AWARD OF DISPUTE RESOLUTION PROFESSIONAL

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: A.M...

1. ORAL HEARING held on 3/10/04.

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:

A.M. was involved in a motor vehicle accident on 12/17/99 from which the within matter arises.

Nature of Dispute:

I. Were pre-certification penalties properly applied to the billing of Open MRI of Rochelle Park, Institute for Physical Therapy and Dr. Dellano?
II. Did respondent properly deny charges for therapeutic exercise billed under CPT code 97530 and 97110?

III. Is Dr. Dellano entitled to reimbursement for office visits?

IV. Were services rendered by Able Physical Therapy reasonable and medically necessary?

The following documentation was submitted for consideration and reviewed:

Claimant:
Demand including bill, assignment, PIP application, medical records.
Submission dated 3/22/04.
Certifications of Services.

Respondent:
Submission dated 11/12/03 including: letter memorandum and attachments.
Submission dated 3/15/04.

There is good cause to accept the submission of claimant as it responded to issues raised in respondent's Rule 17 Submission.

I also heard the arguments of counsel.

I. The Decision Point Review/Precertification Plan ("Plan") of respondent requires a medical provider to submit a request for authorization of treatment and testing at specific intervals during the course of treatment. Failure to submit the required request will result in the assessment of a 50% penalty. The plan including this requirement is provided to all insureds. Claimants stand in the shoes of the insured as assignees.

Respondent maintains that requests were not submitted as to services from Open MRI of Rochelle Park and Dr. Dellano. EORs and EOPs evidencing payments to these providers are supplied by respondent. Although claimant asserts a pre-certification penalty was applied to the services of Institute for Physical Therapy, the EOR and EOP indicate that only fee schedule and usual and customary reductions were made. As such, no penalty was applied. The propriety of certain reductions taken are addressed below. Dr. Kallis (A.M.‘s oral surgeon) who prescribed the MRIs was also aware of the Plan requirements.

Based on the evidence, proper requests were not submitted to respondent and appropriate notice was provided as to the Plan requirements. Thus, I find the penalties were proper. The MRI services were otherwise paid properly.
II. The physical therapy notes are supplied by claimant Institute of Physical Therapy. Therapeutic activities and exercises were billed utilizing CPT codes 97530 and 97110. Respondent denied the services stating that the documentation supplied did not support the billing. The treatment records were provided to respondent and support the billing of services under CPT code 97110 (exercises) but not as to additional therapeutic activities billed under CPT 97530. Based on the fee schedule at the time and the provider's billing the provider is owed $1,200.

III. Office visits were denied separate reimbursement on dates in which chiropractic manipulation was also provided. Respondent maintains that the billing of an office visit is impermissible unbundling. “Unbundling” is defined as “artificially separating or partitioning what is inherently one total procedure into subparts that are integral to the whole” N.J.A.C. 11:3-29.4(g). The medical records are supplied. Sufficient documentation of a distinct and separate examination does not exist and thus, the provider is not owed reimbursement for these services.

Based on the evidence, all other services were paid properly to Dr. Dellano to the extent that is required.

IV. Able Physical Therapy provided services for TMJ related problems from 6/11/02 until 1/21/03 which are unpaid. The patient underwent left and right TMJ arthroscopic examination on 3/13/00 and left and right TMJ open arthrotomies/arthroplasty on 1/24/01. Three months of therapy followed until 5/9/01. The patient suffered an exacerbation of her symptoms. Dr. Kallis (A.M.’s oral surgeon) notes two prior accidents involving the TMJ. Each subsequent injury caused an exacerbation of the prior problems. The nature of her injuries indicates the patient suffered permanent damage with a likelihood of continuing complaints and reoccurrences.

The patient suffered an exacerbation of her TMJ complaints with headaches, jaw pain, dizziness, tinnitus. Spasm, tenderness and reduced jaw motion was noted on examination. A.M. returned for therapy with Able P.T on 6/11/02 which continued until 1/21/03. Improvement is noted throughout therapy records.

Respondent denied payment of therapy after 1/10/02 based upon the IME of Dr. Baruch. Dr. Baruch is an orthopedic surgeon. The examination of the spine revealed no abnormalities. Dr. Baruch reviewed the lumbar MRI films. Dr. Baruch determined no further physical therapy was needed.

Under Miltner vs. Safeco Ins. Co. of America, 175 N.J.Super. 156 (Law Div. 1980), where there is a dispute as to PIP benefits, 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. Claimant must carry that burden by a preponderance of the evidence. See, State v Seven Thousand Dollars, 136 N.J. 233 (1994). Pursuant to the administrative code, a medically necessary treatment or test is "consistent with the clinically supported symptoms, diagnosis or indications of the injured person" and "is the most appropriate level of service that is in accordance with good practice and standard
professional treatment protocols including the Care Paths [applicable to spinal injuries]. N.J.A.C. 11:3-4.2.

Based on the weight of the credible evidence, I find that claimant has sustained its burden as to the medical necessity of the treatment through 1/21/03. There is improvement documented (increased range of motion, less spasm and less positive findings) on a consistent basis in the medical records. Dr. Baruch performed no examination of the jaw and did not review records, including positive TMJ MRIs, as to the patient's TMJ care. A dental termination should be based upon a dental examination, not that of an orthopedist. Further, the patient suffered a relapse in symptoms necessitating additional care which was not addressed by respondent's medical reviewer. The provider causally relates the patient's symptoms to the 12/17/99 accident. The examinations concerning the relapse demonstrates a recurrence of symptoms supporting the need for additional care.

I find that the claimant to be a prevailing party and I award attorney’s fees and costs. Having reviewed the Certification of Services submitted by claimant and considered the opposition of respondent; I award $1,225 in fees and $285 in costs. The fees awarded are in conformity with guidelines set forth in R.P.C. 1.5. See Enright v. Lubow, 215 N.J. Super. 306 (App. Div.) cert denied 108 N.J. 93 (1987); Scullion v. State Farm Ins. Co.345 N.J. Super. 431, 437-438 (App. Div. 2001). There were several providers and issues presented.

No interest calculation or argument was presented to support an award of interest in this matter and the claim is deemed waived.

5. MEDICAL EXPENSE BENEFITS:

<table>
<thead>
<tr>
<th>Provider</th>
<th>Amount Claimed</th>
<th>Amount Awarded</th>
<th>Payable to</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dellano Chiro. Ctr.</td>
<td>$486.95</td>
<td>$0.00</td>
<td></td>
</tr>
<tr>
<td>Instit. of PT</td>
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<td>Provider</td>
</tr>
<tr>
<td>Open MRI of Rochelle Park</td>
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<tr>
<td>Able PT</td>
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<td>$8,129.04</td>
<td>Provider</td>
</tr>
</tbody>
</table>

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

The amount awarded is subject to the New Jersey Fee Schedule, co-payment and deductible obligations of A.M.

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


(A) Other COSTS as follows: (payable to counsel of record for CLAIMANT unless otherwise indicated): $285

(B) ATTORNEYS FEES as follows: (payable to counsel of record for CLAIMANT unless otherwise indicated): $1,225.00

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

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

4/27/04
Date ____________________________
Nanci G. Stokes, Esq.