NON-PRECEDENTIAL DECISION - SEE SUPERIOR COURT I.O.P. 65.37

SEAN M. SMITH Appellant v. ALLSTATE INSURANCE COMPANY Appellee	IN THE SUPERIOR COURT OF PENNSYLVANIA No. 866 MDA 2012

Appeal from the Judgment Entered June 26, 2012
In the Court of Common Pleas of York County
Civil Division at No(s): 2009-SU-00385-01

BEFORE: SHOGAN, J., LAZARUS, J., and OTT, J.

MEMORANDUM BY LAZARUS, J. Filed: January 28, 2013

Sean M. Smith ("Smith") appeals from the order entered in the Court of Common Pleas of York County. After our review, we affirm on the opinion authored by the Honorable Clarence N. Patterson, Jr.,[1] dated May 24, 2011, issued in support of the order granting summary judgment in favor of Allstate Insurance Company ("Allstate").

On August 16, 2003, Smith was injured in a car accident while driving a vehicle insured by Allstate. Smith's injuries included cervical strain/sprain, lumbosacral sprain/strain, muscular injury, somatic dysfunction of thoracic and lumbar spine, herniated disc L5-S1, and aggravation of degenerative

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[1] We note that Judge Patterson is now deceased.

disc disease. Smith underwent lumbar surgery in July 2005. He submitted bills to Allstate for treatment in 2006 and 2007; Allstate paid those claims.

In 2008, Smith submitted claims to Allstate for first-party medical benefits for treatment he had begun in January 2008. Allstate submitted the claims to a peer review organization (PRO), pursuant to section 1797 of the Motor Vehicle Financial Responsibility Law (MVFRL), 75 Pa.C.S.A. § 1797. ***See Terminato v. Pennsylvania Nat. Ins. Co.***, 645 A.2d 1287 (Pa. 1994) (peer review process under MVFRL is mechanism through which insurer may seek professional assessment of reasonableness and necessity of medical treatment in order to independently determine whether claim should be paid or denied; it assists insurers in making informed decision regarding medical claim by mandating review by medical professional when claim is challenged by insurer). After his review, Dr. Timothy Fiorillo concluded that the 2008 treatments were neither medically necessary nor reasonable. Smith sought reconsideration of Dr. Fiorillo's conclusions, and Allstate obtained a second review by Dr. Mary Ann Karp. Dr. Karp noted in her history that Smith reported his pain was much improved post-surgery, that on 10/18/05 he reported minimal pain, and that at his follow up visit on 7/11/06 "he reported only minimal back symptoms, . . . was off all medications and was reportedly very active including biking up to 100 miles at a time." Opinion, Mary Ann Karp, D.O., 8/19/2008, at 2-3. Dr. Karp further noted that at his 7/26/07 visit "he complained of increased back pain after he jammed his back at the beach." ***Id***. at 3. Dr. Karp's analysis and conclusion states:

> Based on the records reviewed, it is my professional opinion that the medical treatment rendered to Sean Smith was both reasonable and necessary. *He reached maximum medical improvement as of 10/18/05 after which time he was able to stop his pain medications and he complained of minimal pain. His pain status was stable until he injured himself again, which prompted his 7/26/07 visit at Greensprings Family Practice*.

Id. (emphasis added). Based on the physicians' conclusions, Allstate denied payment.

Smith filed a complaint against Allstate on January 29, 2009, and he filed an amended complaint on March 17, 2009. In his amended complaint, Smith alleged breach of contract (count I), failure to pay first party benefits pursuant to the MVFRL (count II), and statutory bad faith (count III). Allstate moved for partial summary judgment as to counts II and III[2], which the trial court granted. Smith filed this appeal. He now raises the following claims for our review:

1. Whether the trial court abused its discretion or committed an error of law when it said there were no genuine issues of material fact as to whether Allstate acted reasonably when:
   a. it requested a PRO without reasonable foundation;
   b. it was not a proper PRO due to the focus on causation and maximum medical improvement;
   c. not paying medical bills after Dr. Karp said the medical treatment was both reasonable and necessary; and
   d. not keeping the primary medical provider, Dr. Palmer, informed.

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[2] Smith's breach of contract claim went to trial. The jury returned a verdict in favor of Allstate. Verdict Slip, 3/6/2012.

2. Whether the trial court abused its discretion or committed an error of law when it decided that the Defendant was entitled to judgment on the issues of substantive law when:

   a. the order of July 23, 2009 states the Defendant did not properly follow the PRO process [which] was the law of the case that could not be overturned;

   b. the court said costs incurred in the treatment of a pre-existing medical condition do not consist reasonably necessary and medically appropriate bills under PRO.

   c. the court said costs incurred in the treatment of an intervening and/or superseding medical condition do not constitute reasonably necessary and medically appropriate bills under PRO.

In his opinion, Judge Patterson correctly determined that Smith failed to produce evidence that Allstate had no reasonable basis for its decision to deny the payment for first-party benefits and, therefore, that Smith had no basis for a statutory bad faith claim. ***See Terletsky v. Prudential Property & Cas. Ins. Co.***, 649 A.2d 680, 688 (Pa. Super. 1994) (in order to prevail on statutory bad faith claim, plaintiff must show "defendant did not have a reasonable basis for denying benefits under the policy and that defendant knew or recklessly disregarded its lack of reasonable basis in denying the claim."). As Judge Patterson stated, "[a]n objective reading of Dr. Karp's opinion, in context, reveals her rationale and her conclusion . . . that treatment on or after July 26, 2007 [was] not reasonably necessary or medically appropriate with respect to the 2003 motor vehicle accident." Trial Court Opinion, 5/24/2011, at 17. Judge Patterson properly reasoned, therefore, that since there was "no evidence that the Defendant's failure to

pay the Plaintiff's first party benefits was frivolous, unfounded or done for a dishonest purpose," then "there exists no bad faith on the part of the Defendant." ***Id***. at 21.

