MICHAEL GALATI, Plaintiff/ Appellant, v. USAA INSURANCE COMPANY, Defendant/ Respondent. ------------------------------------x	)))))))))))))	SUPERIOR COURT OF NEW JERSEY APPELLATE DIVISION DOCKET NO.: A-001380-23T2 On appeal from: Superior Court, Civil Division Middlesex County Docket No.: MID-L-006293-22 Sat Below: Hon. Alberto Rivas, J.S.C.

AMENDED BRIEF OF PLAINTIFF/APPELLANT

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FACTS AND PROCEDURAL HISTORY[1]

On October 26, 2021, Plaintiff/Appellant Michael Galati ("Plaintiff") filed a Demand for Arbitration (*i.e.*, a complaint) within an administrative forum known as Forthright seeking personal injury protection ("PIP") benefits from his automobile insurance carrier, Defendant/Respondent USAA Insurance Company ("Defendant"), for a lien consisting of medical expenses improperly paid by Plaintiff's health insurer due to Defendant's prior erroneous denial of reimbursement for the same. Pa12-14; Pca1-4; Pca141. On February 17, 2022, Defendant submitted opposition to Plaintiff's Demand for Arbitration and, in doing so, admitted the medical expenses that made up the lien were, in large part, not paid by Defendant due to its determination that the subject treatment was not medically necessary nor causally related to Plaintiff's automobile accident. Pca5-84. As part of its opposition, Defendant submitted evidence (*i.e.*, the explanation of benefits and the PIP payment ledger) to the arbitrator demonstrating that it had not paid the medical expenses at issue and, based upon the submitted evidence, Defendant presented the arbitrator with an arbitration summary breaking down all of the information necessary to calculate reimbursement pursuant to the New Jersey PIP fee schedule, including: (1) the individual providers; (2) the individual dates of service; (3) the individual CPT

[1] The Procedural History and Statement of Facts are represented together for the Court's convenience and to avoid repetition.

codes; (4) the fee schedule amounts for those CPT codes; (5) the amounts paid by the health insurer; and (6) the amounts paid (or not paid) by Defendant. Pca1-84. Consequently, on February 21, 2022, Plaintiff amended the Demand for Arbitration seeking reimbursement pursuant to the fee schedule for the unpaid medical expenses outlined in Defendant's arbitration summary rather than the lump sum lien and stipulated to the amounts shown in Defendant's own arbitration summary for purposes of calculating reimbursement.[2] Pa15. Plaintiff's amendment to the Demand for Arbitration was authorized by the arbitrator and is recognized in the arbitration award. Pca128.

On March 15, 2022, the arbitrator conducted a hearing.[3] Pca128. On May 16, 2022, the arbitrator determined that much of the unpaid treatment was medically necessary and causally related to the subject motor vehicle accident; however, reimbursement for medically necessary and causally related treatment was nevertheless denied after the arbitrator failed to apply the New Jersey PIP fee schedule -- despite having also relied upon Defendant's breakdown within the arbitration award. Pca128-146.

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[2] Although not required to do so under New Jersey's Collateral Source Rule, N.J.S.A. 39:6A-6 ("The benefits…shall be payable…*without regard to collateral sources* (*i.e.*, health insurance payments) …") (emphasis added), Plaintiff also stipulated to a discount wherein he would accept less than the fee schedule where the amount owed under the fee schedule exceeded payments made by the health carrier. Pa15.

[3] There is no transcript from the hearing. The only record of the arguments made are contained in the briefs submitted to the arbitrator.

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On August 4, 2022, the arbitrator denied Plaintiff's request for modification/clarification because "to award lump sums that do not correlate to CPT codes, etc. is to ask the [arbitrator] to craft an award based upon pure speculation." Pca149. On November 9, 2022, an appellate panel of arbitrators affirmed the Award.[4] Pca151-159.

On December 19, 2022, Plaintiff appealed the arbitration award to the Law Division. Pa1-3. On October 19, 2023, Defendant filed a motion for summary judgment. Pa18-19. On October 23, 2023, Plaintiff filed a cross-motion for summary judgment. Pa26-28. On December 8, 2023, the Law Division granted Defendant's motion for summary judgment and denied Plaintiff's cross-motion for summary judgment after overlooking the law requiring reimbursement pursuant to the New Jersey PIP fee schedule and improperly determining that Plaintiff failed to meet the statutory criteria for vacating and/or modifying an award under N.J.S.A. 2A:23A-13.[5] Pa36-37.

LEGAL ARGUMENT

I. THE DECISION OF THE ARBITRATOR CONSTITUTES PREJUDICIAL ERROR AND/OR THE IMPERFECT EXECUTION OF A FINAL AND DEFINITE AWARD

[Raised below: T10:13-19]

The Appellate Division exercises *de novo* review of legal questions. N.J.

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[4] There was no hearing.

[5] Summary Judgment transcript submitted as 1T (12/08/2023).

Mfrs. Ins. Co. v. Specialty Surgical Ctr. of N. Brunswick, 458 N.J. Super. 63, 70 (App. Div. 2019). Appellate review is proper in situations involving misapplication of the New Jersey PIP fee schedule. *See*, *e.g.*, id. at 65 (wherein the Appellate Division affirmed the Law Division orders that held "the PIP medical fee schedule [did] not provide for payment to an ambulatory surgical center (ASC) for procedures not listed as reimbursable when performed at an ASC") and Endo Surgi Ctr. v. NJM Ins. Grp., 459 N.J. Super. 289, 291 (App. Div. 2019) (wherein the Appellate Division reversed a Law Division order requiring reimbursement for an ASC procedure that was not listed on the PIP fee schedule).

