KRISTI L. EBERHART,	:	IN THE COURT OF COMMON PLEAS OF
	:	LYCOMING COUNTY, PENNSYLVANIA
Plaintiff	:	
	:	
vs.	:	NO. 03-01,733
	:	
JASON T. ZEMKO,	:	
	:	
Defendant	:	MOTION IN LIMINE

Date: October 27, 2004

OPINION and ORDER

Before the Court for determination is the Motion in Limine of Defendant Jason T. Zemko (hereafter "Zemko") filed June 15, 2004. The Court will deny the Motion.

On October 30, 2001, Plaintiff Kristi L. Eberhart (hereafter "Eberhart") was operating her vehicle in an easterly direction on Fourth Street in the city of Williamsport, Pennsylvania. On that same day, Zemko was operating his vehicle in a northerly direction on Park Street in the city of Williamsport. Fourth Street and Park Street intersect. It is at this intersection that the two vehicles collided. Eberhart has alleged in her Complaint that the collision was the result of Zemko's negligent operation of his motor vehicle, and has brought a negligence cause of action against him. In his Answer, Zemko has denied that he was negligent in the operation of his vehicle. Zemko has alleged in his New Matter that at the time of the accident Eberhart was insured under an automobile insurance policy with Travelers Insurance Company, which provided income loss benefits of $1,000 per month/$5,00 per accident. Therefore, Zemko alleges that pursuant to §1722 of the Motor Vehicle Financial Responsibility Law (hereafter "MVFRL") he is entitled to an offset for any wage loss benefits that were paid

or payable through Eberhart's automobile insurance policy. This is one of matters that is the subject of the present Motion in Limine.

The Motion in Limine was filed on June 15, 2004. On July 9, 2004, Travelers Property Casualty, n/k/a St. Paul's Travelers (hereafter "St. Paul's"), filed a Petition to Intervene and Appear in Response to Defendant's Motion in Limine in order to represent its interests in the Motion. The Petition was granted by an Order filed July 22, 2004.[1] On August 5, 2004, St. Paul's filed a brief in support of its position on the Motion. Zemko had filed a brief on June 15, 2004. Eberhart filed a brief on July 6, 2004. All parties were represented at the argument that was held on August 16, 2004.

In the Motion, Zemko is attempting to preclude and/or limit Eberhart's claim for lost income and her claim for medical expenses. As to the income loss claim, Zemko contends that the lost income is not recoverable in this action because it was payable as part of the income loss benefits under Eberhart's automobile insurance policy. Zemko argues that the income loss benefits were payable because they were capable of being paid. Zemko reaches this conclusion on the theory that the income loss benefits were payable because St. Paul's wrongfully denied coverage. Zemko contends that St. Paul's erred when it denied coverage of the benefits on the basis that Eberhart did not miss five full consecutive days of work as required by §1712(2) of the MVFRL. Zemko asserts that there is no requirement in the MVFRL that the five days have to be either full days or consecutive. Zemko argues that a correct interpretation of §1712(2) is that the five-day requirement is a period of time that is

[1] On August 3, 2004, an Order was filed approving the stipulation of the parties that St. Paul's Travelers could intervene and appear to represent its interests in the Motion in Limine. The same Order permitted St. Paul's Travelers to so intervene.

equal to five days. Zemko contends that such an interpretation is in line with the liberal interpretation that is to be given to the provisions of the MVFRL and the goal of the MVFRL to compensate individuals for the loss of income they would have earned but for the injuries received in the accident. Therefore, Zemko argues that since the lost income is properly payable under the automobile insurance policy, Eberhart is precluded by §1722 of the MVFRL from recovering her lost wages in this action.

