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.
GSA INSURANCE COMPANY
(Respondent)

AAA CASE NO.: 18 Z 600 01755 03
INS. CO. CLAIMS NO.: SD1750004249
DRP NAME: Ronald I. Parker
NATURE OF DISPUTE: Reasonable and Necessary

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: Patient and assignor.

1. ORAL HEARING held on November 24, 2003.

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

NO ONE appeared telephonically.

3. Claims in the Demand for Arbitration were NOT AMENDED 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).

4. FINDINGS OF FACTS AND CONCLUSIONS OF LAW:

Assignor, a 34-year-old female, was involved in an automobile accident on January 19, 2002, and began seeing Claimant on January 24, 2002. At that time the patient complained of neck pain, mid and low back pain, right hip pain, right leg pain and right foot pain, etc. Palpation of the cervical spine revealed, "Moderate to severe bilateral muscle hypertonicity with pain C1-7." Palpation of the thoracolumbar spine revealed, "Moderate to severe bilateral muscle hypertonicity with pain T1-12, L1-L5/Sac." Neurological and orthopedic tests were performed and a course of physical therapy was prescribed. Claimant's initial diagnosis was "cervical posterior disc bulge at C5-C6 as well as C6-C7, brachial neuritis/radiculitis, cervicalgia, encephalgia, cervical sprain/strain, subluxation of multiple cervical vertebrae, etc. Patient was re-examined on

February 19, 2002 and orthopedic tests were performed. The patient also saw Dr. Mahalick, Ph.D. for a neuropsychological evaluation on the same day patient was originally seen by Claimant.

The final examination of the patient was on June 14, 2002. Claimant offers the certification of Dr. Mark Zablow, a chiropractor, who indicates, "The patient progressively had less complaints of pain, increased ranges of motion and to a large degree, minimalization or alleviation of trigger point spasm. This improvement continued throughout the subject dates of service (to 6-14-02) when I believed the patient reached a plateau, or maximum medical improvement." Claimant also offers into evidence copies of physical therapy referral, pre-certification, SOAP notes, progress reports and a June 14, 2002 a neurological examination report from Dr. Edward Lev dated June 17, 2002. It was Dr. Lev's diagnosis that the patient had sustained "cervical sprain/strain, lumbar sprain/strain and possible cervical and lumbar radiculopathy."

With regard to the $2,800.00 charge for neuropsychological services on January 29, 2002 Respondent argues that the tests performed were unnecessary. Respondent offers a report from Roy Grzesiak, Ph.D. indicating that early testing "does not have predictive or treatment planning value." Furthermore, he stated that the cognitive and perceptual impairments improve so rapidly in the first few months that "testing other than simple neuropsychological screening is of no value." Finally, Dr. Grzesiak notes, "Improvements continue for as long as 18 months."

I therefore FIND based upon all of the documentation submitted regarding the neuropsychological evaluation, that Claimant has not by a preponderance of credible evidence established that performing this evaluation within ten days of the automobile accident was either reasonable or medically necessary and DENY reimbursement for same.

With regard to the continued chiropractic treatment through June 14, 2002 by Claimant, Respondent offers an April 26, 2002 report of Dr. Keswani regarding pre-certification of chiropractic care from 4/23/02 to 5/24/02. The request was reviewed by Dr. Thomas Catarella, a chiropractor who indicated, "The documents provided to not clinically support his request." He further states, therapy after 4/24/02 "is not clinically supported as medically necessary "Due to lack of significant subjective progress"."

As between the treating physician and the IME physician, who apparently did not have the benefit of the MRI findings and the EMG findings, the treating physician was and is in a better position to assess the patient's progress and determine when maximum benefit had been achieved.

Further, if there is a conflict in testimony of medical experts, our courts often give greater weight to the testimony of the treating physician. See <u>Mewes v. Union Building & Construction Co</u>., 45. N.J. Super. 89 App. Div 1957). It is evident that the petitioner has sustained its burden of showing that the treatment rendered was reasonable and

necessary. See Miltner v. Safeco Ins. Co. of America, 175 N.J. Super. 156 (Law Div. 1980).

The necessity for medical testing is a determination to be initially decided upon by the claimant's treating physician and an objectively reasonable belief in the utility of a treatment or diagnostic method based on a credible and reliable evidence of its medical value is enough to qualify the expenses for PIP. Thermographic Diagnostic v. Allstate, 125 N.J. 491 (1991).

Pursuant to N.J.S.A. 39:6A-4(a), all automobile insurance policies in New Jersey must afford personal injury protection coverage which will provide for "payment of all reasonable medical expenses incurred as a result of personal injury sustained in an automobile accident." Under N.J.S.A. 39:6A-2(e) medical expenses are defined as those "...expenses for medical treatment...and other reasonable and necessary expenses resulting from the treatment prescribed by a person licensed to practice medicine..." contained within the Act itself is a requirement that the statute "...shall be liberally construed so as to effect the purpose thereof." N.J.S.A. 39:6A-16.