After reviewing the parties' briefs, the record, and the relevant law, we find no error or abuse of discretion. ***Pappas v. Asbel***, 768 A.2d 1089, 1095 (Pa. 2001), *cert. denied*, 536 U.S. 938, 122 S.Ct. 2618, 153 L.Ed.2d 802 (2002). Judge Patterson correctly dismissed Smith's claims and his opinion properly disposes of those claims on appeal. ***See*** Trial Court Opinion, 5/24/2011, at 4-21. Therefore, we rely upon Judge Patterson's opinion to affirm the order dismissing counts II and III of Smith's amended complaint. We instruct the parties to attach that decision in the event of further proceedings in this matter.

Order affirmed.

IN THE COURT OF COMMON PLEAS OF YORK COUNTY, PENNSYLVANIA
CIVIL ACTION - LAW

SEAN M. SMITH,

Plaintiff

v

ALLSTATE INSURANCE COMPANY,

Defendant

NO. 2009-SU-000385-01

Motion For Summary Judgment

APPEARANCES:

DONALD B. HOYT, ESQUIRE
DAVID A. MILLS, ESQUIRE
Counsel for the Plaintiff, Sean M. Smith

BRIGID Q. ALFORD, ESQUIRE
Counsel for the Defendant, Allstate Insurance Company

MEMORANDUM ORDER

Before the Court is the following Motion for Summary Judgment filed by the Defendant, Allstate Insurance Company:

1. Plaintiff initiated this matter on January 29, 2009 by filing a Complaint. Defendant timely filed Preliminary Objections to Plaintiff's Complaint on February 26, 2009.
2. On March 27, 2009, Plaintiff filed an Amended Complaint. Defendant timely filed Preliminary Objections, which were overruled by the Court's Order of July 23, 2009.
3. On August 7, 2009 Defendant filed an Answer with New Matter to the Amended Complaint.
4. The case arises from a motor vehicle accident that occurred on August 16, 2003, and Plaintiff's subsequent claim for first party medical benefits under a

motor vehicle insurance policy issued by Allstate Insurance Company to his mother, Shirley M. Smith. **Amended Complaint and Answer to Amended Complaint, paragraphs 3-5, 12.**

5. Defendant Allstate Insurance Company paid first party medical benefits under the subject policy for reasonably necessary and medically appropriate bills through the end of December 2007, and thereafter submitted additional bills for an initial peer review, and a later reconsideration of the same, under and pursuant to Section 1797 of the Motor Vehicle Code.

6. Plaintiff has raised claims against Defendant for Breach of Contract (Count I), Motor Vehicle Financial Responsibility Law (Count II) and insurance bad faith pursuant to 42 Pa. C.S.A. Section 8371 (Count III), related to Defendant's utilization of the peer review process and its denial of first party medical benefits to Plaintiff.

7. The parties have engaged in pretrial discovery and the discovery period has now ended, per a Case Management Order[1] entered by the Court on July 7, 2010.

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[1] 1.1 Statement summarizing the case:

By plaintiff: This is a claim for breach of contract of a policy of insurance, violation of the Motor Vehicle Financial Responsibility Law, 75 Pa. C.S. Section 1797 and Bad Faith under the Insurance Bad Faith Statute, 42 Pa. C.S.A. Section 8371.

By defendant: Defendant concurs with Plaintiff's summary of case, but would add that the action arises from a motor vehicle accident that occurred on August 16, 2003; an application for benefits that Plaintiff thereafter made under a policy issued by Defendant; and Defendant's submission of certain medical bills to the Peer Review Process.

1.2 The facts the parties dispute are as follows:

The medical treatment Sean Smith receives is reasonable and necessary. Allstate used the Peer Review Organization process improperly.

agree upon are as follows:

Sean Smith was involved in an automobile accident on August 16, 2003. Allstate paid benefits for medical treatment until February 22, 2008.

1.3 The legal issues the parties dispute are as follows:

1. Allstate breached its contract;
2. Allstate violated the Motor Vehicle Financial Responsibility Law;
3. Allstate violated the Insurance Bad Faith Statute;
4. Allstate's denial of medical bills incurred since January 2008 was reasonable;
5. 75 Pa. C.S.A. Section 1797 provides the exclusive remedy for Plaintiff's claims;
6. The statutory remedies provided by the Motor Vehicle Financial Responsibility Law preempts Plaintiff's claims under 42 Pa. C.S.A. Section 8371;
7. Any and all other legal issues raised within Defendant's New Matter to the Amended Complaint are incorporated herein by reference.

The legal issues the parties agree upon are as follows:

None.

8. Pursuant to Pa. R.C.P. No. 1035.1, Defendant is filing an Appendix in Support of Motion for Summary Judgment contemporaneously with this Motion, and incorporates the same herein by reference.

9. With respect to the matters raised in the within Motion, there are no genuine issues of material fact, and Defendant is entitled to summary judgment as a matter of law.

A. Motion for Summary Judgment as to Plaintiff's Claim under MVFRL

10. Plaintiff is only entitled to damages under his MVFRL claim if he proves that the Defendant insurer acted with no reasonable foundation in refusing to pay Plaintiff's First-Party medical benefits. **Perkins v. State Farm Insurance Company**, 589 F.Supp.2d 599, 562 (M.D. Pa. 2008) [construing 75 Pa. C.S.A. Section 1798(b)].

11. Plaintiff has no evidence with which to sustain his burden of proof that Defendant acted without a reasonable foundation.

12. Neither the initial Peer Review Report, nor the Reconsideration, concluded that any treatment rendered in 2006 or thereafter was reasonably necessary and medically appropriate.

13. The initial Peer Review Report concluded that the bills at issue were not reasonable or necessary, based upon the types of injuries sustained in the underlying accident.