As to the claim for medical expenses, Zemko argues that Eberhart cannot recover from him the expenses associated with her massage therapy, because she failed to exhaust her remedies under the peer review process implemented by the MVFRL. Zemko argues that the MVFRL established a peer review process to be utilized by insurers to challenge the reasonableness and necessity of treatment provided by health care providers. Zemko asserts that if a party wishes to challenge the determination made by a peer review organization it can either request reconsideration within thirty days or file an action in court against the insurer. Zemko contends that by allowing Eberhart to pursue a claim for the massage therapy expenses through a third party action the Court would be permitting her to circumvent the procedure established by the Legislature to determine whether Eberhart was so entitled to recover those expenses. Zemko further agues that if Eberhart is permitted to pursue her medical expenses claim with regard to her massage therapy and it is determined that these expenses were reasonable, then Eberhart would still not be able to recover them from Zemko pursuant to §1722 of the MVFRL, as the expenses would have been rightly payable under the automobile insurance policy.

In response, Eberhart asserts that she can seek recovery of the lost income and massage therapy expenses from Zemko. As to the income loss claim, Eberhart argues that the lost income benefit was not payable under §1722. Eberhart argues that under the plain meaning of "payable" once her claim for income loss was rejected by St. Paul's it was not capable of being paid. Therefore, she is not precluded from recovering it from Zemko. As to the massage therapy expenses, Eberhart contends that there is no requirement in the MVFRL that she must exhaust the remedies under the peer review process before bringing a claim against the alleged tortfeasor to recover medical expenses arising out of a motor vehicle accident. Initially, Eberhart asserts that there was no peer review from which she could have sought reconsideration or filed a separate action to correct. Regardless, Eberhart argues that there is no right, let alone a requirement, for her to initiate a peer review. Secondly, Eberhart argues that the MVFRL does not impose a requirement upon her to seek reconsideration or contest the decision of her insurance carrier before seeking recovery of medical expenses against a tortfeasor.

Similarly, St. Paul's takes the position that Eberhart may recover the lost income and massage therapy expenses from Zemko. St. Paul's argues that the income loss benefits were not payable since Eberhart did not miss five working days. St. Paul's argues that the clear language of the MVFRL states that it must be five days and does not permit a construction that would allow for an aggregation of time equal to five days. St. Paul's contends that Eberhart's testimony demonstrates that she was able to go to work everyday for at least part of the day. As such, she did not miss five working days and was not entitled to the income loss benefits under the automobile insurance policy. Concerning the massage therapy expenses, St. Paul's

argues that there is no authority which states that the peer review process is the exclusive remedy of an insured to seek recovery of medical expenses resulting from a motor vehicle accident. St. Paul's asserts that it submitted the claim to peer review and denied it based on the peer review organization's (hereafter "PRO") determination. While Eberhart had the option of seeking reconsideration of the PRO's determination or bringing a breach of contract claim against it, St. Paul's argues that she was not required to do so before bringing a cause of action against the alleged tortfeasor. Consequently, Eberhart is free to assert her claim against Zemko to recover the massage therapy expenses. St. Paul's also contends that §1722 does not preclude Eberhart from recovering the massage therapy expense as they were not payable since the claim was denied.

Thus there are two issues before the Court. The first is whether §1722 of the MVFRL precludes Eberhart from recovering her lost income from Zemko. This question requires the Court to determine whether the lost income claim was payable as part of the lost income benefits under Eberhart's automobile insurance policy. The second issue is whether there exists a requirement that Eberhart exhaust her remedies under the peer review procedure before asserting a claim for medical expenses against the alleged tortfeasor.

The Court will address the issue concerning the wage loss claim first. Section 1722 of the MVFRL provides as follows:

> In any action for damages against a tortfeasor, or any uninsured or underinsured motorist proceeding, arising out of the maintenance or use of a motor vehicle, a person who is eligible to receive benefits under the coverage set forth in this subchapter, or worker's compensation, or any program, group contract or other arrangement for payment of benefits as defined in section 1719 (relating to coordination of benefits) shall be precluded from recovering the amount of benefits paid or payable under this

> subchapter, or workers' compensation, or any program, group contract or other arrangement for payment of benefits as defined in section 1719.