Further, subsection b. of N.J.S.A. 2A:23A-13 provides:

> In considering an application for vacation, modification or correction, a decision of the umpire on the facts shall be final if there is substantial evidence to support that decision; provided, however, that when the application to the court is to vacate the award pursuant to paragraph (1), (2), (3), or (4) of subsection c., the court shall make an independent determination of any facts relevant thereto de novo, upon such record as may exist or as it may determine in a summary expedited proceeding as provided for by rules adopted by the Supreme Court for the purpose of acting on such applications.
>
> [N.J.S.A. 2A:23A-13(b)]

Subsection c. states, in relevant part, as follows:

> The award shall be vacated on the application of a party who either participated in the alternative resolution proceeding...if the court finds that the rights of the party were prejudiced by…
>
> (3) In making the award, the umpire's exceeding their power or so imperfectly executing that power that a final and definite award was not made…

> (5) The umpire's committing prejudicial error by erroneously applying law to the issues and facts presented for alternative resolution.
>
> [N.J.S.A. 2A:23A-13(c)]

Subsection e. states:

> The court shall modify the award if:
>
> (1) There was a miscalculation of figures or a mistake in the description of any person, thing or property referred to in the award;
> (2) The umpire has made an award based on a matter not submitted to them and the award may be corrected without affecting the merits of the decision upon the issues submitted;
> (3) The award is imperfect in a matter of form, not affecting the merits of the controversy; or
> (4) The rights of the party applying for the modification were prejudiced by the umpire erroneously applying law to the issues and facts presented for alternative resolution.
>
> [N.J.S.A. 2A:23A-13(e)]

Subsection f. provides the following:

> Whenever it appears to the court to which application is made, pursuant to this section, either to vacate or modify the award because the umpire committed prejudicial error in applying applicable law to the issues and facts presented for alternative resolution, the court shall, after vacating or modifying the erroneous determination of the umpire, appropriately set forth the applicable law and arrive at an appropriate determination under the applicable facts determined by the umpire. The court shall then confirm the award as modified.
>
> [N.J.S.A. 2A:23A-13(f)]

For the reasons set forth below, the Law Division overlooked the law requiring medically necessary and causally related medical expenses to be paid pursuant to the New Jersey PIP fee schedule and, furthermore, the decision of the

arbitrator constitutes both prejudicial error and/or the imperfect execution of a final and definite award as a result of failing to do so in this matter.

A. Medically Necessary and Causally Related Medical Expense Benefits Must be Paid Pursuant to the New Jersey PIP Fee Schedule

[Raised below: Pa15; Pca160-166; Pa38-39; T5:4-6:8; T10:13-11:4]

The Commissioner of the Department of Banking and Insurance ("Department") is required to set a fee schedule for the payment of medical bills for which payment is to be made by an automobile insurer. N.J.S.A. 39:6A-4.6. "To implement the statutory mandate, the Department promulgated regulations and amendments pursuant to N.J.A.C. 11:3-29, as well as a personal injury protection (PIP) fee schedule." In re Adoption of N.J.A.C. 11:3-29, 410 N.J. Super. 6, 13 (App. Div.), *cert. den.*, 200 N.J. 506 (2009). The regulations concerning application of the fee schedules provide:

> (a) Every policy of automobile insurance and motor bus insurance issued in this State *shall provide that the automobile insurer's limit on liability for medically necessary expenses payable under PIP coverage ... is the fee set forth in this subchapter*. Nothing in this subchapter shall, however, compel the PIP insurer ... to pay more for any service or equipment than the provider's usual, customary and reasonable fee, even if such fee is well below the automobile insurer's ... limit of liability as set forth in the fee schedules.
>
> [N.J.A.C. 11:3-29.4(a) (emphasis added).]

N.J.A.C. 11:3-29.1 further provides:

> This subchapter implements the provisions of N.J.S.A. 39:6A-4.6 to establish medical fee schedules on a regional basis for the reimbursement of health care providers providing services or equipment for medical expense

> benefits *for which payment is required to be made by automobile insurers under PIP coverage* and by motor bus insurers under medical expense benefits coverage.
>
> [N.J.A.C. 11:3-29.4(b) (emphasis added).]

The Appellate Division held the rules, regulations and the fee schedule to be valid. In re adoption of N.J.A.C. 11:3-29, 410 N.J. Super. at 13.

In the present case, Plaintiff amended the Demand for Arbitration seeking the fee schedule amounts for the medical expense benefits not paid by Defendant (rather than the lump sum health lien) and, although not required to do so, also offered by way of stipulation a credit for any difference between the fee schedule amounts and any payments made by the health insurer (which would, in effect, provide Defendant with a discount for having improperly denied reimbursement in the first place).[6] Despite the Law Division holding, the New Jersey PIP fee schedule must be applied here as a matter of law. The arbitrator failed to do so. This is not a sufficiency of evidence question. It is undisputed that all of the information necessary to calculate reimbursement pursuant to the fee schedule (*i.e.*, the provider information, the individual dates of service, the individual CPT codes, the individual fee schedule amounts, the individual billed amounts, the amounts paid by the health insurer, etc.…) was presented as evidence to the arbitrator to support the figures found in Defendant's arbitration summary and, in

[6] A PIP carrier is required to provide reimbursement pursuant to the fee schedule without regard to collateral sources. N.J.S.A. 39:6A-6.

any event, Plaintiff adopted Defendant's arbitration summary as his own. Defendant's arbitration summary (as shown in the arbitration award) demonstrates, *inter alia*, the fee schedule amounts owed for the treatment at issue (as well as the prior health payments) and, thus, calculating reimbursement pursuant to the fee schedule was simply of matter of referencing Defendant's own chart (or the body of the award). The decision of the arbitrator, therefore, constitutes prejudicial error and/or the imperfect execution of a final and definite award and, as such, must be vacated and/or modified to reflect reimbursement pursuant to the fee schedule for any and all treatment determined by the arbitrator to be medically necessary and causally related to the motor vehicle accident subject to Plaintiff's stipulated discount.

CONCLUSION

For the foregoing reasons, Plaintiff respectfully requests that the Appellate Division modify and/or vacate the arbitration award to reflect reimbursement pursuant to the fee schedule (subject to Plaintiff's stipulated discount) for all treatment found by the arbitrator to be medically necessary and causally related to Plaintiff's automobile accident.

Respectfully submitted,

/s/ *Daniel O. Sloan*
____
DANIEL O. SLOAN

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Appellate Division

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MICHAEL GALATI, Plaintiff, v. USAA INSURANCE COMPANY, Defendant	On appeal from: SUPERIOR COURT OF NEW JERSEY LAW DIVISION MIDDLESEX COUNTY Docket No. MID-L-006293-22 Sat Below: Hon. Alberto Rivas, J.S.C.

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A. Preliminary Statement

The Respondent, USAA Insurance Company, moves to dismiss this appeal for lack of appellate jurisdiction. This is a PIP reimbursement matter brought under the New Jersey Alternative Procedures for Dispute Resolution Act, ("APDRA") However, this Court does not have jurisdiction over this case and, therefore, this appeal should be summarily dismissed.

Should this Court find that jurisdiction exists, however, there was no error by Judge Rivas in affirming the award. The arbitrator properly reviewed the facts and arguments and determined that Plaintiff failed to meet his burden to demonstrate that certain claims were reimbursable because, for two providers, on a certain dates of service, multiple CPT were listed as being paid, but there was no breakdown as to how much was paid for each CPT code, so there was no way to determine that the payments were in accord with the Fee Schedule.

