FORTHRIGHT

In the Matter of the Arbitration between

STAT IMAGING @ MARLTON A/S/O L.S.

CLAIMANT(s),

v.

Forthright File No: NJ1201001427503
Proceeding Type: In Person
Insurance Claim File No: 67383
Claimant Counsel: Franklin J. Gorsen, LLC
Claimant Attorney File No: 2011-03-0030.000
Respondent Counsel: Law Offices of Nicodemo & Connell
Respondent Attorney File No: 11-293-B RN
Accident Date: 05/28/2010

IFA Insurance Co

RESPONDENT(s).

Award of Dispute Resolution Professional

Dispute Resolution Professional: Grant W. Keller Esq.

I, the Dispute Resolution Professional assigned to the above matter, pursuant to the authority granted under the "Automobile Insurance Cost Reduction Act", *N.J.S.A. 39:6A-5, et seq.*, the Administrative Code regulations, *N.J.A.C. 11:3-5 et seq.*, and the *Rules for the Arbitration of No-Fault Disputes in the State of New Jersey* of Forthright, having considered the evidence submitted by the parties, hereby render the following Award:

Hereinafter, the injured person(s) shall be referred to as: LS

In Person Proceeding Information

A proceeding was conducted on: 12/20/13

Claimant or claimant's counsel appeared in person. Respondent or respondent's counsel appeared in person.

The following amendments and/or stipulations were made by the parties at the hearing:

not applicable.

Findings of Fact and Conclusions of Law

LS was involved in an automobile accident on 05/28/10. Claimant filed this demand by way of assignment from LS for reimbursement for medical services provided on behalf of LS. Claimant argues that the services in issue are reasonable and medically necessary treatments that are causally related to the automobile accident of 05/28/10. Claimant seeks reimbursement in the amount of $939.36 for a lumbar MRI performed on 08/19/10. I have reviewed all submissions of the parties referenced at the arbitration hearing and heard arguments on behalf of the parties at the arbitration hearing. Arguments set forth in written submissions but not argued at the hearing were not considered. The following issues were presented by the parties for determination at the arbitration hearing.

Issues In Dispute
08/19/10
CPT 72148 Lumbar MRI $939.36
Respondent also argues that the policy of auto insurance from which LS seeks PIP coverage and was effective on the date of the auto accident was a "Basic Policy" pursuant to N.J.S.A. 39:6A-3.1 and not a "Standard Policy" pursuant to N.J.S.A. 39:6A-4.3, as proposed by claimant. Respondent argues that the policy of auto insurance provides for "Basic Policy" coverage, which entitles LS to PIP medical benefits of $15,000.00 and imposes a $2,500.00 deductible. Respondent argues that N.J.S.A. 39:6A-3.1 imposes the $15,000.00 PIP policy limit and $2,500.00 deductible on named insureds and resident family members of the named insureds and all other "strangers" to the policy seeking PIP coverage.

Respondent also argues that even if the policy in issue is a "Standard Policy", the PIP limits of $15,000.00 and $2,500.00 PIP deductible apply to LS, even where LS is neither a named insured or resident relative of the named insured.

Claimant argues that the policy effective on the date of the auto accident and from which LS seeks PIP coverage is a "Standard Policy" pursuant to N.J.S.A. 39:6A-4. Claimant argues that the policy of auto insurance provides $15,000.00 PIP medical limits and that LS was a stranger to the policy, thereby providing LS with $250,000.00 PIP coverage and a $250.00 deductible.

Claimant argues: "This is not a Basic Policy in accordance with N.J.S.A. 39:6A-3.1. Respondent call this policy a Basic Policy all they want but that does not make it so. I can call my Toyota a Ferrari all I want, but it is still a Toyota. The only election on the policy that looks remotely like a Basic Policy is the election of $15,000.00 PIP limits which means nothing. If this were truly a Basic Policy as respondent alleges, the insured would not have the coverage noted o the declarations page." Claimant also argues that none of the elections made by the insured are available with a Basic Policy, therefore the policy in issue is a Standard Policy pursuant to N.J.S.A. 39:6A-4.3. Claimant further argues that since LS is not a named insured on the policy of insurance or a resident family member, LS is entitled to $250,000.00 PIP coverage and a deductible of $250.00 pursuant to N.J.S.A. 39:6A-4.3.

Respondent argues that claimant's proofs fail to establish by a preponderance of the evidence that the treatment in issue is clinically supported as reasonable and medically necessary treatment that is causally related to the auto accident. see N.J.A.C. 11:3-4.2 and N.J.S.A. 39:6A-2(m).