New Jersey Courts have consistently and emphatically reinforced the proposition that claims for medical expenses benefit payments are to be processed liberally and promptly. As set forth in Gambino v Royal Globe Insurance Co., 86 N.J. Super. 100, 107 (App. Div. 1981):

> In interpreting the statute to give full effect to the legislative intent, then, the statutory language must be read, whenever possible to promote prompt payment to all insured persons for all of their losses.

The New Jersey Supreme Court held in Amiano v. Ohio Casualty Ins. Co., 85 N.J. 85, 90 (1980):

> Moreover, the Act itself requires us to construe its provisions liberally in order to effect the legislative purpose to the fullest extent possible. N.J.S.A. 39:6A-16. The No Fault Act is social legislation intended to provide insureds with the prompt payment of medical bills, lost wages and other such expenses without making them await the outcome of protracted litigation. Mandated as a social necessity, PIP coverage should be given the broadest application consistent with the statutory language.

In accordance with the broad and liberal construction of PIP, the Courts have also extended the principal to expand the definition of acceptable treatment. As the Court noted, "...reasonable and necessary medical treatment appropriately may be rendered to preserve life or simply to relieve the patient from physical pain." Elkins v. New Jersey Mfrs. Insurance Co., 244 N.J. Super 695, 700 (App. Div. 1990). Accordingly, a PIP carrier has an encompassing duty to provide payment in full for treatment that results in the alleviation of pain, without regard to the curative aspect of treatment. See, Elkins,

supra at 700; Miskofsky v. Ohio Cas. Ins. Co., 203 N.J. Super. 400, 413-414 (Law Div. 1984); Cavagnaro v. Hanover Insurance Co., Inc., 236 N.J. Super. 287, 291-292 (Law Div. 1989).

Any denial of payment must be closely scrutinized in light of the clear indication by the Supreme Court that medical expense benefit claims are to be promptly paid in full and a presumption of necessity and deference granted to the treating physician. Accordingly the treating physician enjoys:

> Wide discretionary latitude in determining the extent of treatment needed for a particular patient in that it is not unusual to witness a genuine dichotomy of medical opinion as to the type and extent of treatment needed for a particular injury. Elkins, supra. at 701; Miskofsky, supra. at 401.

As such, a PIP carrier's denial of payment must be supported by evidence sufficient to overcome the presumption that "...the necessity of incurring medical expenses ordinarily should be decided by the treating physician." Elkins, supra. at 702; Thermographic Diagnostic v. Insurance Co., 219 N.J. Super 208 (L. Div. 1987). In the event a dispute exists between the claimant and the PIP carrier as to whether treatment was medically reasonable and necessary, given the patient's injuries, complaints and symptoms a "preponderance of the evidence" standard must be used to determine which party will prevail. Elkins, supra. at 701.

I therefore FIND that Claimant has by a preponderance of credible evidence clearly established that the chiropractic treatments for May 2, 2002 through June 14, 2002 were reasonable and medically necessary, and CONCLUDE that these bills should be reimbursed.

Finally, Claimant asserts the PT examination on January 28, 2002 was not reimbursed. Respondent offers no documentation as to its failure to reimburse and I FIND that this bill should be reimbursed by Respondent.

The final issues concerns a bill for February 25, 2002, which Claimants asserts Respondent, denied because it was "a duplicative bill." However, in Respondent's analysis it has shown by a preponderance of credible evidence that this bill was paid ten months prior to the filing of the Demand for Arbitration and I FIND that the request for reimbursement for this amount should be denied.

N.J.A.C. 11:3-5.6 by Amendment adopted 10/13/00 provides that an "award may include attorney's fees for a successful claimant in the amount consonant with the award and with Rule 1.5 of the Supreme Court's Rule of Professional Conduct." Among the factors to be considered when determining the reasonableness of the fee are the time and labor required, the skill requisite to perform the legal services properly, the fee customarily charged in locality for similar legal services, the amount involved and the

results obtained. Claimant having prevailed, I award legal fees in accordance with AAA Rule 30 in Section 10(B) below.

5. MEDICAL EXPENSE BENEFITS:

Click here

Provider	Amount Claimed	Amount Awarded	Payable to
Health Medical Rehabilitation Center	$3,964.13	$1,001.68**	Health Medical Rehabilitation Center

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

**Subject to fee schedule, co-payment and deductible, if any.

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): $1,000.00

(C) INTEREST is as follows: Awarded in the amount of $50.00.

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

1/30/04
Date

Ronald I. Parker, Esq.