B. Statement of Facts and Procedural History[1]

This case began with the demand for arbitration filed on February 21, 2022 for PIP arbitration through Forthright. (Pa12-14) This matter arises out

[1] For this Court's ease and because they are inextricably intertwined, the statement of facts and procedural history will be presented together.

of a motor vehicle accident which occurred on or about September 17, 2019. (Pa1).

At the time of the accident, Plaintiff Michael Galati maintained an auto insurance policy with Defendant USAA Insurance Company, which contained PIP benefits. (Pa1-2). After the subject accident, USAA made PIP payments on the policy. (Pca80-84).

For reasons unknown to USAA, some medical bills were also submitted to the Plaintiff's health insurance carrier, who also made payments on bills allegedly related to the subject accident. (See, Pca1-4) Thereafter, that carrier asserted a lien against the Plaintiff. (Id.) On or about October 26, 2021, Plaintiff filed a Demand for Arbitration with Forthright. (Pa12-14). Plaintiff sought reimbursement for the amount of the lien. (See, Pa14, noting medical expense provider is "Optum Lien")

On or about March 15, 2022, an arbitration hearing was held via video conference before DRP Michael A. Hackett, Esq. (Pca128-146). On or about May 16, 2022, DRP Hackett issued his Award and written opinion. (Id.). DRP Hackett based his decision on the Plaintiff's demand, Plaintiff's arbitration submissions with attachments, USAA's arbitration submissions with attachments, and the March 15, 2022 hearing. (Id.)

In calculating his Award, DRP Michael A. Hackett, Esq. found that "the only instance where reimbursement would be supported is where it is clear as to what [CPT] code and amounts were reimbursed." (Pca141).

DRP Hackett further stated that for "[a]ny dates of service where there were multiple codes billed, Claimant has not provided sufficient documentation for reimbursement, and this DRP is unable to substantiate any amount to be awarded without documentation of the specific codes and amounts previously paid." (Id.).

This appeal concerns billing for two providers—Dr. Gregory Gallick and the Center for Ambulatory Surgery—where insufficient documentation was provided, because on a number of dates of service (occasionally, "DOS") for those providers, the lien stated that a single lump sum was paid for several CPT codes, without distinguishing how much was paid on each code. (Id.) This was problematical, because without a breakdown of how much was paid, if any, for each of the CPT codes, there was nothing but speculation to say that any of the payments were in accord with the applicable Fee Schedule. (Id.)[2] Thus, an award in any amount would be speculative.

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[2] The arbitration award specifically denied the claims for reimbursement with respect to NJ Healthcare Specialists, Quest Diagnostics, Richard Bezozo, M.D., Shamik Patel, D.O., and Nikolas Juliano, M.D. as Plaintiff did not demonstrate that they were medically necessary. (Pca140) However, that finding was not appealed by Plaintiff.

The arbitrator awarded reimbursement for three dates of service for treatment by Dr. Gregory Gallick—August 25, 2020, September 15, 2020, and October 5, 2020—as Dr. Gallick only billed one CPT code for those dates of service, so the amount billed for the CPT could be determined for those visits. Thus, the arbitrator found that the Plaintiff met his burden for those days to demonstrate compliance with the Fee Schedule, but that Plaintiffs ***did not*** meet his burden of proof on damages for the remaining DOS for Dr. Gallick and for the Center for Ambulatory Surgery. (Pca141)

Thus, the arbitrator did not award reimbursement for the following DOS with Dr. Gallick: February 18, 2020, July 30, 2020, August 4, 2020, and November 16, 2020. He further did not award reimbursement for the following DOS for the Center for Ambulatory Surgery: July 30, 2020. (Pca142-143)

The DRP awarded the Plaintiff $232.82. (Pca146). USAA paid the Award. Thereafter, Plaintiff filed a request for modification/clarification of the Award, which was denied on or about August 4, 2022. (Pca147-150). On or about September 1, 2022, the Plaintiff filed an appeal of the Award with Forthright, pursuant to Forthright Rule 25. (Pca151).

On or about November 9, 2022, the Dispute Resolution Panel issued an Appellate Award and written opinion, denying Plaintiff's appeal. (Pca151-

158). The Dispute Resolution Panel stated that "while not specified by Claimant, the only possible basis for challenging the Award is that the DRP committed prejudicial error by failing to appropriately apply the law to the facts of the case pursuant to N.J.S.A. 2A:23A-13(c)(5)." (Pca156). The Dispute Resolution Panel found "that there was substantial evidence and legal precedent supporting the DRP's opinion on the issues in dispute." (Pca158).

The Dispute Resolution Panel further found that "the DRP specifically and thoroughly addressed the issue of reimbursement for treatment determined to be medically necessary and causally related to the subject MVA." (Pca158). In fact, the Dispute Resolution Panel stated that "[a] review of all pertinent portions of the Award….shows that the DRP had a full understanding of the facts and performed an exhaustive review of the record evidence." (Pca158).

Finally, the Panel concluded "that the DRP below did not erroneously apply the law to the issue and facts presented in determining reimbursement." (Pca158).

Plaintiff then filed a summary complaint with the Law Division. (Pa1-4) The matter was heard by the Hon. Alberto Rivas, J.S.C. (1T)[3] Judge Rivas found that the DPR's award was based on substantial evidence and did not

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[3] 1T = December 8, 2023 Transcript of Hearings of Summary Judgment Motions.

present any basis under the applicable law to disturb the arbitration award. (1T3:2-12:6) He granted USAA summary judgment, and the appeal to this Court followed. (Pa37)

C. Legal Argument

ISSUE I: THIS COURT DOES NOT HAVE JURISDICTION OVER THIS APPEAL.

This claim was brought by Plaintiff under the New Jersey Alternative Procedures for Dispute Resolution Act ("APDRA"), N.J.S.A. 2A:23A-1 to -19. Plaintiff was dissatisfied with the decision of the Dispute Resolution Professional and filed an a summary complaint in the Superior Court, Law Division, resulting in Judge Rivas's December 8, 2023 order confirming the arbitration award. (Pa36)

Under N.J.S.A. 2A:23A-18(b), there is no right to a further appeal of that determination in this or any other court. Section N.J.S.A. 2A:23A-18(b) reads:

> Upon the granting of an order confirming, modifying or correcting an award, a judgment or decree shall be entered by the court in conformity therewith and be enforced as any other judgment or decree. ***There shall be no further appeal or review of the judgment or decree.***
>
> [N.J.S.A. 2A:23A-18(b) (emphasis supplied.)]

