SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
DOCKET NO. A-3924-15T3

PETER A. LIQUARI, III, and
REBECCA LIQUARI,

Plaintiffs-Appellants,

v.

JENNIFER COMBS,

Defendant,

and

PROCURA MANAGEMENT INC.,
and/or ESURANCE INSURANCE SERVICES,

Defendants-Respondents.

Submitted January 17, 2018 - Decided February 2, 2018

Before Judges Carroll and Mawla.

On appeal from Superior Court of New Jersey, Law Division, Monmouth County, Docket No. L-0327-13.

Spector Foerst & Associates, attorneys for appellants (James M. Foerst, on the briefs).

Morgan Melhuish Abrutyn, attorneys for respondents (Deborah J. Banfield, of counsel and on the brief; Mark T. Hall, on the brief).

PER CURIAM

This appeal arises out of a dispute over the payment of personal injury protection (PIP) benefits. Plaintiff Peter A. Liquari, III brought suit against his automobile insurance carrier, Esurance Insurance Services, Inc. (Esurance), and its claims administrator, Procura Management, Inc. (Procura), for damages he allegedly suffered as a result of defendants' bad faith in delaying and denying his medical treatment. Plaintiff appeals the April 26, 2016 order dismissing his claims against defendants on summary judgment. For the reasons that follow, we affirm.

I.

We provide some brief historical background to lend context to the present dispute. We have previously noted that

> [t]he requirement that an automobile insurance policy include PIP benefits is a fundamental part of the No-Fault Act, N.J.S.A. 39:6A-1 to -35, first enacted in 1972, L. 1972, c. 70, and comprehensively amended in 1998 by enactment of the Automobile Insurance Cost Reduction Act (AICRA), L. 1998, c. 21 and c. 22. Two major objectives of this legislation are facilitating "prompt and efficient provision of benefits for all accident injury victims" and "minimiz[ing] resort to the judicial process. . . ." Gambino v. Royal Globe Ins. Cos., 86 N.J. 100, 105-07 (1981).
>
> [Endo Surgi Ctr., P.C. v. Liberty Mut. Ins. Co., 391 N.J. Super. 588, 592 (App. Div. 2007).]

AICRA represents the Legislature's continued effort to reduce the cost of automobile insurance. In a seminal decision construing the then-recently enacted AICRA, we began by reviewing the Legislature's previous unsuccessful efforts to reduce automobile insurance costs, including AICRA's predecessor, the Fair Automobile Insurance Reform Act (FAIRA), N.J.S.A. 17:33B-1 to -64. See Coal. for Quality Health Care v. N.J. Dep't of Banking & Ins., 348 N.J. Super. 272, 283 (App. Div. 2002). In adopting AICRA, the Legislature "made further comprehensive changes to the no-fault automobile insurance laws in an effort to 'preserve the no-fault system, while at the same time reducing unnecessary costs' which had resulted in increased premiums." Ibid. (quoting N.J.S.A. 39:6A-1.1(b)).

AICRA implemented standard courses of treatment (Care Paths) established by the Commissioner of Banking and Insurance (Commissioner) for soft-tissue injuries of the neck and back. See N.J.A.C. 11:3-4.6. Under AICRA, the Care Paths provide that treatment of existing injuries be evaluated at certain intervals called Decision Points. Upon reaching a Decision Point, an insured must provide information about further treatment he or she expects the insurer to provide. See N.J.A.C. 11:3-4.2. Evaluation of this information is known as Decision Point Review (DPR), and is subject to the mandatory protocols of an insurer's Decision Point

Review Plan (DPR Plan). See N.J.A.C. 11:3-4.7. DPR is also required for PIP reimbursement of certain diagnostic tests under N.J.A.C. 11:3-4.5(b).

Where standard treatment protocols are not appropriate or a new injury arises, the insured's treating physician may provide "precertification" of certain procedures, treatments and diagnostic tests, supported by the physician's clinical findings. See N.J.S.A. 39:6A-3.1(a). Precertification is subject to regulatory approval by the Commissioner.

The insured bears the burden of establishing his or her claims are medically necessary by a preponderance of the evidence. Miltner v. Safeco Ins. Co., 175 N.J. Super. 156, 157-58 (Law Div. 1980). From that point, the insurer bears the burden of providing coverage or proving it is not responsible for the payment. Ibid.

