

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Howard M. Rombom Ph.D. P.C.
(Applicant)

- and -

Geico Insurance Company
(Respondent)

AAA Case No.	17-16-1038-5681
Applicant's File No.	1857581
Insurer's Claim File No.	0484811670101018
NAIC No.	35882

ARBITRATION AWARD

I, Nicholas Tafuri, the undersigned arbitrator, designated by the American Arbitration Association pursuant to the Rules for New York State No-Fault Arbitration, adopted pursuant to regulations promulgated by the Superintendent of Insurance, having been duly sworn, and having heard the proofs and allegations of the parties make the following **AWARD**:

Injured Person(s) hereinafter referred to as: EIP (RE)

1. Hearing(s) held on 01/18/2018, 05/24/2018
Declared closed by the arbitrator on 05/24/2018

Neda Melamed, Esq. from Israel, Israel & Purdy, LLP participated in person for the Applicant

Alberto DeChavez, Claims Representative from Geico Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 923.20**, was NOT AMENDED at the oral hearing.
Stipulations WERE made by the parties regarding the issues to be determined.

Respondent stipulated to Applicant's prima facie case.

Applicant stipulated to the timeliness of Respondent's denial.

Both parties stipulated that there are no fee schedule issues.

3. Summary of Issues in Dispute

EIP (RE) is a 30 year old male, who was a passenger in a motor vehicle involved in an accident on 1/31/16. As a result of the accident, EIP sought medical treatment. On 4/5/16, EIP underwent psychological testing.

Applicant's claim for reimbursement was denied by Respondent based on a peer review by Dr. Michael Rosenfeld.

The issue to be determined at the hearing is whether Applicant is entitled to no-fault reimbursement for health services denied based on a peer review?

4. Findings, Conclusions, and Basis Therefor

I have reviewed the documents contained in the ADR Center Record as of the date of the hearing and this Award is based upon my review of the Record and the arguments made by the representatives of the parties at the Hearing. Pursuant to 11 NYCRR 65-4 (Regulation 68-D), §65-4.5 (o) (1), an Arbitrator shall be the judge of the relevance and materiality of the evidence offered, and strict conformity to legal rules of evidence shall not be necessary. The Arbitrator may question any witness or party, and independently raise any issue that the Arbitrator deems relevant to making an award that is consistent with the Insurance Law and Department Regulations. The case was decided on the submissions of the Parties as contained in the ADR Center Record maintained by the American Arbitration Association, and the oral arguments of the parties' representatives. There were no witnesses.

It is well settled that Applicant establishes its *prima facie* showing of entitlement to No-Fault benefits by submitting evidentiary proof that the prescribed statutory billing forms had been mailed, received by the respondent and that payment of no fault benefits were overdue. Mary Immaculate Hospital v. Allstate Insurance Company, 5 A.D. 3d 742, 774 N.Y.S.2d 564 (2d Dept. 2004). With Applicant establishing its *prima facie* case of entitlement to No-Fault compensation for its claim, the burden then shifts to the Respondent to prove that the bill in question was properly denied.

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Applicant's claim for reimbursement for the psychological testing was denied by Respondent based on a peer review by Dr. Michael Rosenfeld.

Medical Necessity

In order to support a lack of medical necessity defense, respondent must "set forth a factual basis and medical rationale for the peer reviewer's [or examining physician's] determination that there was a lack of medical necessity for the services rendered." See Provvedere, Inc. v. Republic Western Ins. Co., 2014 NY Slip Op 50219(U) (App. Term 2d, 11th and 13th Jud. Dists. 2014.) Respondent bears the burden of production in support of its lack of medical necessity defense, which, if established, shifts the burden of persuasion to applicant. See Bronx Expert Radiology, P.C. v. Travelers Ins. Co., 2006 NY Slip Op 52116 (App. Term 1st Dept. 2006.)

A doctor, providing a peer review report to determine whether the treatment at issue was medically necessary, must establish a factual basis and medical rationale for his/her asserted lack of medical necessity for future health care services. Ying Eastern Acupuncture P.C. v Global Liberty Insurance, 20 Misc.3d 144(A) (App. Term 2d, 11th and 13th Dists. Sept. 3, 2008.)

