

I. BACKGROUND

Plaintiff, Joseph P. Dougherty, a 49 year old cement mason, hurt his right shoulder and neck in a car accident on July 26, 1996. Prior to the accident, Plaintiff had been out of work and on workers compensation due to a lower back injury incurred on the job while lifting a heavy object. Plaintiff had car insurance with State Farm to which he submitted his medical bills. Plaintiff received treatment from Dr. Randall Smith ("Dr. Smith"), an orthopedic surgeon, who had been treating him for his pre-existing back injury sustained at work. Plaintiff also went to Mark Belitsky, D.C., a chiropractor ("Dr. Belitsky"), who had also previously treated him and Dr. Satish Batta, M.D., a pain management specialist ("Dr. Batta").

Plaintiff's claims were originally handled by Ms. Maria Quercetti¹ of State Farm's Medical Payments Coverage Unit ("MPC"). On November 22, 1996, State Farm received a report dated November 12, 1996 from Dr. Smith, in which he noted that the Plaintiff continued to suffer pain in the neck and shoulder despite an ongoing treatment of medication, physical therapy and injections. State Farm paid the accompanying bill. On January 28, 1997, Ms. Quercetti reviewed a bill and report from Dr.

¹ Despite earlier allegations by Plaintiff that Ms. Quercetti acted out of improper motive in submitting Plaintiff's claims for PRO review, Plaintiff later retracted, claiming he never made any allegations that the PRO was conducted in bad faith.

Belitsky for service rendered on December 20, 1996. This report stated that Plaintiff continued to experience pain in the right shoulder despite a strength and conditioning program consisting of kinetic exercise, range of motion exercise, physical conditioning with neuromuscular re-education and physiotherapy. Despite the lack of improvement, Dr. Belitsky recommended continuing with the treatment.

As a result of Dr. Belitsky's report, Ms. Quercetti questioned the reasonableness and necessity of Plaintiff's continuing treatment with Dr. Belitsky and referred the matter for peer review as mandated by 75 Pa. Const. Stat. § 1797(b) on January 29, 1997. A complete copy of Plaintiff's medical file, including all medical bills and reports, was sent to a Peer Reviewer. On February 14, 1997, State Farm received another report from Dr. Smith, dated January 28, 1997, which stated: "Therapy treatments don't seem to be doing much." On February 27, 1997, State Farm received another report from Dr. Belitsky, dated February 20, 1997, in which he noted that Plaintiff continues to suffer from pain. He further noted that the treatments only gave Plaintiff short term relief. He recommended continuing with the treatments.

On March 18, 1997 State Farm received the written opinion of the peer reviewer Dr. Daniel Bowerman, a chiropractor. He advised State Farm that while the initial period of treatment by

Dr. Belitsky was medically reasonable with some limited exceptions, continuation of care beyond March 5, 1997 was not. He based his opinion on the Plaintiff's medical records and a telephone discussion with Dr. Belitsky. Dr. Bowerman did not consult or examine the Plaintiff. State Farm, relying on Dr. Bowerman's PRO report, denied payment to Dr. Belitsky for care beyond the suggested date.

On April 3, 1997, Ms. Quercetti received an operative note and bill from the Spine Center for the March 14, 1997 administration of facet block injections to Plaintiff's spine by Dr. Smith. Because the medical records revealed that several previous injections proved to be ineffective, Ms. Quercetti referred the matter for Peer Review. She also included in the peer review two subsequently received operative notes for injections administered by Dr. Smith in March. In April, Dr. Smith saw the Plaintiff again. In April, Plaintiff received yet another injection from Dr. Batta, a pain specialist. Ms. Quercetti referred Dr. Batta's bills from April 4, 1997 onward.