75 Pa.C.S.A. §1722. The Courts of this Commonwealth have tried to give meaning to the word "payable" as it appears in §1722. In ***Scott v. Erie Insurance Group***, 706 A.2d 357, 359 (Pa. Super. 1998), "payable" was defined as capable of being paid. In ***Schroeder v. Schrader***, 682 A.2d 1305, 1310 (Pa. Super. 1996) (quoting Black's Law Dictionary 1016 (5th ed. 1979)), "payable" was defined as "'capable of being paid; suitable to be paid; admitting or demanding payment; justly due; legally enforceable.'" The "capable of being paid" definition does provide some guidance on the issue, but it does not resolve the question before the Court. Whether something is capable of being paid leaves open a number of possible scenarios that could be encompassed by this definition. The Court finds that the application of this definition in two cases clarifies the definition.

The first case is ***Scott v. Erie Insurance Group***, *supra*. In ***Scott,*** the husband plaintiff was injured in a motor vehicle accident. 706 A.2d at 358. Prior to the accident, the plaintiffs had purchased an automobile insurance policy from the defendant insurance company. A dispute arose between the parties about coverage and damages. The dispute was submitted to arbitration. ***Ibid***. The arbitrators entered an award in favor of the plaintiffs in the total amount of $68,411.86, $13,411.86 of which was for medical expenses. ***Ibid***.

The defendant insurance company filed a petition to vacate the award of the arbitrators. They asserted that the plaintiff husband should not have been awarded a $12,586.86 portion of the medical expenses as those expenses would have been paid by his health insurance provider if the plaintiff husband had gone to a physical therapy practice group

that was a qualified provider under the health insurance policy. ***Scott***, 706 A.2d at 358. The trial court denied the petition to vacate stating that the arbitrators had decided as an issue of fact that the husband plaintiff was not eligible to receive reimbursement for the medical expenses under his health insurance policy. ***Ibid***.

The defendant insurance company appealed the decision of the trial court. The Defendant insurance company argued that it was not responsible for the medical bills as a matter of law pursuant to §1722 of the MVFRL, because the medical expenses were payable by the plaintiff husband's health insurer. ***Scott***, 706 A.2d at 359. The health insurer refused to pay for the physical therapy bills because the group that provided the medical services was not a qualified provider under the policy. The defendant insurance company argued that the medical bills were payable if the plaintiff husband properly sought treatment from a qualified provider. ***Ibid.***

The Superior Court held that the medical expenses regarding physical therapy were not payable and would thereby have been precluded from recovery pursuant to §1722. ***Scott***, 706 A.2d at 359. The medical expenses were not payable because they were not capable of being paid. The Superior Court noted that for the health insurer to be required to cover the physical therapy expenses under the policy the plaintiff husband was required to seek treatment from an approved provider. The Superior Court noted that the plaintiff husband had failed to meet this condition precedent, and, as such, the bills for the physical therapy were not payable under the health insurance policy. ***Ibid***.

The Superior Court rejected the argument that the medical expenses were payable if the plaintiff husband had sought treatment from an approved provider. The Superior

Court noted that the standard under §1722 was not whether the bills could have been payable. As the Superior Court stated, " "Could have been paid" does not equate to "payable" since it involves an alteration of what in fact occurred." ***Scott***, 706 A.2d at 359. The Superior Court went on to say in a footnote that "At the time the arbitration hearing was held, the claim for rehabilitative services was denied by Health America and, therefore, was not "paid or payable." Consequently, the bill for rehabilitative services was a legitimate claims against appellant." ***Ibid***., n.1.

The second case is ***Bennyhoff v. Pappert***, 790 A.2d 313 (Pa. Super. 2001), *app. denied*, 823 A.2d 143 (Pa. 2003). ***Bennyhoff*** arose out of a collision between an armored car and a bicycle ridden by the plaintiff wife. The plaintiffs brought a negligence claim against the armored car company, and a jury returned a verdict in favor of the plaintiffs. ***Id***. at 315. The armored car company appealed and raised as one of its issues improper evidentiary rulings by the trial court. ***Id***. at 316. The plaintiff wife's insurance company denied coverage for the medical bills because she went outside of her plan and was not covered by the policy. *See*, 790 A.2d at 320, n.5. The armored car company argued that the trial court erred in admitting the plaintiff wife's unpaid medical bills into evidence under the rationale of ***Scott***, *supra*. ***Id***. at 319. The armored car company argued that the medical bills were payable and could not be introduced into evidence as they were not recoverable pursuant to §1722 of the MVFRL.