Furthermore, an arbitration under AICRA, such as the present matter, is required to follow APDRA. N.J.A.C 39:6A-5.1, Also, Allstate Ins. Co. v. Sabato, 380 N.J. Super. 463, 470 (App. Div. 2005) (noting that the Commissioner of Banking and Insurance may promulgate rules and regulations respecting the conduct of PIP dispute resolutions); Coal. for Quality Health Care v. New Jersey Dep't of Banking & Ins., 348 N.J. Super. 272, 312 (App. Div. 2002) (noting that the regulation adopting APDRA was authorized by AICRA, and properly approved by the Commissioner.)

The New Jersey Supreme Court and this Court have repeatedly held that the language in N.J.S.A. 2A:23A-18(b) essentially bars any review of a Law Division judge’s confirmation of an award under the APDRA. “We have said that ‘when the trial judge adheres to the statutory grounds in reversing, modifying[,] or correcting an arbitration award, we have no jurisdiction to tamper with the judge's decision or do anything other than recognize that the judge has acted within his jurisdiction.’” Monmouth Med. Ctr. v. State Farm Indem. Co., 460 N.J. Super. 582, 590 (App. Div. 2019) (quoting N.J. Citizens Underwriting Reciprocal Exch. v. Kieran Collins, D.C., L.L.C., 399 N.J. Super. 40, 48 (2008)).

The only exceptions to the bar to further review are “rare circumstance[s]” which do not exist here, such as child support orders or

"where such appellate review is needed to effectuate a 'nondelegable, special supervisory function' of the appellate court." New Jersey Manufacturers Ins. Co. v. Specialty Surgical Ctr. of N. Brunswick, 458 N.J. Super. 63, 68 (App. Div. 2019).

Thus, absent "rare circumstances," an appellate court has "no jurisdiction to tamper with the [trial] judge's decision or do anything other than recognize that the judge has acted within his[or her] jurisdiction." Monmouth Med. Ctr., 460 N.J. Super. at 590 (quoting N.J. Citizens Underwriting Reciprocal Exch., 399 N.J. Super. at 48). Indeed, when "the trial judge act[s] within APDRA's bounds," "N.J.S.A. 2A:23A-18(b) requires a dismissal of an appeal of that determination regardless of whether we may think the trial judge exercised that jurisdiction imperfectly." Fort Lee Surgery Ctr., Inc. v. Proformance Ins. Co., 412 N.J. Super. 99, 103-04 (App. Div. 2010).

The New Jersey Supreme Court upheld the constitutionality of N.J.S.A. 2A:23A-18(b) in Mt. Hope Dev. Associates. v. Mt. Hope Waterpower Project, L.P., 154 N.J. 141, 148-52 (1998). The Court ruled that "the language of APDRA unmistakably informs parties that by utilizing its procedures they are waiving [their] right" to appeal beyond the trial court, and that such a waiver generally must be enforced. Id. at 148.

In this case, the trial judge exercised his jurisdiction to confirm the arbitration award. Judge Rivas correctly applied the proper standard of judicial review to all of the issues of this case and reached a proper determination. (1T3:2-12:6; Pa37) Furthermore, a review of the brief filed by Plaintiff indicates that Plaintiff is not raising any of the "rare circumstances" or this Court's "special supervisory function." Rather, Plaintiff is simply seeking a *de novo* appellate review of the arbitration award because he believed it to be erroneous.

Furthermore, Plaintiff's argument that the case involves a failure to apply the PIP Schedule is false. This case is about Plaintiff's failure to fulfill his burden and provide sufficient evidence of what was paid, in order to support the claim for reimbursement. The evidence merely showed a total amount for the date of service, without breaking down how much, if any, was paid for each of the CPT codes. Thus, Plaintiff did not fulfill his burden of proof.

Nor is there any basis to review the decision of Judge Rivas under this Court's supervisory function, as discussed in Mt. Hope, 154 N.J. at 152 or in Morel v. State Farm Insurance Company, 396 N.J. Super. 472 (App. Div. 2007). In those cases, the Courts have recognized that in very rare circumstances, appellate review may be necessary to carry out this Court's

function. The Mt. Hope Court noted that, for example, an award confirmed, modified or vacated by a biased court should be subject to review, but found no such issues in that case. Mt. Hope, 154 N.J. at 152.

Published cases which have met this standard under APDRA include

- Jignyasa Desai, D.O., LLC v. New Jersey Manufacturers Ins. Co., 473 N.J. Super. 582, 585 (App. Div. 2022) (resolving a split in authority in the interpretation of the governing regulation is subject to supervisory review.)

- Specialty Surgical, supra, 458 N.J. Super. at 69 (resolving a split in authority in the interpretation of the governing regulation is subject to supervisory review)

- Kimba Med. Supply v. Allstate Ins. Co. of NJ, 431 N.J. Super. 463, 481 (App. Div. 2013) (review of whether Law Division had authority to remand a matter to the DRP for additional findings is subject to supervisory review)

- Open MRI & Imaging of Rochelle Park v. Mercury Ins. Grp., 421 N.J. Super. 160, 166 (App. Div. 2011) (review of Law Division action on subject matter beyond the jurisdiction of the DRP is subject to supervisory review)

- Liberty Mut. Ins. Co. v. Garden State Surgical Ctr., L.L.C., 413 N.J. Super. 513, 521 (App. Div. 2010) (review of denial of leave to file an amended complaint or the order dismissing the complaint as untimely subject to supervisory review)

- Sabato, supra, 380 N.J. Super. at 473 (because the award of attorney's fees is governed by

Court Rules and Rules of Professional Conduct, dispute concerning attorney's fees subject to supervisory review.)

Contrarywise, published cases which have found no cause to invoke supervisory review include:

- Monmouth Med. Ctr., supra, 460 N.J. Super. at 588 (remand to DRP because application was improperly denied based on the billing format used was not subject to supervisory review.)

- Fort Lee Surgery Ctr., supra, 412 N.J. Super. at 104 (Law Division's articulation as to how arbitrator applied too restrictive a view of what treatments were medically necessary not subject to supervisory review)

- Riverside Chiropractic Grp. v. Mercury Ins. Co., 404 N.J. Super. 228, 240 (App. Div. 2008) (Law Division correctly applying the statute's standards, and lack of any public policy warranting further review, supervisory review denied.)