Disputes over the payment of PIP benefits are governed by N.J.S.A. 39:6A-5 (Section 5). N.J.S.A. 39:6A-5(g) provides that any claim for PIP medical benefits shall be overdue if not paid within sixty days after the insurer is furnished written notice of the fact of a covered loss and of the amount of same, and that all overdue payments shall bear interest at the percentage of interest prescribed in the New Jersey Rules of Court for judgments, awards, and orders for the payment of money. N.J.S.A. 39:6A-5(h). The No-Fault Act also provides that either the insured or insurer

may submit any dispute regarding payment of PIP medical benefits to alternative dispute resolution, which may consist of either arbitration or review by a medical review organization. N.J.S.A. 39:6A-5.1, -5.2. An insured who prevails in such a proceeding may be awarded attorney's fees. R. 4:42-9(a)(6).

II.

It is against this backdrop that we recount the facts underlying the dispute between insurer and insured. In his complaint, plaintiff sought damages for the injuries he sustained in an April 6, 2011 automobile accident he claimed was caused by the negligence of defendant Jennifer Combs.[1] At the time of the accident, plaintiff was covered under his wife's automobile insurance policy issued by Esurance, which provided PIP coverage of $250,000.

Specifically, the Second Count of plaintiff's complaint alleged that defendants failed to properly and timely provide him with PIP benefits to allow him to receive adequate medical care. The Third Count alleged that defendants negligently failed to timely and properly approve PIP benefits to which plaintiff was entitled under the insurance policy, causing him injury and exacerbating injuries he sustained in the accident. The Fourth

[1] Plaintiff's negligence claim against Combs is not at issue in this appeal.

Count sought punitive damages based on plaintiff's claim that defendants acted "egregious[ly] and outrageous[ly]" by "requir[ing] unreasonable cooperation and deny[ing] reasonable and appropriate medical testing, therapy[,] and treatment." However, as plaintiff's medical treatment progressed, the full $250,000 PIP policy limit was ultimately paid by Esurance, thus rendering moot plaintiff's claim for benefits in Count Two.

With respect to these contentions, the motion record reveals that, following the accident, Esurance provided plaintiff with its DPR Plan, which had been approved by the Commissioner and contained Esurance's internal appeal and dispute resolution processes. The DPR Plan further advised plaintiff and his treating health care providers of Esurance's precertification requirements and the right to arbitrate disputes.

From April 2011 to August 2014, defendants processed plaintiff's precertification treatment plans and medical bills for injuries sustained as a result of the automobile accident. Plaintiff's coverage limit of $250,000 was fully exhausted in August 2014. As described in further detail below, plaintiff contends defendants failed to properly administer its DPR plan and did so in bad faith with regard to: (1) physical therapy to his left knee; (2) physical therapy to his lumbar spine; and (3) neuropsychological treatment. As a result, plaintiff alleges

defendants delayed his overall recovery and caused additional pain, suffering, and disability.

Left-Knee Treatment

On August 18, 2011, plaintiff underwent arthroscopic surgery on his left knee, which was approved by defendants. Thereafter, plaintiff's knee pain did not subside. Plaintiff received follow-up treatment from his treating physician, Dr. Jeffrey Bechler, who requested precertification for physical therapy. Defendants properly received notice of this request for coverage.

Defendants referred the matter to Dr. David S. Wolkstein for a medical director review (MDR). Plaintiff's request for physical therapy was subsequently denied based on Dr. Wolkstein's conclusion that "alternatives in treatment would be more appropriate [than physical therapy]." "However, because of the length of time that has gone by and the persistent symptoms," Dr. Wolkstein recommended plaintiff undergo an additional independent medical examination (IME).

On November 14, 2012, plaintiff underwent an IME with Dr. Kenneth P. Heist. Based on this examination, plaintiff's request for physical therapy for his left knee was denied (although four weeks of physical therapy for plaintiff's right shoulder was approved). Nonetheless, Dr. Bechler continued to treat plaintiff for knee pain and performed an additional arthroscopic surgery on

plaintiff's left knee in December 2012, which was approved and covered by defendants.

Following this surgery, plaintiff received physical therapy from December 2012 to March 2013. On March 27, 2013, plaintiff underwent an IME with orthopedist Lawrence I. Barr, D.O. Dr. Barr concluded plaintiff had "plateaued medically and reached maximum medical improvement. No further treatment appears indicated." Sean Lager, M.D. subsequently conducted an MDR and denied further physical therapy, noting there was "insufficient information provided" to support the request. Specifically, Dr. Lager noted the absence of a recent physical examination and current treatment plan from plaintiff's treating physician, as well as the absence of an operative report regarding plaintiff's recent knee surgery.