The Superior Court held that the trial court did not abuse its discretion by admitting the unpaid medical bills into evidence. ***Bennyhoff***, 790 A.2d at 320. The Superior Court reached this conclusion on the basis that the medical bills were not payable. The Superior Court stated that, "Here, Appellants have provided no reasonable argument that

Christine Bennyhoff's situation differs from the ***Scott*** appellee's such that we should disregard that case." ***Ibid***. Like in ***Scott***, the plaintiff wife was not eligible to receive coverage under the policy and the claim was denied; therefore, the medical bills were not payable.

The Court concludes that the income loss benefits are not payable. Per ***Scott*** and ***Bennyhoff,*** when determining whether a benefit is capable of being paid, the focus is on the current status of the claim. The question is, "At the present point in time, is or will the insurer provide coverage for the benefit to the insured?" If the insurer has denied coverage, then the answer to that question is no and the benefit cannot be considered payable.

The correctness of the insurer's denial of coverage does not determine whether a benefit is payable for purposes of §1722. Saying that benefit is payable because the insurer wrongfully interpreted §1712(2) of the MVFRL and should have paid the benefit is the same as saying that if the insured had stayed within her plan then her medical bills would have been covered. In both instances, one has to alter what in fact has occurred to make the benefit payable. This argument has been rejected by the Superior Court in ***Scott***, *supra*, and ***Bennyhoff***, *supra*. Therefore, whether St. Paul's denial of the income loss benefit was proper is immaterial to the determination as to whether the income loss benefit was payable within the meaning of §1722.

In conclusion, the income loss benefit cannot be considered payable since St. Paul's denied coverage. As such, §1722 does not preclude Eberhart's income loss claim. Furthermore, Zemko is not entitled to an offset in the amount of the income loss benefit since that amount was not paid to Eberhart and she is not entitled to that benefit based on the facts as they now exist.

The Court will now address the issue concerning the medical expenses. The peer review process established by the MVFRL is found at §1797. It provides as follows:

> (b) PEER REVIEW PLAN FOR CHALLENGES TO REASONABLENESS AND NECESSITY OF TREATMENT. —
>
> > (1) PEER REVIEW PLAN. -- 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. An insurer's challenge must be made to a PRO within 90 days of the insurer's receipt of the provider's bill for treatment or services or may be made at any time for continuing treatment or services.
> >
> > (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.(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.

75 Pa.C.S.A §1797(b). Essentially, Zemko's argument on this issue is that once the peer review process has been started under §1797, it must be completed. Under that process, if an insurer, as a result of an unfavorable PRO determination regarding the reasonableness of medical

treatment, denies the insured coverage then the insured has two options. One, the insured can seek reconsideration of the PRO determination under §1797(b)(2). Two, the insured can file a separate cause of action against the insurer per ***Terminato***, *supra*. Zemko contends that a plaintiff must pursue either of these to remedies before she goes elsewhere in an attempt to recover medical expenses so that the process established by the Legislature can be completed.

The MVFRL and the peer review process impose no such requirement on a plaintiff. There is no such explicit requirement to be found in the language of the MVFRL. Furthermore, the two remedies Zemko identifies are not administrative remedies that must be exhausted.