In this case, Judge Rivas properly reviewed and evaluated the DRP's decision and found that the DRP properly evaluated the evidence presented by Plaintiff and found that the evidence failed to establish Plaintiff bore his burden of proof concerning the reimbursements for the claims concerning Dr. Gallick and Center for Ambulatory Surgery, and that the DRP properly rejected Plaintiff's arguments. In doing so, he acted within his jurisdiction and within APDRA's bounds.

As such, this case has none of the type of issues found in cases like Desai, Specialty Surgical, Kimba, Open MRI & Imaging, Garden State Surgical, or Sabato, which justified supervisory review. Indeed, the matter is most akin to Riverside Chiropractic, as Judge Rivas "did not commit any glaring errors that would frustrate the Legislature's purpose in enacting the APDRA [and] correctly applied the relevant provisions of the statute to the facts at issue and clearly supported its finding that the DRP's award should not be reversed." Riverside Chiropractic, 404 N.J. Super. at 240. The present case, like Riverside Chiropractic, "is clearly not an incident where the trial court failed to decide the case by applying the principles dictated by the Legislature." Id. (internal quote omitted.)

Accordingly, this Court simply has no jurisdiction and this appeal should be dismissed.

ISSUE II: STANDARDS OF REVIEW OF AN ORDER DECIDING A MOTION FOR SUMMARY JUDGMENT.

In the alternative, if this Court finds jurisdiction, the review of an order granting summary judgment is plenary and a reviewing court applies the same standard as the motion judge. Elazar v. Macrietta Cleaners, Inc., 230 N.J. 123, 135-36 (2017).

New Jersey Court Rule 4:46-2(c) provides that summary judgment:

> ...shall be rendered forthwith if the pleadings, depositions, answers to interrogatories and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact challenged and that the moving party is entitled to judgment or order as a matter of law. An issue of fact is genuine only if, considering the burden of persuasion at trial, the evidence submitted by the parties on the motion, together with all legitimate inferences therefrom favoring the non-moving party, would require submission of the issue to the trier of fact.
>
> [R. 4:46-2(c).]

Summary Judgment is warranted when the evidence presents no genuine issue of fact or when it is so one sided that one party must prevail as a matter of law. Brill v. Guardian Life Insurance of America, 142 N.J. 520, 536 (1995). To avoid summary judgment, the opposing party must come forward with evidence that creates a genuine issue as to a challenged material fact. Brill, 142 N.J. at 529.

The party opposing summary judgment "must do more than simply show that there is some metaphysical doubt as to the material facts." Triffin v. Am. Int'l Group, Inc., 372 N.J. Super. 517, 523-24 (App. Div. 2004) (citations omitted). "Competent opposition requires 'competent evidential material' beyond mere 'speculation' and 'fanciful arguments.'" Hoffman v. Asseenontv.com, Inc., 404 N.J. Super. 415, 426 (App. Div. 2009) (quoting Merchs. Express Money Order Co. v. Sun Nat'l Bank, 374 N.J. Super. 556,

563 (App. Div. 2005)). A court cannot deny a motion for summary judgment merely because the opposing party points to an insubstantial or controverted fact. Id.

The determination that a genuine issue of material fact exists cannot be made based on a mere argument of counsel or the bare assertion of a conclusion opposite to the factual position of the adversary. Amabile v. Lerner, 74 N.J. Super. 43 (App. Div. 1963); U.S. Pipe & Foundry Co. v. Am. Arbitration Assoc., 67 N.J. Super. 384, 400 (App. Div. 1961); Ocean Cape Hotel Corp. v. Masefield Corp., 63 N.J. Super. 369 (App. Div. 1960). When evidence fails to present sufficient disagreement to require submission to a jury, or when evidence is so one sided that a party must prevail as a matter of law, summary judgment should be granted. Brill, 142 N.J. at 536.

In this case, Judge Rivas properly granted summary judgment, as he found no basis to disturb the arbitration award.

ISSUE III: THERE WAS NO ERROR IN JUDGE RIVAS'S DECISION TO AFFIRM THE ARBITRATION AWARD.

Plaintiff first argues that the Law Division judge erred by "overlook[ing] the law requiring medically necessary and causally related medical expenses to be paid pursuant to the New Jersey PIP fee schedule" and that the arbitrator erred by supposedly failing to do that. (Pb5-6)

For the claims at issue—payments concerning Dr. Gallick and Center for Ambulatory Surgery—the arbitrator found that Plaintiff failed to provide sufficient evidence to support its obligations because although Optum was asserting a lien, its documentation did not break down its payment by CPT code, but only provided a lump sum for each date of service. Consequently, Plaintiff failed to provide adequate documentation to fulfill his burden of proof concerning reimbursement. (Pca141)

Plaintiff's argument simply ignores these facts and argues that the arbitrator was required to simply award the fee schedule amounts. (Pb7-8) However, the issue here is the fact that Plaintiff failed to support his claim with sufficient evidence to determine what was paid to the providers and for what purpose. This was Plaintiff's burden. See, Elkins v. New Jersey Mfrs. Ins. Co., 244 N.J. Super. 695, 701 (App. Div. 1990) (the plaintiff has burden of proving all facts for reimbursement); Miltner v. Safeco Ins. Co. of Am., 175 N.J. Super. 156, 158 (Law. Div. 1980).

N.J.S.A. 2A:23A-13(c) defines the scope of Judge Rivas's jurisdiction. On application of a party, a trial judge may modify or correct an award upon finding that the rights of that party were prejudiced by:

> (1) Corruption, fraud or misconduct in procuring the award;
> (2) Partiality of an umpire appointed as a neutral;
> (3) In making the award, the umpire's exceeding

> their power or so imperfectly executing that power that a final and definite award was not made;
> (4) Failure to follow the procedures set forth in this act, unless the party applying to vacate the award continued with the proceeding with notice of the defect and without objection or
> (5) The umpire's committing prejudicial error by erroneously applying law to the issues and facts presented for alternative resolution.
>
> [N.J.S.A. 2A:23A-13(c)]

N.J.S.A. 2A:23A-13(b) sets forth that when considering a claim under subsection (c)(5), the "decision of the umpire on the facts shall be final if there is substantial evidence to support that decision." Substantial evidence is described as, "such evidence as a reasonable mind might accept as adequate to support that conclusion." In re Application of Hackensack Water Co., 41 N.J. Super. 408, 418 (App. Div. 1956). See, also, N.J. Transit Bus Operations, Inc. v. Amalgamated Transit Union, 187 N.J. 546, 554-555 (2006) (on review of arbitration decision, the standard is whether the whether the interpretation of the contractual language is “reasonably debatable.”) Id. at 554-555. A reviewing court may not substitute its own judgment for that of the arbitrator, despite of the court's view of the correctness. Id. at 554. The policy of strict limiting judicial interference with arbitration, was intended to “promote arbitration as an end to litigation.” Id. at 554. See, also, Country College of Morris Staff Ass'n v. County College of Morris, 100 N.J. 383, 390 (1985) (“to

the extent possible, arbitration should spell the conclusion of litigation rather than the beginning of it.”) Id.