14. The initial Peer Review Report concluded that the bills at issue were not reasonable or necessary, based upon the time frame necessary for musculoskeletal injuries to heal with proper treatment.

15. The initial Peer Review Report concluded that the bills at issue were not reasonable or necessary based upon the Plaintiff's consultations with the treating physician and the Plaintiff's pre-existing degenerative disc disease.

16. Costs incurred in the treatment of a pre-existing medical condition do not constitute reasonably necessary and medically appropriate bills within the context of a Section 1797 Peer Review.

17. The Peer Review Reconsideration concluded that treatment rendered (and bills incurred) up to the date on which the Plaintiff reached maximum medical improvement (i.e. 10/18/05) were reasonable and necessary.

18. Costs incurred in the treatment of an intervening and/or superseding medical condition or injury do not constitute reasonably necessary and medically appropriate bills within the context of a Section 1797 Peer Review.

19. The initial Peer Review Report, and the Reconsideration, constituted a reasonable foundation upon which Defendant refused to pay the medical bills at issue.

WHEREFORE, Defendant respectfully moves the Court to enter summary judgment its favor and against Plaintiff with respect to Count II of the Amended Complaint.

B. Motion for Summary Judgment as to Plaintiff's Claim under the Bad Faith Statute

20. It is well-established that in order to prevail on a claim for statutory bad faith, the Plaintiff must prove by "clear and convincing evidence," and not by a mere "preponderance of evidence":
    a. That Defendant Allstate did not have a reasonable basis for denying benefits under the policy; and
    b. That Defendant Allstate knew or recklessly disregarded its lack of reasonable basis in denying the claim. **Terletsky v. Prudential**, 649 A.2d 680, 688 (Pa. Super. 1994).
21. The fact that Plaintiff's burden at trial is higher than preponderance of the evidence means that Plaintiff's burden in opposing summary judgment is higher as well. **Greco v. The Paul Reverse Life Insurance Company,** 1999 U.S. District Lexis 110 (E.D. Pa. 1999).
22. Plaintiff has no evidence with which to sustain his burden of proof that Defendant did not have a reasonable basis for denying benefits under the policy and Plaintiff has no evidence with which to sustain his burden of proof that Defendant knew or recklessly disregarded any alleged lack of reasonable basis in denying the claim.
23. Alternatively, and in the event that Defendant's motion for partial summary judgment as to Count II of the Amended Complaint should be denied, Plaintiff's 42 Pa. C.S.A. Section 8371 claims are preempted by 75 Pa. C.S.A. Section 1797.

WHEREFORE, Defendant respectfully moves the Court to enter summary judgment in its favor and against Plaintiff with respect to Count III of the Amended Complaint.

FACTS AND PROCEDURAL HISTORY

The Plaintiff filed a Complaint alleging the following claims against the Defendant: Breach of Contract (Count I), Failure to Pay First-Party Benefits pursuant to Motor Vehicle Financial Responsibility Law (Count II) and Statutory Bad Faith (Count III) on January 29, 2009 seeking damages related to an automobile accident

which occurred on August 16, 2003. The Plaintiff asserts that, as a result of an automobile accident in August of 2003, he sustained injuries which required lumbar surgery in July of 2005. Subsequently, the Plaintiff submitted claims for first party medical benefits for treatment received in January of 2008 and thereafter.

In the Complaint, the Plaintiff alleged that the unpaid medical bills corresponded to treatment related to the August 2003 accident. Upon presentation of the bills in 2008, the Defendant determined it appropriate to submit them for peer review under Section 1797 of Pennsylvania's Motor Vehicle Financial Responsibility Law. Based upon the result of the Peer Review and a subsequent Reconsideration requested by the Plaintiff, the Defendant declined to pay the bill.

Discovery is complete and the Defendant has submitted a Motion for Summary Judgment to the Court, which was filed on October 01, 2010. The Plaintiff filed an Answer to the Motion for Summary Judgment and a Brief in Support of their position on November 01, 2010. A Reply Brief was filed by the Defendant on November 05, 2010. Based on the pleadings, the Court hereby **GRANTS** the Defendant's Motion for Summary Judgment.

A Praecipe to List For One Judge/En Banc Disposition was filed by the Plaintiff on November 09, 2010 and the matter was assigned to this Court for disposition under rule 6030 on December 20, 2010.

DISCUSSION

After relevant pleadings are closed, but within such time as not to unreasonably delay trial, any party may move for summary judgment in whole or in part as a matter of law. Summary judgment is appropriate where "there is no genuine issue of any material fact as to a necessary element of the cause of action or defense which could be established by discovery or expert report." **Pennsylvania Rules of Civil Procedure, Rule 1035.2(1).**

Summary judgment is also warranted "if, after completion of discovery relevant to the motion, including the production of expert reports, an adverse party who will bear the burden of proof at trial has failed to produce sufficient evidence of facts essential to the cause of action or defense which in a jury trial would require the issues to be submitted to a jury." **Pennsylvania Rules of Civil Procedure, Rule 1035.2(2).**

Summary judgment is proper only where the pleadings, depositions, answers to interrogatories, admissions of record and affidavits on file support the conclusion that no genuine issue of material fact exists and the moving party is entitled to judgment as a matter of law. **Penn Center House, Incorporated v. Hoffman,** 520 Pa. 171, 553 A.2d 900 (1989).

In determining whether to grant a motion for summary judgment, the court must view the record in the light most favorable to the nonmoving party.

Dorohovich v. West American Ins. Co., 403 Pa. Super. 412, 589 A.2d 252 (1991). In order to be successful in bringing a motion for summary judgment, the moving party must demonstrate that there are no genuine issues of material fact for which the Court is to decide. **First Wisconsin Trust Company v. Strausser**, 439 Pa. Super. 192, 653 A.2d 688 (1994).