The Civil Courts have held that a defendant's peer review or report of medical examination must set forth more than just a basic recitation of the expert's opinion. The trial courts have held that a peer review or medical examination report's medical rationale will be insufficient to meet respondent's burden of proof if: 1) the medical rationale of its expert witness is not supported by evidence of a deviation from "generally accepted medical" standards; 2) the expert fails to cite to medical authority, standard, or generally accepted specifics as to the claim at issue, is conclusory or vague. See Nir v. Allstate, 7 Misc.3d 544 (N.Y. City Civ. Ct. 2005); See also, All Boro Psychological Servs. P.C. v. GEICO, 2012 Slip Op 50137(U) (N.Y. City Civ. Ct. 2012.) "Generally accepted practice is that range of practice that the profession will follow in the diagnosis and treatment of patients in light of the standards and values that define its calling." Nir, supra.

In support of its' contention that the services were not medically necessary, Respondent relies upon the peer review by Dr. Michael Rosenfeld, a New York State licensed psychologist, dated May 27, 2016. Dr. Rosenfeld notes that the EIP was examined by Applicant on April 5, 2016. He presented with the following complaints: headaches, lack of interest, physical pain, irritability, short temper, fatigue, social isolation, mood swings, crying spells, depressed mood, changes in appetite, sleep disturbance, lack of motivation, and flashbacks of the accident. The resultant diagnosis was Post-Traumatic Stress Disorder. Dr. Rosenfeld explains that while the initial interview and follow-up psychotherapy session were medically necessary, the psychological testing administered was not medically necessary under the circumstances of this case. He notes, the diagnostic interview alone is the main tool used by psychologists to determine a diagnosis and a treatment plan. Dr. Rosenfeld concedes that psychological testing can be useful to augment the initial interview, but he notes "this is typically only necessary when the case is complex and the testing administered will augment findings from the initial interview." That said, he refers to this particular EIP's case as straightforward in that the EIP experienced an obvious precipitant (i.e., the motor vehicle accident) and developed psychological symptoms in response to the stressor. As such, Dr. Rosenfeld concluded this additional psychological testing was not required, particularly in this case where the tests consisted of EIP completing pre-formatted symptom checklists. He also notes that any information provided by the testing conducted by Applicant would have been readily available during the face-to-face clinical interview. Thus, the use of this line of testing would not have altered the diagnosis or treatment plan. He cites to medical authority that he believes supports his positions.

Based on the peer review report, I find that Respondent has provided sufficient evidence of a lack of medical necessity.

Where a Respondent meets its burden, it becomes incumbent on the claimant to rebut the peer review. Be Well Medical Supply, Inc. v. New York Cent. Mut. Fire Ins. Co., 18 Misc.3d 139(A), 2008 WL 506180 (App. Term 2d & 11th Dists. Feb. 21, 2008); A Khodadadi Radiology, P.C. v. NY Central Mutual Fire Ins. Co., 16 Misc.3d 131(A), 2007 WL 1989432 (App. Term 2d & 11th Dists July 3, 2007). "Where the defendant insurer presents sufficient evidence to establish a defense based on the lack of medical necessity, the burden shifts to the plaintiff which must then present its own evidence of medical necessity (see Prince, Richardson on Evidence §§

3-104, 3-202 [Farrell 11th ed])." West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co., 13 Misc.3d 131(A), 2006 N.Y. Slip. Op. 5187(U) at 2, 2006 WL 2829826 (App. Term 2d & 11th Dists. Sept. 29, 2006).

In this case, Applicant submits the peer review rebuttal of EIP's provider, Dr. Howard Rombom. Dr. Rombom disputes the peer reviewer's conclusion and avers that the testing was necessary to adequately diagnose the patient and formulate an effective treatment plan. This testing was medically necessary based on the patient's post- traumatic symptoms, which included irritability, short temper, fatigue, mood swings, social isolation, crying spells, depressed mood, appetite changes, sleep disturbances, lost interest, loss of motivation, and fearfulness.

