent advances numerous arguments. The respondent argues the equipment has not been demonstrated to be reasonable or medically necessity, a conclusion premised on the review of the Request for Pre-Certification of same by Dr. Pumo. The respondent also argues that there was improper billing by the claimant in that it billed monthly for supplies that were issued at one time. Further, the respondent argues that the patient failed to appear for his EUO on four occasions. Finally, it is argued the claimant failed to provide certain discovery in violation of NJSA 39:6A-13(b) which requires a dismissal of the claim.

The following documents have been submitted for review and consideration:

Demand for Arbitration;
Medical Bills (HCFA Forms);
Assignment;
Statement of TENS Necessity from Dr. Wesley;
Pre-Certification Form;
Letter confirming delivery of equipment to patient;
Report of Dr. Pumo;
EOB;
Certification of Counsel for the Respondent;
Correspondence scheduling EUOs;
Exemplar Statements of TENS Necessity from Dr. Wesley for 9 different patients;
EUO Transcript of Irene Colon;
EUO Transcript of Juana Canela;
EUO Transcript of Lenduis Centeno;
Excerpt of Deposition Transcript of Chiropractor Christopher Haymes;
Request for Discovery Letter;
Certification of Services;
Report of Dr. Wesley;
MRI report;
Certification of Michael Golowski (President of claimant);
Letter from Michael Golowski.

With respect to the issue of discovery, NJSA 39:6A-13(b) in relevant part would require the provider to furnish a written report of the history, condition, treatment, dates and costs of treatment of injured person, and produce and permit the inspection and copying of its records regarding such history, condition, treatment, dates and costs of treatment. The request of the respondent, first made in December 2002 (two months after the filing

of the Demand for Arbitration and 2 years and 4 months after the date the subject equipment was issued) requests, *inter alia*, records, invoices, purchase orders regarding the TENS unit, complete names and addresses of all persons who have an ownership interest in the medical provider, the name and last known address of each person who performed the diagnostic testing and/or treatment, the serial number, type, make, model and year of each machine used in the diagnostic treatment, a copy of the provider's quality assurance program, evidence of all State Medical Licenses, a complete lists of all academic facilities attended by the providers, evidence respecting the professional business structure, a list of all employees of the medical provider who were employed were at any time from the start of treatment until the present, etc. Clearly, the request for discovery is in the broadest form conceivable and certainly exceeds the bounds of NJSA 39:6A-13(b). I find the provider in no way conducted itself in the course of discovery in a such a manner as to preclude its eligibility for receipt of payment of PIP benefits. It produced documents upon which it intended to rely at the hearing, and such records as were in its possession regarding medical necessity and reasonableness.

With respect to "material misrepresentations" allegedly made by the provider, the respondent relies virtually entirely on deposition testimony of other individuals who at various times received medical equipment from this provider, as well as the excerpts of the testimony of chiropractor Haymes, which is not demonstrated to have any relevance to the issues or parties in this claim. The respondent attempts to extract from these unrelated testimonies what it surmises is a common thread of suspicion, which it then not only arbitrarily applies to the facts of this claim, but also unilaterally elevates the level of material misrepresentation. The deposition transcripts of the patients in these unrelated matters are themselves rife with uncertain answers and confusion and I find no evidence here to support any alleged "material misrepresentation".

With respect to the failure of the patient to appear for EUOs, it must be noted the first of these scheduled EUO dates was in December 2002, two months after the filing of the Demand for Arbitration. No evidence has been presented that any time prior to that date the respondent requested an EUO of the patient. In fact, from the records and evidence presented, it is clear the basis for denial of this claim was solely medical necessity. Having denied payment on that basis, the respondent, subsequent to the filing of an arbitration demand determined an EUO was required, which it now argues is a condition precedent to payment of any PIP benefits. While it is clear the Courts permit limited discovery in the context of PIP actions, including EUOs, the right to conduct same is not absolute and unfettered. It is a right which at least circumscribed by "ordinary standards of reasonableness and fairness". See NJ Auto Full Insurance v. Jallah, 256 NJ Super 134 (App. Div. 1992); see also Prudential Property & Casualty v. Nardone, 332 NJ Super 126 (Law Div. 2000). Both those cases appear to require at least a reasonable, articulable suspicion of fraud. "Proof" of fraud is not required for the conduct of an EUO, only the suspicion thereof based reasonably upon the indicia of same. In this instance, there simply is no evidence presented of such a reasonable, articulable suspicion of fraud. It appears rather disingenuous for a carrier, once it has made a determination not to pay PIP benefits premised on medical necessity, to then continue to impose after the filing of an Arbitration Demand additional obstacles which the claimant/patient must surmount in

order to receive PIP benefits for durable medical equipment. I find this to be wholly at odds with the intent, both express and implied, of the PIP Statute.