Once the moving party has met this burden, the non-moving party must produce sufficient evidence on an issue essential to the case on which he bears the burden of proof such that a jury could return a verdict in his favor. **Ertel v. Patriot-News Company**, 544 Pa. 93, 674 A.2d 1038 (1996). The record should be examined in the light most favorable to the non-moving party and summary judgment should only be granted where the entitlement to judgment as a matter of law is free and clear of doubt. **Electronic Laboratory Supply Co. v. Cullen**, 712 A.2d 304 (Pa. Super. 1998). All doubts as to the existence of a genuine issue of material fact must be resolved against the moving party. **Marks v. Tasman**, 527 Pa. 132, 589 A.2d 205 (1991).

Moreover, in summary judgment proceedings, it is not the court's function to determine the facts, but only to determine if an issue of material fact exists. **Godlewski v. Pars Manufacturing Co.**, 408 Pa. Super. 425, 597 A.2d 106 (1991). Summary judgment serves to eliminate the waste of time and resources of both litigants and the court in cases where a trial would be a useless formality. **Liles v.**

Balmer, 389 Pa. Super. 451, 567 A.2d 691, 692 (1989). Summary judgment should only be granted in those cases which are free and clear from doubt. **Johnson v. Harris**, 419 Pa. Super. 541, 615 A.2d 771 (1992).

According to Pennsylvania Rule of Civil Procedure 1035, when a motion for summary judgment is made and supported as provided in this rule, an adverse party may not rest upon the mere allegations or denials of his pleading, but his response, by affidavits or as otherwise provided by this rule, must set forth specific facts showing that there is a genuine issue for trial. If he does not so respond, summary judgment, if appropriate, shall be entered against him. **Pennsylvania Rules of Civil Procedure, Rule 1035.2**. SEE **Elia v. Olszewski**, 368 Pa. 578, 84 A.2d 188 (1951). "A motion for summary judgment must be granted in favor of a moving party if the other party chooses to rest on its pleadings, unless a genuine issue of fact is made out in the moving party's evidence taken by itself". **Knecht v. Citizens and Northern Bank**, 364 Pa. Super. 370, 376, 528 A.2d 203 (1987).

An adverse party need not file a formal response to a motion for summary judgment, and Rule 1035 contains no provisions for any action by the adverse party except the filing of affidavits in opposition, if he wishes, therefore, a failure to file an answer to a motion for summary judgment or an affidavit in response thereto, does not constitute a waiver of the issues necessary to decide the motion for summary judgment. SEE **Moore v. Gates**, 398 Pa.Super. 211, 214, 580 A.2d 1138 (1990).

However, the failure to file countervailing affidavits may constitute an admission of facts. ***Id.*** In addition, the failure to file a counter-affidavit requires the court to ignore controverted facts appearing only in the pleadings, and to restrict its review to material filed in support of and in opposition to a motion for summary judgment, and to all uncontroverted facts contained in the pleadings and affidavits. SEE **Atkinson v. Haug**, 424 Pa. Super. 406, 411, 622 A.2d 983 (1993). SEE ALSO **Hibbs v. Chester-Upland School District, et al.**, 146 Pa.Cmwlth. 556, 606 A.2d 629 (1992). Further, according to the Pennsylvania Superior Court in **Knecht v. Citizens and Northern Bank**, "mere failure to file counter-affidavits does not assure that summary judgment will be granted to the moving party. The moving party's evidence must clearly exclude any genuine issue of material fact". ***Id.*** citing **Aimco Imports v. Industrial Valley Bank, etc.**, 291 Pa. Super. 233, 435 A.2d 884, 886 (1981).

Should the Court grant summary judgment in favor of the Defendant as to Count II (Counsel Fees, Interest, Costs and Treble Damages under the Motor Vehicle Financial Responsibility Law) **of the Plaintiff's Amended Complaint, as Plaintiff has no evidence to establish, by a preponderance of the evidence, that Allstate lacked a reasonable foundation upon which to decline payment for the medical bills, as being neither reasonably necessary or medically appropriate, under the Motor Vehicle Financial Responsibility Law?**

The standard of review in an action brought under the Motor Vehicle Financial Responsibility Law (MVFRL) for challenges to the reasonableness and necessity of

treatment was stated by the United States District Court for the Middle District of Pennsylvania, as follows:

> The MVFRL requires automobile insurers to provide coverage for "reasonable and necessary medical treatment and rehabilitative services." 75 Pa. C.S.A. Section 1712(1). If an insurer is found to have acted in an "unreasonable manner" in refusing to pay such benefits when due, the insurer must pay the benefits owed, interest at the rate of 12% per annum from the date the benefits become due, and a reasonable attorney fee. *Id.* Section 1716; see also *id.* Section 1798(b) ("In the event an insurer is found to have acted with no reasonable foundation in refusing to pay [first-party benefits] when due, the insurer shall pay, in addition to the benefits owed and the interest thereon, a reasonable attorney fee based upon actual time expended.").

Perkins v. State Farm Insurance Company, 589 F.Supp.2d 559, 562 (M.D.Pa. 2008).

In the event an insurer is found to have acted with no reasonable foundation in refusing to pay first-party benefits when due, the insurer shall pay, in addition to the benefits owed and the interest thereon, a reasonable attorney fee based upon actual time expended. **Id.** [construing 75 Pa. C.S.A. Section 1716 and 1798(b)].[2]

The Defendant asserts that when read in context, both the initial peer review and the reconsideration support its decision to decline payment of the bills at issue.