In early June of 1997, State Farm received the peer review report of Dr. Marc Manzione, an orthopedic surgeon. In his report, Dr. Manzione opined that the record did not support the reasonableness and necessity of the treatment rendered by Dr. Smith beyond March 14, 1997. The necessity and reasonableness of Dr. Batta's treatment was reviewed by Dr. Wilhelmina Korevaar, a

pain specialist. She opined, based upon her review of the record, that Dr. Batta's treatment was redundant and the injections as of April 4, 1997 were not reasonable or medically necessary for the injuries sustained on July 26, 1996. Based on these peer reviews, State Farm declined to pay for the facet injections administered by Dr. Smith and Dr. Batta.

On September 23, 1997, after Plaintiff visited Dr. Smith, Dr. Smith wrote to State Farm informing it of two options he had presented to Plaintiff during the visit. One was to deal with the pain through on-going treatment, which would include medication, equipment, and intermittent Cortisone shots. The other option was surgery of Plaintiff's shoulder. State Farm received this letter on November 7, 1997. Plaintiff, however, did not submit any further claims. In April 1998, Plaintiff's attorney wrote to State Farm, essentially asking State Farm to pay all outstanding bills previously denied. In the letter, he also stated, "I would also respectfully request that you telephone your insured and inform him that he can have the operative procedure suggested by Dr. Smith . . . and you will pay for same." Defendant took this statement as a request for pre-certification of the shoulder surgery.

Plaintiff, in his rebuttal reply to Defendant's response to Plaintiff's response to Defendant's Motion for Partial Summary Judgment, denies making such a request. Furthermore, he

acknowledged that State Farm had no duty to provide a pre-certification under Pennsylvania law. As evidence, Plaintiff's counsel refers to two other letters he wrote to State Farm in June and July 1998, asking for reconsideration of the denial of benefits. Regardless of Plaintiff's intention, on September 30, 1998, Defendant² replied by informing Plaintiff that State Farm does not pre-approve treatment. Instead, State Farm offered Plaintiff an independent medical examination to assess his current condition. Hearing no response, State Farm closed the file on February 10, 1999.

In June of 1999, Plaintiff underwent an Independent Medical Evaluation in connection with his claim against the third party driver's insurance company. Plaintiff met with a Dr. Stuart Gordon for approximately 20 minutes along with Plaintiff's attorney. Prior to the meeting Doctor Gordon also reviewed Plaintiff's medical documentation. In his report, Dr. Gordon recommended shoulder surgery for Plaintiff and further stated that in his opinion, the injections into the shoulder for pain relief were appropriate. This report, dated June 30, 1999, was sent to a Michael R. Droogan, Jr., counsel for the insurance carrier of the third party defendant who drove the car which struck Plaintiff in July 1996, but not to State Farm.

²At this time, Ms. Marcia Evan of State Farm handled Plaintiff's claims.

On July 24, 2000, Plaintiff filed a complaint in the Philadelphia Court of Common Pleas and attached Dr. Gordon's report to the complaint. State Farm claims the first time it saw Dr. Gordon's report was upon receipt of the complaint. Plaintiff's counsel³ later stated he thought that State Farm already had a copy of the report and that in any case, he had no duty to send State Farm a copy of the report. On September 19, 2000, the Defendant removed the case to this Court under diversity jurisdiction.

Following its receipt of Dr. Gordon's report, State Farm authorized its counsel to notify Plaintiff that State Farm would pay for Plaintiff's shoulder surgery. State Farm also decided to pay for the bills of Dr. Batta and Dr. Smith which had been previously denied. It also decided to pay for continuing visits with Dr. Smith in light of the fact that Plaintiff appeared to need shoulder surgery. These decisions were communicated to Plaintiff. On October 24, 2000 Defendant's counsel advised Plaintiff's counsel that State Farm would pay for the shoulder surgery up to its policy limits, subject to the payment of the other bills. Defendant's counsel confirmed this conversation in a letter and asked for Dr. Batta and Dr. Smith's billings.

³In the complaint, Plaintiff alleged that State Farm failed to heed the advice of its own expert, Dr. Gordon, when in fact Dr. Gordon was not State Farm's expert. Counsel for Plaintiff later withdrew this allegation and apologized in his answer to the Defendant's Motion for Partial Summary Judgment.