In July 2013, Dr. Heist conducted an independent medical reexamination and found plaintiff "ha[d] not reached his maximum medical improvement" with regard to his left knee. Dr. Heist recommended three weeks of continued physical therapy, followed by at-home treatment, and opined that plaintiff "can return to work in a sedentary to light duty capacity." On October 3, 2013, Gary L. Yen, M.D., conducted another IME and concluded plaintiff had reached "maximum medical improvement . . . with regard to . . . [the] left knee."

On March 24, 2014, plaintiff's treating physician and medical expert witness, Joseph F. Fetto, M.D., recommended plaintiff undergo a total left-knee replacement. Defendants approved the procedure on June 19, 2014. On August 27, 2014, defendants informed plaintiff that his $250,000 PIP coverage was exhausted.

Lumbar Spine Treatment

In August 2011, plaintiff complained of "a burning sensation across his back" and presented to Dr. Heist for an IME. Although Dr. Heist confirmed plaintiff's continued need for treatment on his left knee and right shoulder, he concluded plaintiff's lower back injuries had "reached maximum medical improvement."

In October 2012, plaintiff presented to Gino Chiappetta, M.D., complaining of low back pain. Dr. Chiappetta sent defendants a precertification request for an MRI of plaintiff's lumbar spine. On November 14, 2012, defendants referred plaintiff to Dr. Heist for an IME. Dr. Heist opined that an MRI of plaintiff's lumbar spine was not medically necessary. Dr. Chiappetta appealed the denial, but was unsuccessful.

On February 14, 2013, Dr. Chiappetta reaffirmed that an MRI of plaintiff's lumbar spine was medically necessary, noting plaintiff was "worsening in terms of his pain and numbness" and an MRI would be "very helpful in terms of detailing the underlying pathology." On February 22, 2013, defendants again denied Dr.

Chiappetta's request. Defendants also denied coverage for physical therapy on March 4, 2013.

Days later, plaintiff underwent an MRI at Jersey Shore Medical Center. The MRI revealed a "small disc herniation" and some "disc degeneration." On March 27, 2013, Dr. Barr conducted an IME and noted plaintiff's complaint of severe back pain, which made his examination of plaintiff difficult. Dr. Barr concluded plaintiff "was at a plateau medically and no further treatment was indicated." On April 1, 2013, defendants approved payment of the MRI. However, Dr. Chiappetta's request that plaintiff receive lumbar fusion surgery was denied following an MDR. Dr. Chiappetta unsuccessfully appealed on April 15, 2013. Plaintiff maintains he was denied medically necessary treatment to his lumbar spine as a result of defendants' actions.

Neuropsychological Treatment

In June 2011, plaintiff underwent a neuropsychological consultation with Brett J. Prince, Ph.D., who concluded plaintiff was suffering from a mood disorder with anxiety. Following Dr. Prince's precertification submission requesting plaintiff receive psychological treatment, an MDR was performed by clinical neuropsychologist Lewis A. Lazarus, Ph.D. Dr. Lazarus approved the neuropsychological evaluation and the requested neuropsychological testing. However, Dr. Lazarus concluded he

could not make a determination of medical necessity with respect to the requests for pain management psychological testing and psychotherapy without additional information from Dr. Prince. On June 30, 2011, Dr. Prince appealed that determination, supplied additional information, and requested an IME be scheduled.

On August 2, 2011, Dr. Lazarus agreed that plaintiff undergo an IME. Theodore J. Batlas, Psy.D. conducted the IME on September 14, 2011. Dr. Batlas concluded plaintiff was suffering from adjustment disorder with anxiety and depression. As a result, certain psychological treatments were approved while others were not.

On October 5, 2011, Dr. Prince submitted a request for reconsideration, noting the decision was unsubstantiated because certain "vital issues" were "unaddressed and unresolved" in Dr. Batlas's IME report. On October 20, 2011, Dr. Prince sent a second request by facsimile stating: "Please review [and] advise. Patient is deteriorating and requires immediate care." Dr. Prince added, "there has been an inappropriate and unlawful delay in sending our request for an IME addendum to [Dr. Batlas], in clear violation of New Jersey Auto PIP [l]aws."

On November 2, 2011, Dr. Batlas issued an IME addendum recommending a "brief program of cognitive therapy" with the expectation that plaintiff would thereby obtain "maximum medical

improvement for cognitive difficulties." Dr. Batlas conducted another IME on January 9, 2012, and recommended plaintiff receive additional individual psychotherapy and cognitive therapy training, while finding "[a]dditional psychotherapy or biofeedback are not medically necessary or indicated."