Here, Plaintiff’s argument fails.

In order to be reimbursed on a lien, it is the Plaintiff’s burden to prove that what the lien seeks is in compliance with the New Jersey Fee Schedule. The crux of this case is that the Plaintiff only submitted the Optum lien and not the underlying EOBs from the health insurer, United Healthcare[4]. The Optum lien document does not break down the health insurance carrier’s payments by CPT codes, but only gives lump sums for a particular date of service. As this breakdown was not provided by Plaintiff, he was essentially asking that the arbitrator guess or speculate as to which CPT codes were reimbursed by the health insurer and which were not. This information is essential to formulating an award, as Defendant is only required to make reimbursement on the ERISA lien to the extent that it complies with the New Jersey Fee Schedule. When multiple CPT codes are at issue and there is no indication which are being reimbursed, it is impossible to know if that reimbursement comports with the Fee Schedule.

The arbitrator’s determination was not erroneous based on the law at issue and the facts presented at the time of arbitration. The arbitrator looked at

[4] United Healthcare and Optum are related entities.

every single line item and awarded those dates of service where the Plaintiff proved medical necessity, causation and the level of reimbursement to which they were entitled. To ask the court to award lump sums paid by Optum without knowing which CPT codes were being reimbursed by the health insurer would be to set aside the New Jersey Fee Schedule and issue an award based upon speculation.

Moreover, it should be noted that Plaintiff repeated notes that he "adopted" USAA's chart of services alleged in its Arbitration Summary (Pca5-6), and argues that therefore the Fee Schedule should have been paid based on that chart. However, the inclusion of the chart in the Arbitration Summary was not a concession that those entries were all reimbursable, did not establish the information the arbitrator found missing, nor did it establish that Plaintiff was somehow relieved of his burden of proof to prove his claim as to each entry.

Rather, it was, as it specifically indicates, merely a summary statement of "the dates of service and amounts alleged at issue." (Pca5) Even with the "adoption" of this chart, Plaintiffs still did not produce the Explanation of Benefits ("EOB") from Plaintiff's health insurer, United Healthcare, upon which the reimbursement was sought, which presumably would have differentiated the payments for each of the CPT codes on each date of service.

Because Plaintiff failed to present that evidence, the arbitrator's decision was proper.

Furthermore, Plaintiff's argument simply ignores the fact that this is a reimbursement claim for bills which were already paid by United Healthcare, so he cannot simply seek PIP benefits pursuant to the Fee Schedule as if the bills had never been paid. (See, Pa14, on Demand for Arbitration, noting that the provider is "Optum Lien")

Further, Judge Rivas committed no error nor overstepped his bounds in reviewing the umpire's decision and confirming it. The question for Judge Rivas was not whether he agreed with the arbitrator's decision, but whether the arbitrator's decision was reasonably debatable.

During the hearing on the cross-motions for summary judgment, Judge Rivas properly recognized that Plaintiff's argument was considered by the arbitrator, but ultimately rejected:

> THE COURT: But there's no suggestion that the arbitrator did not take your arguments into consideration, right, they just rejected them? You're not happy with his or her, I don't know if the arbitrator was him or she, but you're not happy with the arbitrator's decision?
>
> [1T8:4-9]

While Plaintiff denied that suggestion, he offered that there was evidence on the record to support his claim. However, Judge Rivas properly

recognized that this evidence was weighed and balanced by the arbitrator and Plaintiff's position was simply not accepted:

> MR. SLOAN: So there's evidence here. There's no -- there seems to be --
>
> THE COURT: Evidence which the arbitrator considered and looked at before he or she made his decision, their decision.
>
> MR. SLOAN: That I don't know, but because --
>
> THE COURT: Well, I'm to presume, unless you can show me that there was either -- that there was either corruption, fraud or misconduct or partiality or that the arbitrator exceeded their power or failed to follow the procedures that are set forth in the act or that the umpire committed prejudicial error by erroneously applying law to the issues and facts presented for alternative resolution. Those are the bases by which this Court can vacate an award under
>
> 2A:23A-13(c). The fact that --
>
> MR. SLOAN: Right, I'm familiar --
>
> THE COURT: The fact --
>
> MR. SLOAN: Sorry.
>
> THE COURT: The fact that you're not happy, it doesn't -- the record that is before me is that all the issues that you have raised were all in front of the arbitrator and that they took them into account and they made a decision. You may not agree with that decision. Another arbitrator may have come out with another decision looking at the same material because not everybody looks at everything exactly the same way.

> So the question is, did they miss the boat entirely or was there some fraud or was there some partiality? There has been no suggestion of any of those factors here. It looks like the procedures were followed. The arbitrator did not exceed their authority in making the ruling. All the evidence was before it based on both your and her submission, everything was in front of the arbitrator. So based on 2A:23A-13(e), there doesn't appear to be any reason for this Court to disturb the arbitration award at this time and I'm not going to.
>
> [1T8:22-10:9]

Having heard no basis to reverse the arbitrator, Judge Rivas concluded:

> THE COURT: All right. Again, based on the Court's review of the materials, the Court does not find, that there's not a basis here to disturb this arbitration award. Notwithstanding the arguments that have been made on behalf of Galati, I understand, but it does not appear that the arbitrator failed to take into consideration the appropriate factors that have to be taken into consideration. The evidence was not presented and the arbitrator cannot consider stuff that was not presented.
>
> So the Motion for Summary Judgment is granted in favor of the defendant and it's denied as to the plaintiff. All right, folks.
>
> [1T11:19-12:6]

Thus, Judge Rivas did not err in granting USAA Summary Judgment.

D. Conclusion

For all the foregoing reasons, USAA Insurance Company, respectfully requests that this Court dismiss this appeal or, in the alternative, affirm the grant of Summary Judgement in USAA's favor.

Respectfully Submitted,
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MICHAEL GALATI, Plaintiff/ Appellant, v. USAA INSURANCE COMPANY, Defendant/ Respondent.	)))))))))))))	SUPERIOR COURT OF NEW JERSEY APPELLATE DIVISION DOCKET NO.: A-001380-23T2 On appeal from: Superior Court, Civil Division Middlesex County Docket No.: MID-L-006293-22 Sat Below: Hon. Alberto Rivas, J.S.C.