In addition, State Farm contacted Dr. Gordon to ask for his opinion regarding the medical necessity of Dr. Belitsky's treatment. In reply, Dr. Gordon stated in a letter dated November 27, 2002 that "Any treatment rendered beyond three to four months after the injury would be, in my opinion, inappropriate and not in the best interest of the patient." Furthermore, Dr. Bowerman, one of the Peer Reviewers, remained constant in his opinion that chiropractic treatments were not necessary, even though Defendant informed him that Plaintiff was now a surgical candidate.

State Farm continued in its attempt to get information from Plaintiff's attorney regarding Plaintiff's treatment with Dr. Batta and visits to Dr. Smith's office. State Farm also enquired as to the shoulder surgery. See Letters from Defendant's counsel to Plaintiff's counsel, dated October 27, 2000; December 4, 2000; May 10, 2001; May 29, 2001. Finally on July 20, 2001, State Farm received the requested bills. Plaintiff's counsel claims there was some confusion regarding Dr. Smith's billing system which caused the delay. State Farm paid Dr. Smith⁴ and Dr. Batta⁵ in

⁴On August 17, 2001, Defendant paid Dr. Smith a total of \$347.94 for services rendered on April 22, 1997, August 26, 1997 and September 23, 1997.

⁵On August 24, 2001, Defendant paid Dr. Batta a total of \$839.16 for services rendered on the following dates in 1997: April 4th, 9th, 25th; May 30th; June 6th, 13th, 27th; July 18th; August 1st, 15th, 29th; and November 7th and 14th.

August 2001. As for the shoulder surgery, the Court has, to this date, not been notified whether it has yet taken place.⁶

1. DEFENDANT'S MOTION FOR PARTIAL SUMMARY JUDGMENT

STANDARD OF REVIEW

Under Federal Rule of Civil Procedure 56(c), 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 and that the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c). This Court is required, in resolving a motion for summary judgment pursuant to Rule 56, to determine whether "the evidence is such that a reasonable jury could return a verdict for the nonmoving party." Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 248 (1986). In making this determination, the evidence of the nonmoving party is to be believed, and the district court must draw all reasonable inferences in the nonmovant's favor. See id. at 255. Furthermore, while the movant bears the initial

⁶On June 5, 2001 Plaintiff testified in his deposition that he was under the impression that State Farm had agreed to pay for the surgery, but that in some way the offer had been retracted. State Farm reiterated their offer to pay for the surgery in a letter dated June 12, 2001. Plaintiff's counsel admitted in his deposition that he had not personally spoken to Dr. Smith since October 24, 2000 and that he only forwarded State Farm's letters promising payment for the shoulder surgery after receiving the June 12 letter from State Farm.

responsibility of informing the court of the basis for its motion, and identifying those portions of the record which demonstrate the absence of a genuine issue of material fact, Rule 56(c) requires the entry of summary judgment "after adequate time for discovery and upon motion, against a party who fails to make a showing sufficient to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof at trial." Celotex Corp. v. Catrett, 477 U.S. 317, 322-23 (1986).

DISCUSSION

In Pennsylvania, an insurer's obligation to act in good faith and fair dealing with its insured is generally governed by 42 Pa. Cons. Stat. § 8371⁷. See O'Donnell v. Allstate Ins. Co., 734 A.2d 901, 905 (Pa. Super. Ct. 1999)(citations omitted). Pennsylvania courts define "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

⁷ Section 8371 states:

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 interest plus 3%.
- (2) Award punitive damages against the insurer.
- (3) Assess Court costs and attorney fees against the insurer.

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.

O'Donnell, 743 A.2d at 905. The insured has the burden of presenting "clear and convincing evidence that the insurer did not have a reasonable basis for denying benefits under the policy and that the insurer knew of or recklessly disregarded its lack of reasonable basis in denying the claim." Id. at 906.