Law
N.J.S.A. 39:6A-3.1
Election of basic automobile insurance policy; coverage provided

As an alternative to the mandatory coverages provided in sections 3 and 4 of P.L. 1972 (C.39:6A-3 and 39:6A-4) any owner or registered owner of an automobile or principally garaged in this state may elect a basic automobile insurance policy providing the following coverage:

a. Personal injury protection coverage, for the payment of benefits without regard to negligence, liability or fault of any kind, to the named insured and members of his family residing in his household, who sustained bodily injury as a result of an accident while occupying, entering into or alighting from or using an automobile or as a pedestrian, caused by an automobile or by an object propelled by or from an automobile, and to other persons sustaining bodily injury while occupying, entering into, alighting, form or using the automobile of the named insured, with the permission of the named insured. Personal injury protection coverage issued pursuant to this section means and includes payment of medical expense benefits, as provided in the policy and approved by the commissioner for the reasonable and necessary treatment of bodily injury in an amount not to exceed $15,000.00 per person per accident; except that, medical expense benefits shall be paid in an amount not to exceed $250,000.00: (1) for all medically necessary treatment of permanent or significant brain injury, spinal cord injury, or disfigurement, or (2) for medically necessary treatment of other permanent or significant injures rendered at a trauma center or acute care hospital immediately following the accident and until the patient is stable, no longer requires critical care and can be safely discharged or transferred to another facility in the judgment of the attending physician.

N.J.S.A. 39:6A-23(a) through (f)
(a)The applicant shall indicate the options elected on the coverage selection form which shall be signed and returned to the insurer. (c)Any notice of renewal of an automobile insurance policy with an effective date subsequent to July 1, 1984, shall be accompanied by a written notice of all policy coverage information required to be provided under subsection a of this section. (e)A properly completed and executed coverage selection form shall be prima facie evidence of the named insured's knowing election or rejection of any option. (f) Each named insured on an automobile insurance policy shall, at least annually or as otherwise ordered by the commissioner, receive a buyer's guide and coverage selection form.

N.J.S.A. 39:6A-4.3(e)
Coverage lower than the standard PIP coverage of $250,000.00 must be affirmatively chosen by the insured. The selection of this lower coverage must be evidenced by a written selection by the insured. The coverage selection form shall contain a statement, clearly readable and in 12 point bold type, in a form approved by the commissioner, that election of any of the aforesaid medical expense benefits options results in less coverage than $250,000.00 medical expense coverage mandated prior to the effective date of P.L. 1998, c. 21. If none of the aforesaid medical expense benefits options is affirmatively chosen in writing, the policy shall provide $250,000.00 medical expense benefits coverage.

NJSA 39:6A -4.3(f)
An option elected by the named insured in accordance with this section shall apply only to the named insured and any resident relative in the named insured's household who is not a named insured under another automobile insurance policy, and not to any other person eligible for PIP injury protection benefits required to be provided in accordance with section 4.

Medical Necessity and Causation
Claimant has the burden of establishing that the services for which payments are demanded were reasonable, necessary and causally related to the subject automobile accident. Miltner v. Safeco Ins. Co. of America, 175 N.J. Super. 156, 158 (Law Div. 1980).

In Bowe v. N.J. Mfrs. Ins. Co., 367 N.J. Super. 128 (App. Div. 2004) the court affirmed that claimant must also prove by a preponderance of the evidence that the injuries for which treatment was rendered were proximately caused by the particular automobile accident. Where a PIP carrier asserts that the insured's condition is exclusively related to a pre-existing injury or condition, the insured has the burden of proving that the treatment at issue is causally related to either an aggravation of a pre-existing injury or a new injury either of which must have resulted from the particular accident. 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 credible and reliable evidence of its medical value is enough to qualify the expense for PIP purposes. Claimant's burden of proof for establishing "medical necessity" is by a preponderance of the evidence. Thermographic Diagnostics v. Allstate, 125 N.J. 491 (1991).

N.J.S.A. 39:6A-2(m) defines reasonable and necessary treatment as follows:

'Medically necessary' means that the treatment is consistent with the symptoms or diagnosis, and treatment of the injury (1) is not primarily for the convenience of the injured person or provider, (2) is the most appropriate standard or level of service which is in accordance with standards of good practice and standard professional treatment protocols, as such protocols may be recognized or designated by the Commissioner of Health and Senior Services or with a professional licensing or certifying board in the Division of Consumer Affairs in the Department of Law and Public Safety, or by a nationally recognized professional organization, and (3) does not involve unnecessary diagnostic testing.