Insofar as the respondent raises the defense of Pre-Certification, I find the claimant did submit a Request for Pre-Certification on August 11, 2001, in compliance with the respondent's plan. NJAC 11:3-4.8 establishes an additional co-payment penalty not to exceed 50% of the eligible charge for a provider's failure to comply with Pre-Certification requirements. That penalty does not attach for failure to secure a Certification approval. Clearly, if Pre-Certification is denied (or as is in the case here, simply not responded to), the issue becomes one of medical necessity. I find the provider herein did in fact comply with the respondent's requirement regarding Pre-Certification.

Thus, the central remaining issue is one of medical necessity. Where as here the issue is medical necessity, the claimant has the burden of proof to a preponderance of the evidence. Where there is a dispute, the burden rests on the claimant to establish that the services for which he seeks PIP Payment were reasonable, necessary and causally related to an automobile accident. Miltner v. Safeco Insurance Company of America, 175 N.J. Super 156 (Law Div. 1980). 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 it's medical value is enough to qualify the expense for PIP Purposes. Medical expenses have been considered necessary even if the services only provide temporary relief from symptoms and will neither cure nor repair a medical condition or problem. Miskofsky v. Ohio Casualty Insurance Company, 203 N.J. Super 400 (Law Div. 1984). 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 it's medical value is enough to qualify the expense for PIP purposes. Thermographic Diagnostics v. Allstate, 125 N.J. 491 (1991). While the fact that a treatment is only intended to provide relief from symptoms is not alone a reason to deny benefits, such treatment must still be reasonable and necessary. Palliative care is compensable under PIP when it is medically reasonable and necessary. Elkins v. New Jersey Manufacturers Insurance Co., 244 N.J. Super 695 (App. Div. 1990).

Additionally, pursuant to Case Law developed in this State, where there is a conflict of testimony of medical experts, generally greater weight is to be given to the testimony of the treating physician. Mewes v. Union Building & Construction Company, 45 NJ Super 89 (App. Div. 1957); Biaco v. H. Baker Milk Company, 38 NJ Super 109 (App. Div. 1955); Abelit v. General Motors Corporation, 46 NJ Super 475 (App. Div. 1957).

The physician's statement of medical necessity of Dr. Wesley dated 8/10/01 declares that the dual channel multimode EMS unit was necessary to produce analgesia, reduce edema, reduce pain and inflammation, increase range of motion and rehab and strengthen muscles. In his report, Dr. Wesley indicated that at the time of the patient's initial evaluation on 8/6/01 he complained of moderate right shoulder pain, severe low back pain and stiffness, moderate bilateral hip and thigh pain, moderate left knee pain and

moderate pain in both legs. Dr. Wesley's physical examination of the cervical and lumbar spine revealed the presence of moderate tenderness and spasm as well as decreased ranges of motion. Clearly, as the treating physician, Dr. Wesley establishes the basis for the prescription of this device. The Physician Advisory Determination Summary Report of Dr. Pumo indicated that Certification of the EMS Unit was denied because he could not establish the medical necessity therefor. While there is an indication that he called the provider's office and did not receive a callback, there is no indication what notice of deficiency of information may have been sent to the provider in order to enable Dr. Pumo to make an informed determination on the issue of medical necessity, or to afford the provider the opportunity to correct the deficiency. I find the report of Dr. Pumo unconvincing as to the absence of medical necessity.

However, the discussion of the billing does not end here. The Statement of Necessity of Dr. Wesley in addition to the issuance of the unit, order the issuance of "supplies as needed." The billing of the claimant includes bills for those supplies which were issued on a monthly basis, for September, October, November, December 2001 and January and February 2002. The only medical statement of necessity with respect to the issuance of the unit or any supplies therefor was supplied on August 10, 2001. Absolutely no evidence is introduced by the claimant to indicate the issuance of subsequent supplies has been determined to be "needed". In the absence of such a showing, it cannot be maintained that supplies issued after the initial month of use, i.e. billings from September 2001 and thereafter, were reasonable and medically necessary, a showing which must be made in accordance with the New Jersey Administrative Code.

"Medically Necessary" is defined in NJAC 11:3-4.3 as medical treatment or diagnostic testing which is consistent with the clinically supported symptoms, diagnosis or indications of the injured person. The same section of the Administrative Code defines "clinically supported" as meaning that a health care provider prior to selecting, performing or ordering the administration of a treatment or diagnostic has "(1) personally examined the patient to insure that the proper medical indications exist to justify ordering the treatment or tests; (2) physically examine 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…;(4) recorded and documented these observations…."