On January 31, 2012, Dr. Prince expressed his dissatisfaction with Procura's failure to provide a copy of Dr. Batlas's January 9, 2012 IME report. Specifically, Dr. Prince informed Procura that its "repeated unwillingness to produce this report has not only led to a dangerous delay in curative treatment for [plaintiff] but is in direct violation of established New Jersey PIP [a]uto laws." On February 7, 2012, defendants approved an additional ten weeks of cognitive treatment, while denying other aspects of the requested treatment.

Defendants moved for summary judgment on March 2, 2016. They contended their administration of plaintiff's PIP claim complied with their contractual obligations under the DPR and precertification plans, as well as all applicable statutes and regulations. Defendants also argued that Section 5 provides the exclusive remedy and bars plaintiff from recovering any damages beyond the payment of attorney's fees, costs, and interest on overdue benefits.

Plaintiff opposed the motion, arguing he was entitled to punitive damages due to Procura's negligent or willful failure to properly provide benefits under the statutory framework. Plaintiff further contended that defendant's failure to comply with the DPR constituted a genuine issue of material fact warranting the denial of summary judgment.

In a detailed written opinion, the motion judge found defendants complied with their DPR, which in turn complied with the PIP statutes and accompanying regulations. The judge determined:

> Defendants' use of MDRs and IMEs were in compliance with their policy and the statutory requirements of . . . N.J.S.A. 39:6A-5 and N.J.A.C. 11:3-4 and were not used to delay treatment or harass . . . [p]laintiff. For treatment that [p]laintiff alleges . . . [d]efendants delayed or denied, he had the option to appeal a denial of treatment to arbitration. . . . Plaintiff admitted that he did not attempt to arbitrate his treatment.

Consequently, the judge concluded plaintiff was not entitled to recovery beyond the remedies provided in Section 5, and dismissed the complaint against defendants. This appeal followed.

III.

Plaintiff targets his arguments on appeal solely toward Procura. Plaintiff contends Procura's bad faith in delaying approval for his medical treatment exacerbated his injuries and

"constituted an independent negligence action, exclusive of its duty to pay for treatment under N.J.S.A. 39:6[A]-5." Plaintiff further contends that summary judgment was improper because whether Procura violated its duty of good-faith and fair dealing was a genuine issue of material fact for the jury to decide.

When reviewing the grant of summary judgment, we analyze the decision applying the "same standard as the motion judge." Globe Motor Co. v. Igdalev, 225 N.J. 469, 479 (2016) (quoting Bhagat v. Bhagat, 217 N.J. 22, 38 (2014)).

> That standard mandates that summary judgment be granted "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 a judgment or order as a matter of law."
>
> [Templo Fuente De Vida Corp. v. Nat'l Union Fire Ins. Co., 224 N.J. 189, 199 (2016) (quoting R. 4:46-2(c)).]

"To defeat a motion for summary judgment, the opponent must 'come forward with evidence' that creates a genuine issue of material fact." Cortez v. Gindhart, 435 N.J. Super. 589, 605 (App. Div. 2014) (quoting Horizon Blue Cross Blue Shield of N.J. v. State, 425 N.J. Super. 1, 32 (App. Div. 2012)), certif. denied, 220 N.J. 269 (2015). "[C]onclusory and self-serving assertions by one of the parties are insufficient to overcome the motion."

Puder v. Buechel, 183 N.J. 428, 440-41 (2005) (citations omitted). "When no issue of fact exists, and only a question of law remains, [we] [afford] no special deference to the legal determinations of the trial court." Templo Fuente De Vida, 224 N.J. at 199 (citing Manalapan Realty, L.P. v. Twp. Comm. of Manalapan, 140 N.J. 366, 378 (1995)).

Our Supreme Court has recognized that "an insurance company owes a duty of good faith to its insured in processing a first-party claim." Pickett v. Lloyd's, 131 N.J. 457, 467 (1993). Further,

> an insurance company may be liable to a policyholder for bad faith in the context of paying benefits under a policy. The scope of that duty is not to be equated with simple negligence. In the case of denial of benefits, bad faith is established by showing that no debatable reasons existed for denial of the benefits. In the case of processing delay, bad faith is established by showing that no valid reasons existed to delay processing the claim and the insurance company knew or recklessly disregarded the fact that no valid reasons supported the delay. In either case (denial or delay), liability may be imposed for consequential economic losses that are fairly within the contemplation of the insurance company.
>
> [Id. at 481 (emphasis added).]