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[2] The Plaintiff asserts that this Court has already determined that the Defendant was found to have acted in an "unreasonable manner" in refusing to pay such benefits when due in an Opinion written by the Honorable Michael E. Bortner dated July 23, 2009. In the instant motion, this Court is given a wider scope. Summary Judgment is properly granted when the pleadings, deposition, answers to interrogatories, and admissions on file, together with any affidavits, show that there is no genuine issue of material fact and that the moving party is entitled to judgment as a matter of law. Kenney v. Jeanes Hospital, 769 A.2d 792 (Pa. Super. 2001). This Court is free to explore each PRO decision entirely and determine whether or not either or both reviews ultimately concluded Plaintiff's treatment to not be reasonable and necessary.

The Defendant had paid all medical bills up to the time of the peer reviews; however, questions arose as to whether bills for services rendered in 2008 and forward were reasonably necessary and medically appropriate under the statute. Utilizing the peer review process provided by statute, the Defendant submitted the bills for peer review to an independent third party vendor – Perspective Consulting. **Deposition Testimony, Lisa Burke, page 0221.** In the words of the adjustor to whom the file was re-assigned as part of a corporate reorganization in 2008, Ms. Burke chose to invoke the peer review process "to make sure what I'm paying for is medically reasonable and necessary." **Deposition Testimony, Lisa Burke, page 0206.** Not a medical care provider herself, the adjustor deferred to the peer reviewer. Once the matter was submitted to Perspective Consulting, Perspective assigned the initial peer review to Timothy J. Fiorillo, D.O., a doctor of osteopathic medicine. Dr. Fiorillo's report, dated May 12, 2008; provides for the following:

The following is a comprehensive peer review on the reasonableness and necessity of treatment, referrals, and prescriptions rendered by Greensprings Family Medicine (Memorial Enterprises, Inc.). The above named claimant, Sean Smith, was apparently involved in an MVA dated 08/16/03. The following records were available for my review:

1. Office notes from Dr. David Scarpelli, M.D. dated 08/20/03 through 12/02/03.
2. Orthopedic evaluation performed by Dr. Chad Rutter, D.O. dated 12/31/03 with subsequent follow-up evaluations through 09/06/07.
3. Report of Operation from the Surgical Center of York dated 01/05/04 and 09/10/07.
4. Orthopedic evaluation performed by Dr. Steven Triantafyllou, M.D. dated 05/05/05.

5. Emergency Department record from Memorial Hospital In York dated 07/04/05.
6. MRI's of the lumbar spine performed at York Imaging Center dated 07/27/05, 08/10/06 and 08/14/07.
7. X-rays of the lumbar spine, performed at Memorial Hospital dated 07/27/05, 08/10/06 and 07/30/07.
8. Office notes from Memorial Enterprises, Inc. dated 12/03/03 through 03/11/08.

Discussion:

The claimant, Sean Smith, was apparently involved in an MVA dated 08/16/03. The claimant was the restrained driver of his vehicle which was stopped at a stop sign when he was struck from behind by another vehicle. He states that he actually hit the left side of his head on the steering wheel without LOC. He was not in any immediate pain and left the scene of the accident. He proceeded to the emergency room the next day. He was evaluated and x-rays were apparently negative. He was diagnosed with cervical and trapezius strain and given Motrin. He was next evaluated by Dr. Scarpelli, M.D. on 08/20/03. Dr. Scarpelli diagnosed the claimant with upper and lower back muscular strain and he was placed on Ibuprofen and Valium. It was noted that the claimant had no radiation of pain "down the arms or legs". He last saw Dr. Scarpelli on 12/02/03. At that time he was complaining of increasing pain in his lumbar area with radiation of pain into his lower extremities. He was ordered to return to physical therapy and he was scheduled an MRI of the lumbar spine. The MRI of the lumbar spine was performed on 12/03/03. The study revealed chronic discopathy of the L5-S1 level with a possible small central to right paracentral subligamentous herniation.

The claimant was next evaluated by Greensprings Family Medicine (Memorial Enterprises, Inc.) on 12/03/03 for a second opinion. The claimant was diagnosed with lumbar strain and sprain rule out disc herniation and resolved cervical strain and sprain. The claimant was given OMT, Medrol dose pack, recommended moist heat and back school. The claimant was next evaluated by Dr. Chad Rutter, an orthopedic surgeon on 12/31/03. Dr. Rutter diagnosed the claimant with DDD and a mild bulge at the L5-S1 level with possible radiculitis. He was scheduled for an epidural steroid injection at the L5-S1 level. The claimant had an epidural injection on 01/05/04. The claimant apparently only experienced one day of relief and the symptoms returned. Dr. Rutter felt that the claimant's symptoms were most likely due to his underlying DDD. Dr. Rutter did NOT recommend further epidural steroid injections and advised that the treatment at this time would be lumbar fusion. He also recommended that the claimant wait until his pain was "absolutely miserable" to have this surgery performed.

The claimant continued to follow with Greensprings Family Medicine (Memorial Enterprises, Inc.) on a monthly basis receiving OMT to his lumbar spine and Vicodin prescriptions. The claimant apparently had an effusion of the L5-S1 level with posterior fusion on 07/25/05 by Dr. Rutter. The claimant continued to follow with Greensprings Family Medicine (Memorial Enterprises, Inc.) through 03/11/08 continuing to receive OMT and Percocet prescriptions.

Conclusions:

This reviewer was asked to perform a comprehensive peer review and offer a medical opinion regarding the reasonableness and necessity of treatments, referrals, and prescriptions rendered by Greensprings Family Medicine (Memorial Enterprises, Inc.). I was also asked to address maximum medical improvement.

The claimant, Sean Smith, was involved in an MVA on 08/16/03. The claimant suffered musculoskeletal type injuries to the cervical and lumbar spines and apparently and underlying DDD of the lumbar spine. The claimant was treated with appropriate physical therapy through approximately 11/10/03. Therapy discharged the claimant as did Dr. Scarpelli on 11/10/03. The claimant returned to see Dr. Scarpelli on 12/02/03 with a recurrence of his low back pain. The claimant was evaluated by orthopedics and it was determined by Dr. Rutter that the claimant's pain was due to his DDD and not from an acute radiculitis.

