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
(Respondent)

AAA CASE NO.: 18 Z 600 19076 01
INS. CO. CLAIMS NO.: 4042611857
DRP NAME: James H. Garrabrandt
NATURE OF DISPUTE: PPO Issue

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: CS.

1. ORAL HEARING held on September 9, 2002.

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

ALL PARTIES appeared telephonically.

3. Claims in the Demand for Arbitration were AMENDED and permitted by the DRP at the oral hearing (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).

The caption was amended to change the name of the Respondent from NHR/NF to Allstate.

4. FINDINGS OF FACTS AND CONCLUSIONS OF LAW:

This matter arises out of a motor vehicle accident that occurred on February 4, 2001 and is, therefore, subject to AICRA.

As explained by Respondent's counsel, NHR is simply the third party administrator of Allstate's PIP claims; NHR is not a PIP carrier and does not write insurance of any kind. As noted in Paragraph 3, above, the caption was amended to change the name of the Respondent from NHR/NF to Allstate, so as to reflect the latter as the properly named Respondent in this case.

Injured in the accident, CS underwent a course of treatment with Claimant.

Bills submitted for payment for dates of service March 21, 2001 through April 9, 2001 were paid after PPO reductions totaling $604.75 were taken by Respondent. Copies of EOB's of record show the amount of the PPO reductions taken by Respondent prior to paying the bills submitted by Claimant for those dates of service.

The validity of those PPO reductions is the issue in this case.

Amongst the documents submitted by Respondent were a Facility Service Agreement (PPO Agreement) between Consumer Health Network Plus, LLC (CHN), Agreement To Lease CHN Network between CHN and National Healthcare Resources, Inc. (NHR) and New Jersey Medical Claim Management Agreement for Services between NHR and Allstate New Jersey Insurance Company (ANJ).

Respondent contends that (i) the Facility Service Agreement between CHN and Claimant is valid and (ii) Claimant was properly reimbursed for services rendered in accordance with certain provisions, as well as a fee schedule in the Agreement and, therefore, is not entitled to any additional payments.

In support of its contentions, Respondent produced an unreported Opinion rendered by the Hon. Fred Kieser, Jr., J.S.C. (Middlesex County Family Courthouse) of the Superior Court of New Jersey, Law Division - Special Civil, Middlesex County, in ruling on motions for summary judgment filed by the parties in a case entitled, Seaview Orthopaedics v National Healthcare Resources, Inc. v Consumer Health Network, Docket No.: 10307-01. In the Opinion, the Court, inter alia, upheld the validity of PPO reductions taken by Allstate pursuant to a PPO Agreement.

Neither the parties, nor the DRP are bound by the decision of the Court in an unreported Opinion rendered by a Superior Court Judge in a Special Civil matter.

Claimant challenges the validity of the PPO Agreement, generally, and contends that the scheme for reimbursement for services rendered as set forth in the Agreement and the fee schedule within the Agreement, specifically, is inconsistent with the intention of the PIP statute.

The issue of the validity of PPO Agreements in the context of automobile accidents has been addressed by the Courts and other DRP's. There is a divergence of opinion regarding the validity of the Agreements. The Appellate Division has not decided the issue.

It is undisputed that on the dates it rendered treatment to CS, Claimant was a party to a Facility Service Agreement with CHN, wherein Claimant, as a participating provider, agreed to provide services for eligible persons of various unspecified insurance

companies and to accept a reduced fee for those services based upon a "fee schedule" provided by CHN.

Section 2.5 of the Agreement reads

> "'Payor' means the party responsible for the actual payment for Covered Services rendered to Eligible Persons that has, directly or indirectly, entered into a Payor Agreement with CHN. ..."

Section 3.1.2 reads

> "Facility shall provide Medically Appropriate Covered Services to Eligible Persons of each Payor executing a Payor Agreement with CHN or revising an existing Payor Agreement if the terms and fee schedules are substantially similar to the Standard Terms and the Fee Schedule."

Section 3.1.3 reads

> "If an additional Payor executes a Payor Agreement with CHN or an existing Payor revises a Payor Agreement and Section 3.1.2 applies, CHN shall provide notice to Facility of the identity of the Payor and any other information necessary for the Facility to fulfill the obligations of Facility hereunder."

Section 4.4 reads:

> "CHN shall use reasonable efforts to obtain current information from each Payor on a timely basis with regard to the identity of Payors and disseminate such information the Participating Providers of CHN and CHN, shall, in its sole discretion, deem appropriate to keep each Participating Provider reasonably informed as to the identity of Payors."

No proofs have been submitted and, therefore, there is no evidence that Respondent entered into a Payor Agreement with CHN; or if Respondent had entered into such an Agreement, that Claimant was notified of its having done so.

CHN did notify Claimant that Respondent was on CHN's client list; and perhaps it can be inferred from the category "Client/Payor" on the list that Respondent had entered into a Payor Agreement with CHN.

There is no Payor Agreement of record in this case.

Respondent is not a direct party to the Agreement between CHN and Claimant.

Claimant has not executed a contract directly with the Respondent in this case.