It is clear that Dr. Wesley, as the treating physician, made a determination with respect to the prescription of the unit itself. The anticipated efficacy of the unit is set forth in the physician's statement of medical necessity. I therefore find the initial prescription of the dual channel multimode EMS unit as reflected in the bill for date of service 8/16/01 is for an item of durable medical equipment which was both reasonable, medically necessary and for a condition or conditions causally related to the subject accident. Payment of that initial bill in the amount of $780.50 is awarded, subject to reduction by such portion of the relevant policy of insurance deductible and co-payment as remains open and unsatisfied.

With respect to the bills of the provider for dates of service September 2001 through February 2002, the statement of necessity signed by Dr. Wesley indicates that the identified equipment is medically necessary for an estimated period of time (12 months) "or indefinite." The supplies are prescribed to issued on a "as needed" basis, according to that form. As is pointed out hereinabove, absolutely no medical reports or records from Dr. Wesley have been submitted which would indicate that the continued issuance of supplies was "needed" or "medically necessary". Therefore, the portion of the claim which seeks payment of bills for supplies issued after the date of the initial furnishing of the unit (8/16/01) is denied as totally devoid of any medical support or evidence for same.

As to the issue of "usual, customary and reasonable billing", the Court in Cobo v. Market Transition Facility, 293 NJ Super 374 (App. Div. 1996), citing 24 NJR 1348 (April 6, 1992) stated as following:

> "The provider, in submitting the billings, makes the initial determination as to what his or her usual, customary and reasonable fee is. It is incumbent on the insurer, based on its experience with the particular provider or other providers in the region, to determine whether, in fact, the usual, customary and reasonable fee has been billed."

The Court further noted that "thus, the scheme envisions that the health care provider will set its own customary fee, not the insurer or the insurer's auditor." Here, the provider has in the submission of the billing, stated its usual and customary fee for the equipment at issue. In a Certification and letter format, the claimant has attempted to explain (albeit belatedly), the basis upon which it relies in establishing that cost base. The respondent has submitted no evidence in support of the argument that the amount is not in keeping with "usual, customary and reasonable" billing practices. No exemplar bills from other providers in the similar geographical area have been provided, nor have any EOBs from this carrier to this claimant been provided. I find the respondent has offered no evidence to challenge the usual, customary and reasonable billing of the claimant in this matter.

The claim of the claimant is awarded in the sum of $780.50.

Inasmuch as no calculation of interest has been provided, the claim for interest is deemed to have been waived.

I further find the claimant was successful and is entitled to an award of counsel fees. Counsel for the claimant has submitted a Certification of Services which seeks legal fees in the amount of $1,380.00 together with costs of $325.00. Counsel for the respondent has entered a vehement objection to any award of counsel fees, with particular opposition to both the total number of hours billed (9.2) and the hourly billing rate ($150.00). I have reviewed the line item entries reflected in the Certification of Services and I find that an award of counsel fees in the amount of $1,380.00 is consonant with the amount at issue

herein and is consistent with the requisites of RPC 1.5 as well as consistent with the degree of effort, expertise and experience required for a successful prosecution of this claim. I also award costs in the amount of $325.00. I further find the award of counsel fees in that amount to be consistent with the mandates of the Court in Enright v. Lubow, 215 NJ Super 306, (App. Div.), cert. Denied 108 NJ 193 (1987) as well as of Scullion v. State Farm, 345 N.J. Super 431 (App. Div. 2001).

This matter was the subject of an oral hearing conducted on August 5, 2003. The hearing was held open to afford the parties the opportunity to make additional submission, which both parties did, and was declared closed of October 3, 2003.

5. MEDICAL EXPENSE BENEFITS:

Awarded

Provider	Amount Claimed	Amount Awarded	Payable to
Electrical Medical Systems	$1214.14	$780.50	Electrical Medical Systems

Explanations of the application of the medical fee schedule, deductibles, co-payments, or other particular calculations of Amounts Awarded, are set forth below.

6. INCOME CONTINUATION BENEFITS: Not in Issue

7. ESSENTIAL SERVICES BENEFITS: Not in Issue

8. DEATH BENEFITS: Not in Issue

9. FUNERAL EXPENSE BENEFITS: Not in Issue

10. I find that the CLAIMANT did prevail, and I award the following COSTS/ATTORNEYS FEES under N.J.S.A. 39:6A-5.2 and INTEREST under N.J.S.A. 39:6A-5h.

(A) Other COSTS as follows: (payable to counsel of record for CLAIMANT unless otherwise indicated): $325.00

(B) ATTORNEYS FEES as follows: (payable to counsel of record for CLAIMANT unless otherwise indicated): $1380.00

(C) INTEREST is as follows: Waived.

This Award is in **FULL SATISFACTION** of all Claims submitted to this arbitration.

November 12, 2003
Date

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John J. Fannan, Esq.