"The exhaustion of administrative remedies requirement is a judge-made rule intended to prevent premature intervention into the administrative process." ***Larry Pitt & Assocs., P.C. v. Butler***, 785 A.2d, 1092, 1097 (Pa. Cmwlth. 2001). " 'The doctrine of exhaustion prohibits prospective parties of administrative agency actions from bypassing that process and challenging the administrative action directly to the courts.'" ***Estate of Merriam v. Philadelphia Historical Comm'n***, 777 A.2d 1212, 1219 (Pa. Cmwlth. 2001) (quoting ***Gardner v. Commonwealth of Pennsylvania, Dep't of Environmental Resources***, 658 A.2d 440, 444 (Pa. Cmwlth. 1995)). "Where the Legislature provides a statutory remedy that is mandatory and exclusive, the general rule is that a court is without power to act." ***Terminato***, 645 A.2d at 1291. This is because " '[w]hen the Legislature has seen fit to enact a pervasive regulatory scheme and to establish a governmental agency possessing expertise and broad regulatory and remedial powers to administer that statutory scheme, a court should be reluctant to interfere in those matters and disputes which were intended by the Legislature to be

considered, at least initially, by the administrative agency.'" ***Ibid***. (quoting ***Feingold v. Bell of Pennsylvania***, 383 A.2d 791, 793 (Pa. 1977)). As such, "[i]t is only where the legislature provides 'a specific, exclusive, constitutionally adequate method for the disposition of a particular kind of dispute' that the statutory remedy must be exhausted before the courts may adjudicate the dispute." ***Id.*** at 1292 (quoting ***West Homestead Borough Sch. Dist. v. Allegheny County Bd. of Sch. Dirs.***, 269 A.2d 904, 907 (Pa. 1970)).

The Pennsylvania Supreme Court has held that the reconsideration provision of §1797(b)(2) is not an administrative remedy that must be exhausted before an insured can bring a separate cause of action to recover medical expenses. ***Terminato***, 645 A.2d at 1292. The Court addressed the issue in the context of a claim by an insured against the insurer, but the reasoning of ***Terminato*** is equally applicable to the case *sub judice*. The thrust of the ***Terminato*** opinion is that the peer review process is not the exclusive method designed by the Legislature to dispose of disputes concerning the payment of medical expenses arising out of a motor vehicle accident.

In ***Terminato***, the Supreme Court held that the peer review process, including the reconsideration provision, was not the forum in which disputes regarding payment of medical expenses were to be decided. 645 A.2d at 1292. The Supreme Court stated that the Legislature did not give authority to a PRO to entertain litigation arising out of the nonpayment of medical benefits and provided no remedy under the peer review process for the nonpayment of benefits. ***Ibid***. This is because the peer review process was intended as a cost containment device and not as a method for disposing with disputes concerning the payment of medical expenses. *See*, ***Ibid***.

In light of ***Terminato***, *supra*, the Court finds that Eberhart was not required to seek reconsideration of the PRO determination before brining her cause of action against Zemko to recover her medical expenses.

As to the requirement that a plaintiff bring a separate cause of action against her insurer first to recover medical expenses, the Court finds there to be no such requirement. The language of the MVFRL imposes no such requirement. And while ***Terminato***, *supra*, may have held that an insured could bring a cause of action against the insurer to recover medical benefits without seeking reconsideration under §1797(b)(2), that case did not say that a plaintiff must do so before bringing a claim against the alleged tortfeasor. Furthermore, there is nothing in that case from which such a requirement can be inferred.

Zemko's final argument related to this issue is that if Eberhart is permitted to pursue her medical expenses claim concerning her massage therapy and it is determined that these expenses were reasonable, then Eberhart would still be precluded from recovering them from Zemko pursuant to §1722 of the MVFRL as the expenses would have been rightly payable under the automobile insurance policy. The Court finds that §1722 would not preclude recovery of the medical expenses related to massage therapy. The same analysis and reasoning that was applied to the income loss benefit issue applies here. Consequently, the claim for medical expenses related to the massage therapy cannot be considered payable since St. Paul's denied the claim.

Accordingly, Zemko's Motion in Limine is denied in all respects.

O R D E R

It is hereby ORDERED that the Motion in Limine of Defendant Jason T. Zemko filed June 15, 2004 is DENIED.

BY THE COURT:

William S. Kieser, Judge

cc: Thomas Waffenschmidt, Esquire
Christopher M. Reeser, Esquire
Judges
Christian J. Kalaus, Esquire
Gary L. Weber, Esquire (Lycoming Reporter)