In addition to § 8371, the Pennsylvania legislature sought to regulate automobile insurers' conduct under the Pennsylvania Motor Vehicle Financial Responsibility Law by requiring insurers to contract with a peer review organization ("PRO")⁸ to confirm that "treatment, products, services or accommodations conform to the professional standards of performance and are medically necessary." 42 Pa. Con. Stat. Ann. § 1797(b)(1). Disputes over denial of benefits are governed by the procedures and remedies outlined in § 1797(b).⁹ Generally, a plaintiff may not seek

⁸Section 1797(b)(1) states:

Insurers shall contract jointly or separately with any peer review organization established for the purpose of evaluating treatment, health care services, products or accommodations provided to any injured person. Such evaluation shall be for the purpose of confirming that such treatment, products, services or accommodations conform to the professional standards of performance and are medically necessary.

⁹

Section 1797(b) which governs peer review plans for challenges to reasonableness and necessity of treatment

states:

(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.

(3) **Pending determinations by PRO.**--If the insurer challenges within 30 days of receipt of a bill for medical treatment or rehabilitative services, the insurer need not pay the provider subject to the challenge until a determination has been made by the PRO. The insured may not be billed for any treatment, accommodations, products or services during the peer review process.

(4) **Appeal to court.**--A provider of medical treatment or rehabilitative services or merchandise or an insured may challenge before a court an insurer's refusal to pay for past or future medical treatment or rehabilitative services or merchandise, the reasonableness or necessity of which the insurer has not challenged before a PRO. Conduct considered to be wanton shall be subject to a payment of treble damages to the injured party.

(5) **PRO determination in favor of provider or insured.**--If a PRO determines that medical treatment or rehabilitative services or merchandise were medically necessary, the insurer must pay to the provider the outstanding amount plus interest at 12% per year on any amount withheld by the insurer pending PRO review.

(6) **Court determination in favor of provider or insured.**--If, pursuant to paragraph (4), a court determines that medical treatment or rehabilitative services or merchandise were medically necessary, the insurer must pay to the provider the outstanding amount plus interest at 12%, as well as the costs of the challenge and all attorney fees.

punitive damages under § 8371 where the plaintiff is complaining of the denial of first party benefits determined through the use of a PRO as specified under § 1797(b). See Gringeri v. Maryland, Civ. A. No. 97-7373, 1998 U.S. Dist. Lexis 5931, *8-9 (E.D. Pa. Apr. 28, 1998)(citations omitted). Defendant therefore argues that challenges to denial of first party benefits is exclusively governed by § 1797; thus barring Plaintiff's § 8371 bad faith claim.

As noted above, § 1797 is generally the exclusive means to challenge denial of first party benefits where the insurer utilized a proper PRO for its intended limited purpose, to confirm that "treatment, products, services or accommodations conform to the professional standards of performance and are medically necessary." § 1797(b). In such cases, punitive damages and other remedies under § 8371 are unavailable. Gringeri, 1998 U.S. Dist. Lexis 5931, at *11. The statutory scheme of MVFRL,

(7) **Determination in favor of insurer.**--If it is determined by a PRO or court that a provider has provided unnecessary medical treatment or rehabilitative services or merchandise or that future provision of such treatment, services or merchandise will be unnecessary, or both, the provider may not collect payment for the medically unnecessary treatment, services or merchandise. If the provider has collected such payment, it must return the amount paid plus interest at 12% per year within 30 days. In no case does the failure of the provider to return the payment obligate the insured to assume responsibility for payment for the treatment, services or merchandise.

which contains its own procedures, remedies and penalties supports this reading. For example, where an insurer has failed to submit a PRO and the denial of benefits is "wanton," the statute allows treble damages. See § 1797(b)(4).