Respondent is not a direct party to the Facility Service Agreement; nor is there any privity of contract between Claimant and Respondent.

It is basic contract law that there must be privity of contract between two parties for those parties to be obligated under a contract, unless there is some other legal authority permitting the parties to claim a benefit or obligation under a contract; such as where a person or entity is an intended third party beneficiary of a contract, or where an assignment of rights or benefits has been executed.

There has been no showing of any intended third party beneficiary rights for Respondent under the CHN Agreement in this case.

Without privity of contract, or any third party beneficiary rights, then, Respondent cannot apply the reduced fee schedule (PPO) rates set forth in the CHN Agreement to the bill submitted by Claimant, herein.

Also of significance, PPO Agreements, Payor Agreements and/or Agreements to Lease PPO Networks are not specifically mentioned in AICRA, or the Administrative Code. There is, then, no direct statutory support for those Agreements. Nor are those Agreements included in Respondent's policy form, or decision point review/pre-certification plan approved by DOBI. Without DOBI approval, those Agreements are invalid and enforceable.

Moreover, the CHN Agreement, itself, is in violation of the Automobile Insurance Cost Reduction Act (AICRA) and the Administrative Code.

Section 10.1 Provider-Patient Relationship of the Agreement provides that

> "Nothing contained in this Agreement shall interfere with or in any way alter any provider-patient relationship and Facility shall have the sole responsibility for the care and treatment of Eligible Persons under Facility's care. Nothing contained herein shall grant CHN or any party performing utilization management the right to govern the level of care of a patient. ..."

There is no mention of the insurance company's right to decision point review, peer review or independent medical examinations with regard to the treatment of its insured for injuries sustained in PIP related accidents.

Under AICRA and the Administrative Code, in a claim for PIP benefits, the insurer does have the right to limit and/or terminate treatment on the basis of decision point reviews, pre-certification requirements and independent medical examinations. The CHN Ageement is, then, in direct conflict with AICRA and the Administrative Code.

The Agreement is also invalid in that neither CHN, nor Respondent has the right to refer an insured involved in an automobile accident to a particular facility. The facility could not otherwise legally obtain a referral of an injured person involved in an automobile accident. An injured insured has the absolute right to select and obtain his or her own medical care.

Under the Agreement, Exhibit 2.8 CHN New Jersey Fee Schedule sets forth charges for various CPT codes and imposes a maximum daily reimbursement for physical medicine and rehabilitation procedures administered and billed under certain CPT codes.

There is no provision in the CHN Agreement dealing with the interplay between AICRA, the Administrative Code and the prevailing medical fee schedule and the comprehensive scheme set forth therein for dealing with the treatment of injuries sustained in automobile accidents; or how the CHN fee schedule is expected to coordinate with the provisions AICRA, the Administrative Code and the prevailing medical fee schedule in controlling the cost of medical treatment.

An insurance carrier should not be permitted to apply PPO rates to reduce a provider's fee from the maximum allowable fee under a statutory medical fee schedule and then apply certain cost containment features of AICRA (ie: deductible and co-payments) to further reduce that fee. Respondent should not be permitted to elect favorable features from the New Jersey statutory scheme for cost containment of medical treatment and then choose favorable provisions within the CHN Agreement when paying bills submitted to it.

Again, the CHN Agreement is silent on the interaction between the Agreement, AICRA and the Administrative Code. The Agreement is poorly written, ambiguous and does not reveal to the medical provider the relationship between the Agreement, AICRA and the Administrative Code. Given its ambiguity, then, the Agreement must be construed against the drafter.

The intent of AICRA was to provide a cost containment procedure for medical bills which in turn would result in a reduction of insurance premiums. The CHN Agreement does not provide a mechanism for the reduction of an insured's automobile insurance premium. The attempt by Respondent to apply the PPO Agreement, then, is in direct contravention with AICRA and the Administrative Code.

For the various foregoing reasons, then, the CHN Facility Service Agreement is invalid and unenforceable. Any PPO reductions taken by Respondent before paying the bill submitted by Claimant were, therefore, inappropriate. Any such reductions are invalid and the amount of those reductions is due and owing to the Claimant in this case.

PPO reductions totaling $604.75 were improperly applied to Claimant's bill.

Respondent shall reimburse Claimant $604.75.

Medical expense benefits are awarded as set forth in Paragraph 5, below.

With respect to attorney's fees in this matter, and as set forth in RPC 1.5, consideration has been given, but not limited to, the novelty and difficulty of the questions involved, the skill requisite to perform the legal services properly, 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.

An attorney's fee of $600.00 is consonant with the amount of the Award and in keeping with the other guidelines of RPC 1.5.

Costs are awarded in the sum of $325.00.

5. MEDICAL EXPENSE BENEFITS:

Awarded

Provider	Amount Claimed	Amount Awarded	Payable to
Hudson Physical Therapy	$1,217.25	$604.75*	Hudson Physical Therapy

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

*Net Award

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): $600.00

(C) INTEREST is as follows: waived per the Claimant. .

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

March 25, 2003 _____
Date James H. Garrabrandt, Esq.