Upon review of the available information and based upon a reasonable degree of medical certainty the office visits, treatments, referrals and prescriptions rendered by Greensprings Family Medicine (Memorial Enterprises, Inc.) should NOT be considered reasonable or necessary. This decision is based upon the types of injuries sustained in the MVA of 08/16/03, the time frame necessary for musculoskeletal injuries to heal with proper treatment, the consultations with Dr. Rutter and the claimant's underlying DDD which was NOT from injuries sustained in the MVA of 08/16/03.

Next, this reviewer was asked to address the question of maximum medical improvement. Within a reasonable degree of medical probability, MMI, for the musculoskeletal injuries from the MVA of 08/16/03 occurred on 11/10/03. This decision is again based on the time frame necessary for these types of injuries to heal with proper treatment, the claimant's discharge from physical therapy, and the underlying DDD of the lumbar spine which was NOT sustained in the MVA of 08/16/03.

These conclusions are based upon the standard of care in the medical community for musculoskeletal type injuries with referencing the "Guide to the Evaluation of Permanent Impairment", American Medical Association, 5th Edition, 2001.

A telephone conversation did NOT occur with the provider as one was not requested.

If you have any questions, then please contact me at your earliest convenience.

Dr. Firorillo's conclusion was that the bills submitted to him were neither reasonable (i.e. reasonably appropriate) or necessary (i.e., medically necessary) based upon the types of injuries sustained in the underlying accident and based upon the time frame necessary for musculoskeletal injuries to heal with proper treatment. In addition, the initial Peer Review Report concluded that the bills at issue were not reasonable or necessary based upon the Plaintiff's consultations with the treating physician and the Plaintiff's pre-existing degenerative disc disease. Costs incurred in the treatment of a pre-existing medical condition do not constitute reasonably necessary and medically appropriate bills within the context of a Section 1797 Peer Review. The Plaintiff took exception to this review and requested reconsideration, as was his statutory right. SEE 75 Pa. C.S.A. Section 1797(b)(2).[3]

The Defendant complied with the Plaintiff's request and referred the matter a second time to Perspective Consulting seeking a reconsideration and again, with a medical care provider whose credentials (Doctor of Osteopathic Medicine) were similar to those of the provider whose bills, treatment, services, etc. were being reviewed. Perspective Consulting assigned the reconsideration to Mary Ann Karp, D.O., whose report provided the following:

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[3] (2) **PRO Reconsideration.** – An insurer, provider or insured may request a reconsideration by the PRO of the PRO's initial determination. Such a request for reconsideration must be made within 30 days of the PRO's initial determination. If reconsideration is requested for the services of a physician or other licensed health care professional, then the reviewing individual must be, or the reviewing panel must include, an individual in the same specialty as the individual subject to review.

DOCUMENTS REVIEWED

1. Letter from Perspective Consulting requesting a reconsideration of a peer review for Sean Smith.
2. Letter from Donald B. Hoyt of Blakey, Yost, Bupp & Rausch, LLP., dated 7/8/08 and 7/18/08, regarding a reconsideration of the peer review.
3. Letter from Hugh E. Palmer, D.O. dated 6/30/08.
4. Progress notes from David J. Scarpelli, M.D., dated 8/20/03, 8/28/03, 9/10/03, 9/16/03, 10/6/03, 11/10/03, 12/2/03.
5. Letters from Chad M. Rutter, D.O., of Mitrick, Pollack, Rutter Orthopedics, dated 12/31/03, 1/20/04, 1/4/04, 8/9/05, 9/6/05, 10/18/05, 7/11/06, 9/6/07, along with invoices dated 7/11/06, 9/6/07 and 9/10/06.
6. Progress notes and messages from Greensprings Family Medicine dated 12/3/03, 12/10/03, 12/22/03, 1/12/04, 1/26/04, 2/24/04, 3/17/04, 4/21/04, 5/26/04, 6/22/04, 7/21/04, 8/10/04, 9/10/04, 9/13/04, 9/27/04, 9/28/04, 10/18/04, 11/29/04, 12/29/04, 1/26/05, 3/2/05, 3/14/05, 3/18/05, 4/18/05, 3/30/05, 4/22/05, 4/25/05, 4/28/05, 5/2/05, 5/5/05, 5/9/05, 5/10/05, 5/11/05, 5/16/05, 5/18/05, 5/20/05, 5/23/05, 5/31/05, 6/6/05, 6/10/05, 6/13/05, 6/20/05, 6/27/05, 7/5/05, 7/8/05, 7/13/05, 7/19/05, 7/26/05, 8/2/05, 8/11/05, 8/17/05, 8/19/05, 824/05, 8/30/05, 9/6/05, 9/14/05, 9/19/05, 10/6/05, 11/10/05, 1/19/06, 1/23/06, 2/22/06, 4/20/06, 7/20/06, 8/24/06, 9/6/06, 9/29/06, 10/27/06, 11/29/06, 12/27/06, 1/29/07, 2/27/07, 3/27/07, 5/27/07, 6/27/07, 7/26/07, 8/9/07, 8/13/07, 8/17/07, 8/27/07, 9/4/07, 9/12/07, 9/21/07, 10/1/07, 10/9/07, 10/11/07, 10/23/07, 10/31/07, 11/27/07, 1/16/08, 2/13/08, 2/15/08, 2/18/08, 2/19/08, 2/20/08, 3/11/08. Invoices from office visits included.
7. Radiologic reports including: MRI lumbar spine – 12/3/03, x-ray left hand – 10/4/04, MRI lumbar spine – 4/26/05, x-ray left index finger – 7/4/05, x-ray chest – 7/20/05, x-ray lumbar spine – 7/27/05, 8/10/06 and 7/30/07, MRI lumbar spine 0 8/13/07. Invoices for studies done on 8/10/06 and 8/16/06.
8. Disability letters from Hugh Palmer, M.D. dated 8/30/05 and 10/11/05.
9. Operation reports for lumbar epidural steroid injection by James Gilhool, D.O. dated 1/5/04 and 9/10/07 with invoice dated 9/10/07.
10. Orthopedic consult by Steven J. Triantafyllou, M.D. dated 5/5/05.
11. Emergency Room report by Daniel Oberdick, D.O. dated 7/4/05.
12. Receipts from Eckerd Drug dated 5/7/07 and from Dick's Sporting Goods dated 5/12/07.