"Medical necessity" is also defined in N.J.A.C 11:3-4.2 as follows:

'Medically necessary' or 'medical necessity' means that the medical treatment or diagnostic test is consistent with the clinically supported symptoms, diagnosis or indications of the injured person and:
1. The treatment is the most appropriate level of service that is in accordance with the standards of good practice and standard professional protocols including the Care Paths in the Appendix, as applicable;
2. The treatment of the injury is not primarily for the convenience of the injured person or provider; and
3. Does not include unnecessary testing or treatment.

"Clinically supported" is defined in N.J.A.C. 11:3-4.2 as follows:

'Clinically supported' means that a health care provider prior to selecting, performing or ordering the administration of a treatment or diagnostic test has:
1. Personally examined the patient to ensure that the proper medical indications exist to justify ordering the treatment or test;
2. Physically examined 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 and the results and

which are relevant to the proposed treatment or test; and
4. Recorded and documented these observations, positive and negative findings and conclusions on the patient's medical records.

N.J.S.A. 39:6A-4(a) states that medical treatments, diagnostic tests, and services provided by the policy shall be rendered in accordance with commonly accepted protocols and professional standards and practices which are commonly accepted as being beneficial for treatment of the covered injury. Protocols and professional standards and practices and lists of valid diagnostic tests which are deemed to be commonly accepted pursuant to this section shall be those recognized by national standard setting organizations, national or state professional organizations of the same discipline as the treating provider, or those designated or approved by the commissioner in consultation with the professional licensing boards in the Division of Consumer Affairs in the Department of Law and Public Safety. Protocols shall be deemed to establish guidelines as to standard appropriate treatment and diagnostic tests for injuries sustained in automobile accidents, but the establishment of standard treatment protocols or protocols for the administration of diagnostic tests shall not be interpreted in such a manner as to preclude variance from the standard when warranted by reason of medical necessity.

Findings of Fact and Conclusions of Law
Respondent submits the following argument regarding the issue of "Basic" vs. "Standard" policy:
"NJ.S.A. 39:6A-3.1 (Election of basic automobile insurance policy; coverage provided) states in pertinent part:

> "As an alternative to the mandatory coverages provided in section 3 and 4 …., any owner or registered owner of an automobile registered or principally garaged in this State may elect a basic automobile insurance policy providing for the following coverage:
>
> a. Personal injury protection coverage, for the payment of benefits without regard to negligence, liability or fault of any kind, to the named insured and members of his family residing in his household, who sustained bodily injury as result of an accident while occupying, entering into, alighting from or using an automobile or by an object propelled by or from an automobile, **and to other persons sustaining bodily injury while occupying, entering into, alighting from or using the automobile of the named insured, with the permission** of the **named insured.** "Personal injury protection coverage" issued pursuant to this sections means and includes payment of medical expense benefits ... not to exceed $15,000.00 per person per accident; ...". {Emphasis added}

In addition, N.J.S.A. 39:6A-3.1 makes clear that payment of medical expense benefits is further subject to the chosen deductible, wherein it states:

> "... Medical expense benefits payable in accordance with this subsection may be subject to a deductible and copayment as provided for in the policy, if any.....".

Unlike NJ.S.A. 39:6A-4.3, there is no restriction of this selection to the named insured and resident relatives." Respondent adds further:

"Respondent respectfully submits that a review of NJ.S.A. 39:6A-3.l makes clear that the selection of a basic policy and any deductible applicable thereto applies to not only the named insured and any resident relatives, but also permissive users of the vehicle seeking coverage under said policy. Unlike N.J.S.A. *39:6A-4.3*, there is no caveat that the selections made by the named insured would be limited to the named insured and his or her family. Accordingly, Respondent respectfully submits that it has properly applied the $2,500.00 deductible and that any benefits ultimately awarded should be made subject to any remaining deductible and co-payment, as well as the policy limits of $15,000.00."

Respondent submitted a copy of a Personal Auto Declaration Page from IFA Insurance Company issued to SS for the period of 11/01/09 to 11/01/10. There is no dispute that the policy of auto insurance from Which LS seeks PIP coverage is the policy referred to in this Declaration Page. There is no dispute that LS is neither a named insured nor resident relative of a named insured under this auto policy and that LS is a "stranger" to the auto policy. The personal injury protection is described as "Basic". The coverage include bodily injury limits of $25/50 thousand per person/ accident, property damage coverage of $10,00.00 per accident, uninsured motorist coverage of $25/50 thousand dollars per person/accident, PIP limit of $15,000.00 and $2,500.00 PIP deductible.