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PRELIMINARY STATEMENT

At the heart of this appeal lies the arbitrator's failure to adhere to the New Jersey Personal Injury Protection ("PIP") fee schedule (hereinafter "fee schedule"), N.J.A.C. 11:3-29, Appendix, Exhibit A (2024), despite Plaintiff's authorized amendment to the Demand for Arbitration aimed at ensuring accurate and fair reimbursement. The mandatory statutory and regulatory provisions governing PIP benefits were incorrectly deemed inapplicable, leading to a flawed arbitration award erroneously upheld by the Law Division. The arbitrator and the Law Division's disregard for the amendment, due to an oversight in understanding its substance, and the applicable law necessitates a comprehensive review by the Appellate Division to correct this critical error.

FACTS AND PROCEDURAL HISTORY[1]

The present matter originated from the nonpayment of benefits for medical treatment rendered to Plaintiff/Appellant Michael Galati ("Plaintiff"), which Defendant/Respondent USAA Insurance Company ("Respondent") improperly denied as medically unnecessary. Pca141. Consequently, the medical providers billed the health insurer—a scenario potentially financially advantageous to Respondent, especially if later required to reimburse the insured for any subsequent ERISA lien, given that health insurance rates are typically lower than

[1] The Procedural History and Statement of Facts are represented together for the Court's convenience and to avoid repetition.

those set by the fee schedule. Pca1-4.

Initially, Plaintiff sought reimbursement based on the health lien. Pa12-14. However, due to the nature of the billing information obtained from the health insurer's third-party subrogation services provider—and recognizing that the PIP carrier must reimburse medical expenses irrespective of collateral payments—Plaintiff amended the Demand for Arbitration. Pa15; Pca5-84. This amendment followed Respondent's admission that the bills for the medical expenses contained in the lien had been submitted to the PIP carrier and denied. Pca5-79. The amendment therefore sought direct reimbursement for the outstanding medical *bills* in accordance with the fee schedule, adopting the admissions made by Respondent in its own breakdown of what was outstanding. Pa15.

Furthermore, Plaintiff's medical providers, having received payment from Plaintiff's health insurer, were not seeking additional reimbursement for the amounts they were still owed under the fee schedule. As such, Plaintiff's amendment to the Demand for Arbitration included a stipulation for reimbursement wherein Plaintiff would accept as reimbursement the amounts paid by the health insurer—rather than the higher amounts mandated by the fee schedule—whenever those amounts due under the fee schedule exceeded the amount of the payments made to Plaintiff's medical providers. Pa15. This stipulation resulted in a significant benefit to Respondent after having improperly denied the bills originally.

Despite Plaintiff's amendment, the arbitrator erroneously ruled that the absence of a detailed payment breakdown in the health insurance lien documentation, or the lack of "United Healthcare EOBs"—a non-party to the case, precluded the application of the fee schedule. Pca141. The arbitrator failed to recognize that Plaintiff's amended Demand for Arbitration called for direct reimbursement of the outstanding medical *bills* under the fee schedule, not merely the lien. Pa15. This critical oversight was exacerbated by the presence of clear and undisputed evidence (*i.e.*, Respondent's own Explanation of Benefits ("EOBs") and payment ledger) that supported a precise calculation of reimbursement for the unpaid medical bills, including all necessary CPT codes and related data, as documented within Respondent's own submission.[2] Pca5-84.

Although the arbitrator acknowledged this evidence and the amendment in the arbitration award, there was a failure to appropriately consider them when rendering the decision, resulting in an award that did not comply with the statutory mandates. Pca134-143. This fundamental error in applying the relevant laws to the presented issues and facts was not only overlooked but also perpetuated by the Law Division, which upheld the arbitrator's flawed decision. Pa37. The Law Division ignored the arbitrator's critical failure to apply the fee

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[2] For purposes of the stipulation made by Plaintiff, Respondent's breakdown, submitted for purposes of calculating reimbursement and which Plaintiff adopted, also accounts for the amounts paid by Plaintiff's health insurer for each date of service. Pca5-6; Pca1-4.

schedule in light of Plaintiff's amended Demand for Arbitration, thereby replicating the same legal error. 1T5:12-6:8; 1T9:16-10:9.

LEGAL ARGUMENT

I. MISAPPLICATION OF LAW BY THE ARBITRATOR AND SUBSEQUENT OVERSIGHT BY THE LAW DIVISION (Raised Below: 1T5:12-6:8; 1T9:16-10:9)

Respondent contends that the arbitrator's decision was justified, arguing that Plaintiff failed to provide sufficiently detailed documentation delineating the amounts paid by the health insurer for each CPT code on specific service dates. According to Respondent, the absence of such detailed itemization means any reimbursement would be based on speculation rather than a precise calculation under the fee schedule. This argument fundamentally misinterprets the Plaintiff's amendment, which was specifically designed to simplify the reimbursement process by directly applying the fee schedule to the unpaid medical bills and adopting the admissions made by Respondent regarding what was outstanding. As a conciliatory stipulation to further streamline the reimbursement calculations, Plaintiff agreed to accept as reimbursement the amounts paid by health insurance where those payments fell below the fee schedule rates. This stipulation aimed to ensure equitable reimbursement for the outstanding medical expenses, particularly since there was no independent pursuit of additional reimbursement by the medical providers who were paid by Plaintiff's health insurer.

However, Plaintiff's conciliatory action continues to be mischaracterized by Respondent, who initially argued and still maintains that the Plaintiff failed to produce adequate health insurance documentation, leading the arbitrator to adopt this flawed perspective. This mischaracterization improperly influenced the arbitrator's decision and led to nonpayment, which has unfairly benefitted Respondent. Respondent's insistence on detailed breakdowns from the health insurance lien ignores the substantive changes introduced by the Plaintiff's authorized amendment and its own documentation, which clearly set forth the calculations for reimbursement. Plaintiff's amended Demand for Arbitration was intended to streamline the calculation process by applying the fee schedule directly to well-documented unpaid bills and substituting lower reimbursement amounts by stipulation, where necessary, to account for Plaintiff's actual loss. Respondent provided the documentation, including the EOBs, which contained all necessary details to correctly apply the fee schedule to the outstanding bills. Respondent's breakdown, which incorporates the lien documentation provided by the health insurer's subrogation services provider, accounted for the payments made by the health insurer and, thus, also contains all the necessary details to appropriately calculate reimbursement in light of Plaintiff's stipulation.[3] Despite

[3] While not applicable here, even where an arbitrator may be unable to incorporate health payments into an arbitration award, the fee schedule must still be applied in any scenario where the treatment is deemed medically necessary

this, the arbitrator overlooked the substance of the amendment as the finding that additional itemization was required directly contradicts Plaintiff's authorized amended Demand for Arbitration, the stipulations contained therein, and the documented evidence presented. Consequently, the arbitrator failed to apply the fee schedule to the outstanding bills found to be medically necessary and causally related to Plaintiff's motor vehicle accident in violation of N.J.A.C. 11:3-29 (authorized pursuant to N.J.S.A. 39:6A-4.6), constituting prejudicial error in applying the applicable law to the issues and facts presented for arbitration as well as the imperfect execution of a final and definite award pursuant to N.J.S.A. 2A:23A-13.