HISTORY

Sean Smith was involved in a motor vehicle accident on 8/16/03 when his car was rear ended by another vehicle traveling at about 40 miles per hour. He was not in pain directly after the accident but did go to the ER later that day with a complaint of stiffness. X-rays were performed which were negative and he was released home with a diagnosis of trapezius and cervical strain. Dr. Scarpelli first saw Mr. Smith on 8/20/03 with complaint of law back stiffness without radiation along with upper back and neck stiffness. He was advised to continue with the Motrin 800mg, and was given Valium. He was seen on 8/28/03 for continuing stiffness but noted improvement. He was given script for Flexeril and physical therapy. It was also recommended that he be out of work for 2-3 weeks. Mr. Smith's only complaint at his 9/10/03 visit was left shoulder pain. Neck x-rays were recommended and a soft cervical collar. His 9/16/03 visit showed continued improvement in his neck and shoulder pain. No other complaints were noted. At his 10/6/03 visit a tentative return to work date was given of 11/10/03. Mr. Smith was ready to go back to work without restrictions per his 11/10/03 visit. Mr. Smith was next seen on 12/2/03 with complaint of low back pain that radiated down both legs that started a week after returning to work. An MRI was ordered which showed chronic discopathy at L5/S1 with a possible small central to right paracentral subligamentous disc herniation. It was recommended he stay out of work but he was unable to do so.

Mr. Smith was first seen at Greensprings Family Practice on 12/3/03 for a second opinion regarding his radiating back pain. Osteopathic manipulative therapy (OMT) was performed and he was given a script for a Medrol Dose Pack. Mr. Smith's visits on 12/10/03 and 12/22/03 were essentially the same and he was referred to Dr. Rutter, orthopedist. He saw Dr. Rutter on 12/31/03 complaining of continuing significant low back pain with radiating numbness and tingling into his posterior thighs at times. He was scheduled to get an epidural and informed if it did not help the pain was probably coming from to his degenerative disc disease. Mr. Smith was seen at Greensprings again 1/12/04 after his epidural complaining of increased pain. He had a follow up appointment with Dr. Rutter on 1/20/04 where he was advised that the next step would be a spinal fusion, but only if he became absolutely miserable. He was seen for follow up at Greensprings 1/26/04 still with the pain stating that Vicodin took the edge off. OMT was performed. Subsequent visits and phone calls 2/24/04 through 7/19/05 was mostly for OMT and prescription refills. Mr. Smith was seen gain by Dr. Rutter 1/4/05. Dr. Rutter still felt that his continuing pain was from the degenerative disc disease and that next step would be surgery. Mr. Smith underwent a spinal fusion in July of 2005. He was seen for follow up with Dr. Rutter 13 days post op on 8/9/05. He reported that his back pain was much improved without radicular complaints. There was continued improvement reported

at his 9/6/05 appointment with Dr. Rutter. At this visit it was also noted that the motor vehicle accident of 8/26/03 aggravated the already existing degenerative disc disease. Mr. Smith reported minimal back pain at his 10/18/05 visit with Dr. Rutter. Only some stiffness was noted on physical exam. At his follow up visit on 7/11/06 with Dr. Rutter, Mr. Smith reported only minimal back symptoms. He was off all medications and was reportedly very active including biking up to 100 miles at a time. Mr. Smith's visits at Greensprings Family Practice from 8/2/05 through 6/27/07 showed continued back pain complaint with good and bad days. At his 7/26/07 visit he complained of increased back pain after he jammed his back at the beach. He was given a prescription for Percocet and advised to remain off work. On 8/9/07 he still complained of low back pain and spasms and was recommended to get an MRI. The MRI was done on 8/13/07 and showed findings consistent with his previous surgery and some scarring and mild bulging at L4-L5 and L3-L4 with minimal ventral thecal flattening. On 8/17/07 he was seen and recommended to see Dr. Gilhool for an epidural injection, which was performed 9/10/07. Visits and phone calls dated 9/21/07 to 3/11/08 were for the continuing back pain. OMT was performed and prescriptions refills for Percocet were given.

ANALYSIS AND CONCLUSION

Based on the records reviewed, it is my professional opinion that the medical treatment rendered to Sean Smith was both reasonable and necessary. He reached maximum medical improvement as of 10/18/05 after which time he was able to stop his pain medications and he complained of minimal pain. His pain status was stable until he injured himself again, which prompted his 7/26/07 visit at Greensprings Family Practice. No telephone conversation was requested by the medical providers.

An objective reading of Dr. Karp's opinion, in context, reveals her rationale and her conclusion. From the date of the underlying 2003 accident until October 18, 2005, the date on which the Plaintiff reached "maximum medical improvement," Plaintiff's treatment was reasonable and necessary. The Defendant had paid the related first-party benefits within that time frame. Further, Dr. Karp's analysis and conclusion was that treatment on or after July 26, 2007 were not reasonably necessary or medically appropriate with respect to the 2003 motor vehicle accident. Costs

incurred in the treatment of an intervening and/or superseding medical condition or injury do not constitute reasonably necessary and medically appropriate bills within the context of a Section 1797 Peer Review.