Respondent argued initially that N.J.S.A. 39:6A-4.3(a) permits imposing the PIP limits and PIP deductible upon a person who is not a named insured and who is not resident relative of the named insured, Respondent initially argued that the $2,500.00 PIP deductible and $15,000.00 PIP limit applies to LS because N.J.S.A. 39:6A-4.3 applies the following language only to the issue of selection of healthcare primary coverage, not to the limit of PIP coverage and deductible. Respondent cites the following:

"N.J.S.A. 39:6A-4.3 goes on to state:

An option elected by the named insured in accordance with this section shall apply only to the named insured and any resident relative in the named insured's household who is not a named insured under another automobile insurance policy, and not to any other person eligible for personal injury protection benefits required to be provided in accordance with Section 4 .... "

Respondent argues that the section referred to is the prior section that discussed the health care primary option, therefore the above language applies to the health care primary option. Respondent argues that the above statutory language was changed from prior language that referred specifically to deductibles and exclusions that would not apply to non-named insureds or resident relatives (policy strangers). Respondent argues that the findings in Swydersky v. Prudential Commercial Ins. Co., 240 N.J. Super. 37, 40 (App. Div. 1990) found that chosen PIP coverage and deductible did not apply to strangers to the policy because that decision was based on the prior language for N.J.S.A. 39:6A-4.3.

Claimant points out that a "Basic Policy" under N.J.S.A. 39:6A-3.1 does not allow for $10,000.00 property damage (as only $5,000.00 is permitted), does not allow for $25/50 thousand bodily injury coverage, (as the only choices are $10,000.00 or $0 for a Basic Policy), and a Basic Policy does not provide any option for underinsured/uninsured motorist coverage.

Based upon the proofs submitted, the auto insurance policy in issue is a "Standard " auto policy pursuant to N.J.S.A. 6A-4.3. Claimant correctly argues that regardless of respondent's label placed upon the

Declaration Page for the policy of auto insurance, the actual coverage supports the criteria for a "Standard" policy, rather than a "Basic" policy. The proofs further establish that LS is not a named insured or resident relative of the named insured, and therefore is not restricted to PIP limits of $15,000.00 and a $2,500.00 deductible. Both the wording of the statute and the findings in Swydersky v. Prudential Commercial Ins. Co., 240 N.J. Super. 37, 40 (App. Div. 1990) support claimant's argument that LS is entitled to coverage of $250,000.00 of PIP medical expense coverage and subject to a $250.00 deductible. We no turn to the issues regarding medical necessity and causation below.

08/19/10
CPT 72148 Lumbar MRI $939.36

Respondent argues that LS was involved in a subsequent auto accident on 06/08/10 wherein he injured his left knee and left. Respondent also argues that LS suffered a fall from a chair on 07/29/10 wherein LS aggravated low back, left knee, and left shoulder conditions. Respondent argues that the lumbar MRI performed on 08/19/10 is therefore not causally related to the auto accident of 05/28/10.

Claimant argues that there is no indication from the proofs submitted that LS injured his low back in the 06/08/10 auto accident and Dr. Panaia had already recommended an MRI of the lumbar spine prior to LS' fall on 07/29/10.

According to the initial examination report from Dr. Panaia, he noted that LS is a 40 year old male who was involved in an auto accident on 05/28/10. Dr. Panaia states that LS was the driver of an auto that was stopped when his car was struck from the rear by another vehicle. Dr. Panaia reported complaints on examination of cervical spine pain 8/10, difficulty with free range of motion of the head, headaches, a swollen right hand, lumbar spine pain rated at 7/10 with spasm in the mid and low back, difficulty walking and bending.

On examination, Dr. Panaia recorded decreased range of motion of the cervical and lumbar spines with positive Tinel's on the right, positive straight leg raise on the right, positive Bragard's on the right and palpable spasm bilaterally at L1-5 with tenderness. He diagnosed cervical and dorsolumbar sprain and strain with radiculopathy in the legs bilaterally and dorsolumbar myofascial syndrome. He recommended an MRI of the brain and lumbar spine if symptoms persist. He also began LS on a course of chiropractic treatment.