In defining what constitutes bad faith refusal to pay a first-party claim, the Court stated "[i]f a claim is 'fairly debatable,' no liability in tort will arise." Id. at 473 (quoting Bibeault

v. Hanover Ins. Co., 417 A.2d 313, 319 (R.I. 1980)). The Court continued:

> To show a claim for bad faith, a plaintiff must show the absence of a reasonable basis for denying benefits of the policy and the defendant's knowledge or reckless disregard of the lack of a reasonable basis for denying the claim. It is apparent, then, that the tort of bad faith is an intentional one. Implicit in that test is our conclusion that the knowledge of the lack of a reasonable basis may be inferred and imputed to an insurance company where there is a reckless indifference to facts or to proofs submitted by the insured.
>
> [Ibid. (quoting Anderson v. Continental Ins. Co., 271 N.W.2d 368, 376-77 (1978) (emphasis added).]

However, in the PIP context, we have concluded

> that the sole remedy for a wrongful denial of PIP benefits is an award of the interest mandated by N.J.S.A. 39:6A-5(h) and [that conclusion] is also supported by the statutory mandate that either the insured or the insurer may require submission of any dispute regarding payment of PIP benefits to the alternative dispute resolution procedures provided by N.J.S.A. 39:6A-5.1. The evident purpose of this provision is to establish an expeditious non-judicial procedure for resolving any dispute regarding the payment of PIP benefits, in furtherance of the No-Fault Act's objectives of facilitating "prompt and efficient provision of benefits for all accident injury victims" and "minimiz[ing] resort to the judicial process. . . ." Gambino, 86 N.J. at 105. Moreover, even if these alternative dispute procedures are not utilized, there is no right to a jury trial in an action for unpaid PIP benefits. Manetti

> [v. Prudential Prop. & Cas. Ins. Co., 196 N.J. Super. 317, 320-21 (App. Div. 1984)]. However, if an insured (or an insured's assignee) were allowed to pursue a common law claim for an alleged bad faith denial of PIP benefits, under which there would be an entitlement to a jury trial, this would open the door to circumvention of the statutorily mandated alternative dispute resolution procedure provided by N.J.S.A. 39:6A-5.1.
>
> [Endo Surgi Ctr., 391 N.J. Super. at 594-95.]

In reversing the trial court's decision denying the insurer's motion to dismiss the bad faith claim, we distinguished Pickett as follows:

> In concluding that an insured can maintain a common law action for breach of good faith for denial of a PIP claim, the trial court relied primarily upon Pickett, 131 N.J. at 466-80, in which the Court held that a trucker who suffered economic losses in addition to the value of his truck as a result of his insurance carrier's failure to pay collision damage benefits could pursue a claim for a bad faith denial of benefits. The Court also held that the insured could seek punitive damages if the insurance carrier's conduct was wantonly reckless or malicious. Id. at 475-76. However, the court expressly recognized . . . that a claim for a wrongful failure to pay statutorily mandated insurance benefits such as PIP should be treated differently than a claim that is not subject to statutory regulation:
>
> > We also concur with the courts holding, in the highly-regulated area of personal injury protection, see N.J.S.A. 39:6A-5, that wrongful failure to pay benefits, wrongful withholding of benefits or other

> violation of the statute does not thereby give rise to a claim for punitive damages.
>
> [Id. at 476.]
>
> The Court also indicated that even though a punitive damages claim is not maintainable for an alleged bad faith denial of a statutorily regulated insurance benefit, an insured still may pursue a claim for compensatory and punitive damages for an "independent tort" committed by an insurance carrier in response to a claim for benefits, "such as threats by the insurer's agents to kill the insured and the insured's children . . . ." Id. at 475.
>
> [Endo Surgi Ctr., 391 N.J. Super. at 595.]

The decision we reached in Endo Surgi Center is no less applicable in the present case. Plaintiff does not allege that defendants committed any such independent tort here. Plaintiff's sole claim is that defendants' delay, and in some instances denial of payments of PIP benefits, was undertaken in bad faith. Therefore, even if defendants improperly delayed or denied payments of PIP benefits, plaintiff is only entitled to payment of the improperly denied benefits plus interest thereon and attorney's fees he incurred to collect those benefits. Endo Surgi Center, 391 N.J. Super. at 595-96. Here, Esurance paid the full $250,000 in PIP benefits pursuant to the policy limits, so that no further benefits are due. Plaintiff is not entitled to additional compensatory or punitive damages for defendants'

alleged bad faith. Accordingly, summary judgment was properly granted dismissing plaintiff's claims of bad faith.

Affirmed.