Where, however, a PRO is utilized for purposes other than as specified under § 1797(b) or the PRO process itself is a sham, then the general claim of bad faith under § 8371 may go forward. See Schwartz v. State Farm Ins. Co., Civ. A. No. 96-160, 1996 WL 189839, at *4-5 (E.D. Pa. Apr. 18 1996); Bacstrom v. State Farm Ins. Co., 40 Pa. D. & C. 4th 330, 338 (1998). In Schwartz, the plaintiff alleged that defendant State Farm had improperly used the PRO, not for its intended purpose as specified under § 1797(b) to determine whether the treatment was reasonable and necessary. 1996 WL 189839, at *4-5. Where a PRO process was improperly used, such as to determine causation, the court held that a bad faith claim under § 8371 was permissible. Id. at *5. In Bacstrom, the plaintiff alleged that the PRO itself was a sham and that State Farm used a captive reviewer who had a financial interest in providing State Farm with biased reviews. 40 Pa. D. & C. 4th at 338. As such, the court allowed the bad faith claim to go forward. Id.

Plaintiff here may not avail himself of the exceptions noted in Schwartz or Bacstrom. Unlike Schwartz, the Defendant here used the PRO for its intended purpose, to determine whether

the treatments were medically necessary and reasonable. Not only is this evident from the facts, but the Plaintiff conceded that the PROs were properly utilized. Furthermore, unlike Bacstrom, Plaintiff here has not alleged nor provided any evidence that the PRO itself was a sham. Hence, even if the PRO was invalid as suggested by the Plaintiff, Plaintiff is only entitled to bring suit under § 1797 which provides the sole remedy for denials of benefits made pursuant to PRO determinations.

Plaintiff, in an attempt to bypass the general rule that § 1797 is the exclusive remedy for his claim, denies making any allegation that the PRO was done in bad faith and admits that "the PRO was done in a manner consistent with the MVFRL." Rather, he argues, he should be allowed to pursue a § 8371 claim because "[t]he constant reliance of defendant on the result of a peer review after change of diagnosis from shoulder strain and sprain to the need for an operative procedure and their refusal to properly investigate the consequences of that decision is the basis for plaintiff's claim under 8371." See Reply of Pl. to Br. of Def. in Rebuttal to Pl.'s Resp. to Mot. for Partial Summ. J.

Plaintiff's attempt to remove this dispute from the PRO process of § 1797(b) fails. Possibly, Plaintiff could have made the above stated argument if he had submitted new claims to State Farm which, relying on the prior PROs, had continued to deny Plaintiff's new claims. Plaintiff, however, did not present any

new claims. Rather, he sought reconsideration of previously denied benefits and sought reassurance from State Farm that it would pay for future claims. As noted by Plaintiff himself, State Farm has no obligation to pre-approve any treatments. As such, the only possible claim that the Plaintiff has against State Farm is the continued denial of payments previously submitted to State Farm. These claims, as is evident from the evidence and as conceded by Plaintiff, fall squarely within the PRO procedure outlined under § 1797(b). Even if, as Plaintiff maintains, the PROs were invalid and moot because the peer reviewers relied on a diagnosis of the simple shoulder strain and sprain rather than the final diagnosis,¹⁰ § 1797(b) provides the remedy. Plaintiff may not bring a separate § 8371 claim.¹¹

Accordingly, summary judgment as to Count II is granted in favor of the Defendant.

¹⁰Defendant disagrees with Plaintiff's characterization of the basis for the PRO reports because an earlier report in Plaintiff's medical file, dated September 30, 1996, already indicated a shoulder tear and tendonitis. In addition, Dr. Smith had mentioned the possibility of surgery as early as November 12, 1996. As such, Defendant argues that since the peer reviewers were aware of Plaintiff's condition at the time they disapproved of Dr. Batta and Dr. Smith's treatments, State Farm's continued reliance on the PRO was proper.

¹¹Even if Plaintiff was allowed to bring a bad faith claim, the facts of the case do not rise to the level of bad faith.

