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.
NEW JERSEY MANUFACTURERS INSURANCE COMPANY
(Respondent)

AAA CASE NO.: 18 Z 600 04621 02
INS. CO. CLAIMS NO.: 00-707157-01
DRP NAME: Barry K. Odell
NATURE OF DISPUTE: Fee Schedule, 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: P.W.

1. ORAL HEARING held on April 7, 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 made by the parties regarding the issues to be determined (Stipulations, if any, set forth below).

1. The parties stipulate that the provisions of AICRA apply to the within claim.
2. The parties stipulate that no issues are being raised as to the Claimant's compliance with the Pre-Certification/Decision Point Review plan of Respondent.

4. FINDINGS OF FACTS AND CONCLUSIONS OF LAW:

The within matter arises from an automobile accident which occurred on December 12, 2000. Based upon the date of the accident and the stipulation of the parties, I find that the provisions of AICRA apply to the within claim.

At issue in this case are the bills which the patient, P.W., incurred with Health Medical Rehabilitation Center, LLC under the care of Dr. Mark Zablow, D.C. His first date of treatment was December 12, 2000. The treatment continued up to and through May 17, 2001. Two distinct portions of the claim are presented. First, for treatment rendered prior to Respondent's Termination of Benefits based upon medical necessity, Claimant argues that on various dates of treatment, from January 16, 2001 to March 29, 2001, Claimant was reimbursed improperly. Claimant argues that C.P.T. Code 98941 was improperly paid, and on some occasions both the first and second procedures were reduced improperly by the multiple-procedure reduction formula by 50%. On other occasions, the primary and secondary procedures were reversed by Respondent, according to Claimant, and the reimbursed amount was therefore improperly reduced. No contrary computation has been provided by Respondent to indicate the amount which should have been paid, and accepting Claimant's mathematical analysis, I award the amounts claimed for treatment rendered from January 16, 2001 through March 29, 2001.

With regard to the second portion of the claim, Claimant indicates that it was denied any benefits for treatment rendered from April 4, 2001 through May 17, 2001. Claimant argues that this treatment was medically necessary and that it was "cut-off" on March 28, 2001. Claimant argues that it was not notified of this termination until June 6, 2001 and that based on the medical documentation and the fact that the Respondent performed an impermissive "retroactive cut-off", all bills should be paid in full.

First, I find that the unpaid bills are still subject to a medical necessity defense. Respondent was given notice of the treatment, and Pre-Certification/Decision Point Review notices have not been alleged to have been deficient. However, Claimant has provided nothing to support the legal conclusion that Claimant could not make a determination after the treatment was rendered that it was not medically necessary and deny reimbursement for same. I find that Respondent would not be barred from denying these bills based upon a medical necessity defense raised after treatment had been completed.

Second, the facts do not bear out that this occurred. Based upon documentation provided by Respondent, it is apparent that denial of authorization notices were sent to the provider on March 27, March 28 and April 13, 2001. Some of these notices are contained in Claimant's Arbitration Statement as being part of the Claimant's file.

Respondent has denied this claim for treatment provided after March 29, 2001 based upon the report and opinion of Dr. H. Katherine Denow, B.S., D.C., FIACA, DIBCN, Board Certified Chiropractic Neurologist. In her report dated March 28, 2001, she stated that the requested care was three days a week of chiropractic care and two days a week of physical therapy at the same facility. She found that daily treatment beyond the first week of injury was not appropriate. She noted that treatment for over three months was already provided and that the treatment sheets she reviewed did not show any appreciable improvement in subjective complaints or objective findings. Dr. Denow felt that it was questionable whether the treatment was of any benefit and whether it should be continued

at even a reduced frequency. Treatment was in fact provided at a much reduced frequency, not one visit per day but ten billed visits over a period of 43 days.

Provided in support of this claim are the notes and reports of Dr. Zablow. In Dr. Zablow's daily office notes, some improvement in range of motion and orthopedic testing is apparent. However, little information can be secured from these brief daily sheets. Comparing the January 11, 2001 and February 11, 2001 examination notes reveals some increase in range of motion, lowered reports of pain and sensitivity and a lesser number of positive orthopedic test findings. No examination results are provided for dates of treatment after April 11, 2001. The only further note provided is for visit number 33 held on April 17, 2001. The only notation on that date is that the patient complained that her mid-back hurt.

Dr. Zablow's reports are provided. His undated report regarding all treatment rendered is two pages in length. It indicates that he treated through May 17, 2001 and although there were temporary setbacks due to exacerbations, the patient progressively had less complaints of pain, increased range of motion and a minimization or alleviation of trigger point spasm and other improvement. He indicated this improvement continued throughout all dates of services to the last claimed, May 17, 2001.

In Dr. Zablow's January 17, 2002 report, written seven months after the last date of treatment, he indicates again that treatment benefited the patient through the last date of treatment. However, the final examination date is listed as being April 11, 2001. At that time the patient still had several positive findings. His report notes range of motion studies were performed on April 17, 2001, although notes of same are not contained on that daily treatment record. Current subjective complaints are listed as of April 11, 2001 as being pain in patient's neck and lower back. However, on the office note from the last date of treatment referenced in the notes, April 17, 2001, the patient was complaining only of mid-back pain. The report further noted that as of April 11, 2001, the patient was unable to complete her recommended care plan at the time of the examination.

I find that some treatment was medically necessary after the March 28, 2001 evaluation of Dr. Denow. Slight improvement is noted until the April 11, 2001 final examination note prepared by Dr. Zablow. I find that all treatment rendered through that time is medically necessary. I find that based upon the records and reports submitted, and considering Dr. Denow's opinion, treatment rendered after April 11, 2001 was not medically necessary. I therefore deny the claim for treatment rendered from April 17, 2001 through May 17, 2001 and award, as per Claimant's computation, $899.25 to the provider. Interest is awarded as per Claimant's computation.

Claimant has submitted a Certification of Services seeking counsel fees and costs in this matter in the amount of $2,103.75. Answers to Interrogatories were prepared. An Arbitration Statement with a summary of the claim and medical records was provided. Attendance at hearing was required. Counsel did include some items in its Certification of Services which appear to be for routine/clerical services. Based upon a review of the file, I find that a counsel fee in the amount of $1,500.00 would be consonant with both

the amount of the award and with Rule 1.5 of the Supreme Court Rules of Professional Conduct. See, Enright v. Lubow, 215 N.J. Super. 306 (App. Div) cert. den. 108 N.J. 193 (1987). I also award reimbursement of costs in the amount of $325.00.

5. MEDICAL EXPENSE BENEFITS:

Awarded

Provider	**Amount Claimed**	**Amount Awarded***	**Payable to**
Health Medical Rehabilitation Center	$1,412.25	$899.25	Provider

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

*Amount awarded is subject to no further reduction.

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): $1,500.00

(C) INTEREST is as follows: Awarded in the amount of $90.67.

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

May 14, 2003
Date

Barry K. Odell, Esq.