After review, there was nothing improper, inappropriate, or statutorily deficient about Dr. Karp's reconsideration or the Defendant's reliance upon it, nor does the Plaintiff have any documentary or testamentary evidence to the contrary. SEE *Plaintiff's Answers to Defendant's Request for Production of Documents*, Request Number 3, App., Page 0018. There is no genuine issue of fact as to whether the Defendant had a reasonable foundation in its denial of benefits. There is no genuine issue of fact as to whether the Defendant acted contrary to the Motor Vehicle Financial Responsibility Law and the peer review process thereunder. There is no genuine issue of fact as to whether the Defendant's conduct was "willful, wanton, and malicious," as alleged by the Plaintiff at Paragraph 30 of his Amended Complaint. As a result, we hereby **GRANT** the Motion for Summary Judgment as it relates to Count II of the Amended Complaint.

Should the Court grant summary judgment in favor of the Defendant as to Count III (Bad Faith under the Insurance Bad Faith Statue, 42 Pa. C.S.A. Section 8371**) as Plaintiff has no evidence to establish, by clear and convincing evidence, that the Defendant acted in bad faith with respect to its handling of the underlying claim?**

The Defendant asserts that the Plaintiff cannot demonstrate by clear and convincing evidence that it lacked a reasonable basis for its conduct. 42 Pa. C.S.A. Section 8371, commonly known as the "Bad Faith Statute", states as follows:

> **Section 8371. Actions on insurance policies**
> In an action arising under an insurance policy, if the court finds that the insurer has acted in bad faith toward the insured, the court may take all of the following actions:
> (1) Award interest on the amount of the claim from the date the claim was made by the insured in an amount equal to the prime rate of interest plus 3%
> (2) Award punitive damages against the insurer
> (3) Assess court costs and attorney fees against the insurer

The Courts have defined statutory "bad faith" as follows:

> 'Bad faith' on part of insurer is any frivolous or unfounded refusal to pay proceeds of a policy; it is not necessary that such refusal be fraudulent. For purposes of an action against an insurer for failure to pay a claim, such conduct imports a dishonest purpose and means a breach of a known duty (i.e. good faith and fair dealing), through some motive of self-interest or ill will; mere negligence or bad judgment is not bad faith.

Bergman v. USAA, 742 A.2d 1101, 1106 (Pa. Super. 1999); **Hall v. Brown**, 526 A.2d 413 (Pa. Super. 1987). SEE ALSO **Polselli v. Nationwide Mutual Fire Insurance Company**, 23 F.3d 747, 751 (Third Circuit 1994).

Under Pennsylvania law, good faith standard requires the insurance company to evaluate a case in an honest, intelligent and objective manner. **Empire Fire and Marine Insurance Company v. Jones**, 739 F.Supp.2d 746 (Middle District PA 2010). In addition, "[b]ad faith cases are commonly decided at the summary judgment stage, with the court determining, as a matter of law, that the insurer had

a reasonable basis for its actions." **Quaciari v. Allstate Insurance Company**, 998 F.Supp. 578, 581 note 3 (E.D. Pa. 1998); **Deary v. Liberty Mutual Insurance Company**, 1997 U.S. District LEXIS 3091 (E.D. Pa. 1997).

As the Pennsylvania Superior Court explained in **Terletsky v. Prudential Property and Casualty Insurance Company**, 649 A.2d 680, 688 (Pa. Super. 1994), "[T]o recover under a claim for bad faith, the plaintiff must show that the defendant did not have a reasonable basis for denying benefits under the policy and that defendant knew or recklessly disregarded its lack of reasonable basis in denying the claim." SEE **Horowitz v. Federal Kemper Life Assurance Company**, 57 F.3d 300, 307 (Third Circuit 1995).

A plaintiff bears a heightened burden of proof under the Bad Faith Statute, as he/she must prove his/her case by "clear and convincing evidence." **Terletsky** at page 688. In order to meet this stringent standard, the Plaintiff must present credible evidence and witnesses: the facts of the alleged lack of reasonable basis; the alleged knowledge or reckless disregard; and the details thereof. The evidence must also be so clear, direct, weighty and convincing as to enable the finder of fact to come to a clear conviction, without hesitancy, of the truth of the precise facts in issue. **Patterson v. Reliance Insurance Companies**, 481 A.2d 947, 950 (Pa. Super. 1984).

The first prong of the **Terletsky** is an objective one: if there is a reasonable basis for denying a claim there cannot, as a matter of law, be bad faith. **Jung v. Nationwide Mutual Fire Insurance Company**, 949 F.Supp. 353, 359 (E.D. Pa. 1999); **Hyde Athletic Industry v. Continental Casualty Company**, 969 F.Supp. 289, 307 (E.D. Pa. 1997). As we have previously determined that there is no evidence that the Defendant's failure to pay the Plaintiff's first party benefits was frivolous, unfounded or done for a dishonest purpose, then under the first prong there exists no bad faith on the part of the Defendant. SEE **Klinger v. State Farm Mutual Auto Insurance Company**, 895 F.Supp. 709, 713 (M.D. Pa. 1995). Accordingly, we hereby **GRANT** the Defendant's Motion for Summary Judgment as to Count III of the Amended Complaint.

CONCLUSION

Based on the pleadings, the Defendant has met its burden of showing that there are no disputed issues of material fact and the Plaintiff has failed to set forth specific facts showing that there is a genuine issue for trial. In doing so, we find that the entry of summary judgment is proper and, therefore, the Defendant's Motion for Summary Judgment is GRANTED and Count II and Count III of the Amended Complaint are hereby **DISMISSED.**

Sean M. Smith v. Allstate Insurance Company
No. 2009-SU-000385-01

MEMORANDUM ORDER

BY THE COURT,

CLARENCE N. PATTERSON, JR., JUDGE

DATE: **May 24, 2011**