2. PLAINTIFF'S MOTION TO PROHIBIT INTRODUCTION OF EVIDENCE

To the extent Plaintiff seeks to exclude evidence of Defendant's post-complaint conduct as to the bad faith claim, the issue is now moot. The Court notes, however, that the Pennsylvania superior court has ruled, "the conduct of an insurer during the pendency of litigation may be considered as evidence of bad faith under section 8371." O'Donnell, 743 A.2d at 907. The court reasoned that "the broad language of section 8371 was designed to remedy all instances of bad faith conduct by an insurer, whether occurring before, during or after litigation." Id. Hence, it seems that if a plaintiff can use post-complaint conduct evidence to prove bad faith, a defendant could also use it to rebut charges of bad faith.

As to the remaining breach of contract claim, neither the post-complaint payments of medical expenses for treatment nor Defendant's proposal to pay for additional treatment will be excluded at this time. Post-complaint payments of medical expenses for treatment rendered before the filing of the complaint are at least relevant to the issue of damages. As to the circumstances surrounding Defendant's proposed payment for additional treatment, specifically the shoulder surgery, Defendant argues it is relevant to determine whether Plaintiff in fact intends to have surgery. Relevance is a broad standard and any evidence "having any tendency to make the existence of any

fact that is of consequence to the determination of the action more or less probable than it would be without the evidence." F.R.E. 401.

Moreover, Plaintiff has not cited nor does this Court see any applicable rules of exclusion. Plaintiff cites Federal Rules of Evidence 403¹², 407¹³ or 408¹⁴ in his attempt to exclude evidence of State Farm's post-complaint conduct. The Court is not convinced that such evidence should be excluded under Rule 403 because there is no unfair prejudice nor will the prejudice substantially outweigh any probative value.

As for Rule 407 and 408, neither is applicable in this case. Rule 407 is generally invoked by a defendant who seeks to prohibit a plaintiff from introducing subsequent remedial measures by the defendant when the evidence is offered to show

¹² Federal Rule of Evidence 403 states: Although relevant, evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury, or by considerations of undue delay, waste of time, or needless presentation of cumulative evidence.

¹³ Federal Rule of 407 states: When after an injury allegedly caused by an event, measures are taken that if taken previously, would have made the injury or harm less likely to occur, evidence of subsequent measures is not admissible to prove negligence, culpable conduct

¹⁴ Federal Rule of Evidence 408 states: Evidence of (1) furnishing or offering or promising to accept, a valuable consideration in compromising a claim which was disputed as to either validity or amount, is not admissible to prove liability for or invalidity of the claim or its amount.

defendant's culpability for Plaintiff's injury. Additionally, Rule 407 is usually applied in a products liability or personal injury cases where a defendant takes some step to fix the defect or instrumentality which caused the harm to avoid future injury. Even if Rule 407 were applied here, Plaintiff will not prevail because the post-complaint payments and offer to pay for the surgery are not subsequent remedial measures intended to avoid future harm which may arise from some defect in Defendant's claim processing procedures. Lastly, Rule 408 does not come into play here because there was no offer for settlement in this case nor were any of the statements made in the course of a settlement.

Accordingly, Plaintiff's Motion to exclude is denied.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Joseph P. Dougherty	:	CIVIL ACTION
Plaintiff,	:	
	:	
v.	:	
	:	
State Farm Mutual Ins. Co.,	:	
Defendant.	:	No. 00-4734

O R D E R

AND NOW, this day of February 2002, in consideration of the Motion to Prohibit Introduction of Proposed Evidence (Doc. No. 36) filed by the Plaintiff, Joseph P. Dougherty, and the Response of the Defendant, State Farm Mutual Ins. Co., thereto, and the Motion For Partial Summary Judgment filed by Defendant (Doc. No. 37) and the Response of the Plaintiff thereto, the following is **ORDERED**:

1. Plaintiff's Motion to Prohibit Introduction of Proposed Evidence is **DENIED**.
2. Defendant's Motion For Partial Summary Judgment is **GRANTED**. Judgment is **ENTERED** in favor of Defendant, State Farm Insurance Co., and against Plaintiff, Joseph P. Dougherty, as to Count II of the Complaint. Count I remains.

BY THE COURT:

JAMES MCGIRR KELLY, J.