Respondent submitted office notes from Dr. Panaia for dates of service 06/07/10 through 08/05/10. Dr. Panaia consistently noted from early June 2010 forward, that there were continued complaints of neck and low back pain with spasm and radicular pain into the legs. He further consistently recorded findings of tenderness and positive orthopedic and neurologic findings in the cervical and lumbar areas, as discussed in the initial examination. These observations regarding ongoing symptoms of the cervical and lumbar areas continued up to and after the 07/29/10 fall from a chair recorded in the office note of 07/29/10. The office notes leading up to 07/29/10 indicate no notable changes from prior visits.

Respondent submitted a copy of Dr. Panaia's office note dated 07/01/10. In this office note, Dr. Panaia states that LS continues to complain of neck and low back pain with decreased range of motion in both areas. He further states that there is continued spasm and tenderness in the cervical and lumbar spines with positive orthopedic and neurologic findings. He further notes that LS was seen by Dr. Gleimer, who recommended MRI studies of the knee and back due to continued pain walking, bending and lifting.

In addition to submitting treatment records from Dr. Panaia, (which were also submitted by respondent as discussed above) claimant submitted a copy of an initial office visit from Dr. Gleimer, orthopedist, dated 07/01/10. Dr. Gleimer found that an MRI of the lumbar spine was necessary due to ongoing low back pain with pain radiating to the lower extremities and paresthesia.

Based upon the proofs submitted, claimant has established by a preponderance of the evidence that the MRI performed on 08/19/10 is clinically supported as reasonable and medically necessary treatment that is causally related to the auto accident of 05/28/10. While respondent argues that there were two subsequent incidents involving LS that resulted in injuries, it is clear from the proofs submitted that the medical providers for LS recommended a lumbar MRI prior to these incidents due to complaints and findings related to the auto accident of 05/28/10. Claimant's proofs therefore satisfy the criteria for clinically supported as reasonable and medically necessary treatment that is causally related to the auto accident as set forth in N.J.A.C. 11:3-4.2 and N.J.S.A. 39:6A-2(m), discussed above. Claimant is therefore awarded $939.36 for the MRI performed on 08/19/10.

Counsel Fees and Costs

Claimant is a prevailing party. N.J.A.C. 11:3-5.6(d)(3), states that the award of the dispute resolution professional "may include attorney's fees for a successful claimant in an amount consonant with the award and with Rule 1.5 of the Supreme Court's Rules of Professional Conduct."

Claimant submits a certification of attorney's fees in the amount of $2,220.00 consisting of attorney billing of 1.5 hours at a rate of $325.00 per hour and 7.4 hours at a rate of $300.00 per hour. Costs of $249.64 are also demanded. Respondent argues that in the event of an award in favor of claimant that the award of attorney fees and costs be at the rate customarily charged in this locality for similar legal services and according to the complexity of the issues presented in this matter. .

RPC 1.5 sets forth criteria to be considered for the award of reasonable attorney's fees. The award of attorney's fees is within the discretion of the fact finder and criteria include, but are not limited to, consideration of the complexity of the issues, the outcome obtained, the experience of the attorney, and the amount of damages.

In Enright v. Lubow, 215 N.J. Super. 306 (App. Div.), certif. den., 108 N.J. 193 (1987) and Scullion v. State Farm Ins. Co., 345 N.J. Super. 431 (App. Div. 2001) the court affirmed that the award of attorney's fees is within the court's discretion. Also, in N J Coalition for Health Care v. DOBI, 323 N.J. Super. 207 (App. Div.) at page 261, the court stated "an award of counsel fees to an insured who successfully obtains an arbitration award against an insurance carrier for payment of PIP benefits, or who prevails against an insurance carrier in a lawsuit for PIP benefits, has been the statutory and historical jurisprudence of our State."

The issue of counsel fees was also addressed in the matter of Litton Industries v. IMO Industries 200 N.J. 372 (2009). In Litton the court considered the "lodestar" argument, "which is that number of hours reasonably expended by the successful party's counsel in the litigation, multiplied by a reasonable hourly rate." The court also considered a "proportionality" test, which considers "the damages sought and the damages actually recovered…The court must evaluate the reasonableness of the total fee requested compared to the amount of the jury award. That is when the amount actually recovered is less than the attorney's fee request, the court must consider that fact in determining the overall reasonableness of the attorney's fee award."