The Law Division's subsequent failure to address Plaintiff's argument and correct the arbitrator's decision further compounded the legal error. By endorsing the arbitrator's flawed approach, the Law Division failed to ensure that the arbitration award adhered to the governing statutes and legal standards. This oversight by the Law Division not only upheld an incorrect application of the fee schedule but also set a concerning precedent that undermines the fair and just application of law in cases involving agreed upon amounts outstanding. Thus, the decision of the arbitrator must be vacated and corrected and the subsequent confirmation by the Law Division must be reversed.

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and causally related to the automobile accident because those benefits must be paid regardless of collateral sources. N.J.S.A. 39:6A-6.

II. PLAINTIFF HAS STANDING BEFORE THE APPELLATE DIVISION (Not Raised Below)

For the reasons set forth below, Plaintiff's standing before the Appellate Division is justified for two reasons: (A) the necessity for *de novo* review arises from a legal question concerning the proper application of the fee schedule; and, (B) appellate oversight is necessary due to the Law Division's failure to conduct an appropriate review of the issue presented on appeal.

A. The Application of the Fee Schedule Constitutes a Legal Question, Necessitating *De Novo* Review (Not Raised Below)

This Court is confronted with a definitive legal question concerning the correct application of the fee schedule—a task that demands *de novo* review to ensure uniform application of legal standards. As demonstrated in N.J. Mfrs. Ins. Co. v. Specialty Surgical Ctr. of N. Brunswick, 458 N.J. Super. 63 (App. Div. 2019), the Appellate Division has upheld the necessity for appellate oversight in the interpretation and application of the fee schedule to ensure the law is applied correctly and consistently. Specialty Surgical involves the application of statutory and regulatory mandates—specifically, N.J.S.A. 39:6A-4.6 and N.J.A.C. 11:3-29—that govern the reimbursement practices under PIP insurance coverage. Id. at 66. In Specialty Surgical, the Court affirmed the Law Division's interpretation of these mandates after determining that certain procedures not listed on the fee schedule as reimbursable when performed at a surgery center are not compensable. Id. at 65. This precedent demonstrates the need for precise

and legally sound interpretation of the fee schedule, emphasizing that such interpretations are purely legal determinations rather than factual ones.

The issue on appeal does not involve a factual question such as whether the treatment rendered was medically necessary. Rather, like Specialty Surgical, the arbitrator's failure to apply the mandated fee schedule despite Plaintiff's amendment to the Demand for Arbitration and his stipulated reliance upon Respondent's own breakdown—undisputedly supported by clear evidence of the necessary CPT codes and acknowledged within the award—presents a scenario where certain procedures listed for reimbursement on the fee schedule were nevertheless found to be non-compensable by the arbitrator in violation of N.J.S.A. 39:6A-4.6 and N.J.A.C. 11:3-29. As such, this Court has the authority to ensure that these legal standards are interpreted and applied correctly. Thus, Plaintiff has standing to bring this matter before the Appellate Division.

B. Exceptional Circumstances Warrant the Invocation of the Appellate Division's Supervisory Function (Not Raised Below)

Moreover, should there be any doubt as to the legal nature of the issue, this case independently warrants appellate review under the New Jersey Alternative Procedures for Dispute Resolution Act because the present circumstances require the invocation of the Appellate Division's supervisory function, as demonstrated in Morel v. State Farm Insurance Company, 396 N.J. Super. 472 (App. Div. 2007). In Morel, the Appellate Division reversed a lower court's confirmation of

an arbitration award after determining that the Law Division had failed to conduct an appropriate review of the case. Id. at 476. The Morel decision highlights the Appellate Division's duty from a public policy standpoint to ensure that the Law Division does not deviate from the statutory and regulatory mandates concerning the PIP arbitration process by, for example, failing to properly address an issue presented on appeal. Id. at 476.

In the present case, after the arbitrator did not apply clear statutory and regulatory mandates—specifically, the fee schedule—even though Plaintiff sought reimbursement for the unpaid medical bills pursuant to the fee schedule and the necessary CPT codes were undisputedly presented as evidence and acknowledged by the arbitrator within the award, the Law Division did not address the issue of whether the arbitrator improperly disregarded the fee schedule in light of Plaintiff's amendment to the Demand for Arbitration. Instead, the Law Division incorrectly held that the arbitrator's decision was supported by a lack of evidence under the mistaken belief Plaintiff had pursued reimbursement pursuant to an ERISA lien. This Court's intervention is, therefore, not only necessary to address the specific legal errors made in the application and interpretation of the fee schedule but also to ensure that Law Division review of PIP arbitration appeals is conducted properly by adequately addressing the issues presented. Without applying such oversight and review in cases where the Law Division fails to appropriately address an issue presented on

appeal, the PIP arbitration statutes and regulations risk being diluted, leaving those insureds that have been improperly denied PIP benefits vulnerable to unrectified errors and the inconsistent application of the law. Accordingly, exceptional circumstances exist warranting appellate review and, as such, Plaintiff has standing to bring this matter before the Appellate Division.

CONCLUSION

The arbitrator's failure to issue reimbursement for medically necessary treatment pursuant to the fee schedule, despite the Plaintiff's authorized amendment to the Demand for Arbitration, represents a significant legal oversight, erroneously endorsed by the Law Division. This misapplication of the law undermines statutory mandates and offends the interests of justice. It is, therefore, respectfully submitted that this Court reverse the Law Division's decision and mandate compliance with the fee schedule for all medically necessary treatment, reflecting any stipulations made by Plaintiff. Alternatively, the matter should be remanded for proceedings consistent with New Jersey law. Such actions will ensure justice in this case and uphold the integrity and meaningfulness of appellate review in PIP cases.

Respectfully submitted,

/s/ *Daniel O. Sloan*

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DANIEL O. SLOAN