Where attorney's fees for a successful claimant are requested, the DRP shall make the following analysis consistent with the jurisprudence of this State to determine reasonable attorney's fees, and shall address each item below in the award:

1. Calculate the "lodestar," which is the number of hours reasonably expended by the successful claimant's counsel in the arbitration multiplied by a reasonable hourly rate in accordance with the standards in Rule 1.5 of the Supreme Court's Rules of Professional Conduct.

i. The "lodestar" calculation shall exclude hours not reasonably expended;

ii. If the DRP determines that the hours expended exceed those that competent counsel reasonably would have expended to achieve a comparable result, in the context of the damages prospectively recoverable, the interests vindicated, and the underlying statutory objectives, then the DRP shall reduce the hours expended in the "lodestar" calculation accordingly; and

iii. The "lodestar" total calculation may also be reduced if the claimant has only achieved partial or limited success and the DRP determines that the "lodestar" total calculation is therefore an excessive amount. If the same evidence adduced to support a successful claim was also offered on an unsuccessful claim, the DRP should consider whether it is nevertheless reasonable to award legal fees for the time expended on the unsuccessful claim.

2. DRPs, in cases when the amount actually recovered is less than the attorney's fee request, shall also analyze whether the attorney's fees are consonant with the amount of the award. This analysis will focus on whether the amount of the attorney's fee request is compatible and/or consistent with the amount of the arbitration award. Additionally, where a request for attorney's fees is grossly disproportionate to the amount of the award, the DRP's review must make a heightened review of the "lodestar" calculation described in (e)1 above.

Rule 22 New Jersey No-Fault PIP Arbitration Rules
Rule 22 Attorney Fees and Costs became effective on April 1, 2011. Rule 22 states the following: "The attorney for the claimant shall submit a written Attorney Fee Certification, which shall include the following information for each date upon which legal work was performed: date, description of work, name of person performing the work, hourly rate, time in fractions of one hour, total charges for all work and itemized costs. All parties may present arguments on the claimed amount. A sample attorney Fee Certification form is available for downloading at www.nj-no-fault.com. Failure to submit the required certification shall result in the DRP denying the claims for attorney's fees and costs."

Based upon the proofs submitted and the authority cited above, I find that a reasonable fee and costs for this matter is $1,000.00 in fees and costs of $249.64. Claimant's counsel did prepare a detailed legal argument and statement of facts and addressed respondent's proofs. Claimant's proofs provided a basis for recovery in this matter. These services are reasonable in light of the standards cited above in Litton and Enright.

I have also conducted a review of the "lodestar" calculation standard as cited above in N.J.A.C. 11:3-5.6 (e). I have determined that the amount sought by claimant's counsel exceeds those that competent counsel reasonably would have expended to achieve a comparable result, in the context of the damages prospectively recoverable, the interests vindicated, and the underlying statutory objectives. I have

therefore reduced the hours expended in the "lodestar" calculation accordingly. The award of counsel fees has taken into consideration whether the award of counsel fees is consonant with the award of reimbursement for medical bills in the amount of $939.36 for a lumbar MRI. Therefore, the work performed and the amount awarded were factored into the award of counsel fees and the reasonable amount of time that an attorney of claimant's experience is anticipated to expend on a claim of this nature. I find that the counsel fee award and award of medical service reimbursement are consonant based upon the above considerations.

Therefore, the DRP ORDERS:

Disposition of Claims Submitted

1. Medical Expense Benefits: Awarded:

Medical Provider	Amount Claimed	Amount Awarded	Payable To
STAT IMAGING @ MARLTON	$939.36	$939.36	STAT IMAGING @ MARLTON

The Award is subject to application of the New Jersey Physician Fee Schedule for PIP and PIP limits of $250,000.00 and deductible of $250.00.

2. Income Continuation Benefits: Not in issue
3. Essential Services Benefits: Not in issue
4. Death or Funeral Expense Benefits: Not in issue
5. Interest: I find that the Claimant did prevail. Interest is awarded pursuant to *N.J.S.A. 39:6A-5h.*: Respondent will calculate interest based upon statutorily mandated rates.

Attorney's Fees and Costs

☐ I find that the Claimant did not prevail and I award no costs and fees.

☒ I find that the Claimant prevailed and I award the following costs and fees (payable to Claimant's attorney unless otherwise indicated) pursuant to *N.J.S.A. 39:6A-5.2g:*

Costs: $ 249.64 Attorney's Fees: $ 1,000.00

THIS AWARD is rendered in full satisfaction of all claims and issues presented in the arbitration proceeding.

Entered in the State of New Jersey

Grant W. Keller

Grant W. Keller, Esq.
Dispute Resolution Professional

Date: 02/12/14