In this case, the patient's symptoms necessitated a more thorough assessment through the utilization of psychological testing. With the help of the psychological testing process, patients are able to more fully perceive and articulate their specific anxieties and fears regarding their physical symptoms, sleep difficulties, flashbacks, and anxieties about riding in cars and fears of enduring additional, future accidents. Moreover, it also enables them to recognize and discuss their overwhelming fears about the accident, and its impact on both work and living situations. Testing allows for the augmentation of further relevant findings with those from the initial interview, thereby placing the treating doctor in a better position to determining proper course of treatment for the patient. Psychological treatment sessions are for treating emotional symptoms, but it would be inappropriate to sacrifice the valuable time needed for a successful therapeutic session conducting a thorough psychological/emotional assessment. It is medically necessary to more fully assess the patient's condition for clinical decision making, to assess whether continued treatment is needed, and to provide a more detailed picture of the patient's psychological status throughout the course of treatment for the purposes of proper, professional medical documentation. Dr. Rombom addresses in detail the points raised by the peer reviewer. He also cites to authority that supports his position for performing the psychological testing at issue.

In an addendum, dated April 23, 2018, Dr. Rosenfeld adheres to his opinion that the psychological testing was not medically necessary, and reiterates that the diagnosis in this case was straightforward and evident based upon the clinical interview, history, and mental status examination of the claimant, and the testing would not have had a meaningful impact on the diagnosis or treatment of this claimant.

After reviewing the totality of the admissible and credible evidence, as well as hearing the arguments of the parties, I deem Applicant's proof to be more persuasive and credible than the peer review report. I find Dr. Rombom successfully rebutted the peer review report, exhibited a sound rationale, and justified the need for the testing at issue. Consequently, the rebuttal was sufficient to meet the Applicant's burden of proving medical necessity by a preponderance of the evidence.

Accordingly, Applicant's claim is granted. Applicant is awarded \$923.20.

This decision is in full disposition of all claims for no-fault benefits presently before this arbitrator.

5. Optional imposition of administrative costs on Applicant.
Applicable for arbitration requests filed on and after March 1, 2002.

I do NOT impose the administrative costs of arbitration to the applicant, in the amount established for the current calendar year by the Designated Organization.

6. **I find as follows with regard to the policy issues before me:**

- ☐ The policy was not in force on the date of the accident
- ☐ The applicant was excluded under policy conditions or exclusions
- ☐ The applicant violated policy conditions, resulting in exclusion from coverage
- ☐ The applicant was not an "eligible injured person"
- ☐ The conditions for MVAIC eligibility were not met
- ☐ The injured person was not a "qualified person" (under the MVAIC)
- ☐ The applicant's injuries didn't arise out of the "use or operation" of a motor vehicle
- ☐ The respondent is not subject to the jurisdiction of the New York No-Fault arbitration forum

Accordingly, the applicant is AWARDED the following:

A.

Medical		From/To	Claim Amount	Status
	Howard M. Rombom	04/05/16 -	\$923.20	Awarded:

	Ph.D. P.C.	04/26/16		\$923.20
Total				\$923.20
			\$923.20	Awarded: \$923.20

- B. The insurer shall also compute and pay the applicant interest set forth below. 06/30/2016 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Respondent shall compute and pay to Applicant the amount of interest from the aforesaid filing date of the Request for Arbitration, at a rate of 2% per month, simple interest (i.e. not compounded) using a 30-day month and ending with the date of payment of the award, subject to the provisions of 11 NYCRR 65-3.9(c).

I note that this matter was originally scheduled for a hearing on 1/18/18. On consent, the hearing was adjourned, and the Arbitrator stayed interest. Accordingly, interest is stayed from 1/18/18 to 5/24/18.

C. Attorney's Fees

The insurer shall also pay the applicant for attorney's fees as set forth below

For cases filed prior to February 4, 2015, the attorney's fee shall be calculated as follows: 20% of the amount of first party benefits awarded herein, plus interest thereon, subject to a minimum fee of \$60 and a maximum of \$850. 11 NYCRR 65-4.

For cases filed on or after February 4, 2015, the attorney's fee shall be calculated as follows: 20% of the amount of first-party benefits awarded, plus interest thereon, subject to no minimum fee, and a maximum fee of \$1,360.00. 11 NYCRR 65-4.6(d).

- D. The respondent shall also pay the applicant forty dollars (\$40) to reimburse the applicant for the fee paid to the Designated Organization, unless the fee was previously returned pursuant to an earlier award.

This award is in full settlement of all no-fault benefit claims submitted to this arbitrator.

State of New York

SS :

County of Nassau

I, Nicholas Tafuri, do hereby affirm upon my oath as arbitrator that I am the individual described in and who executed this instrument, which is my award.

06/22/2018

(Dated)

Nicholas Tafuri

IMPORTANT NOTICE

This award is payable within 30 calendar days of the date of transmittal of award to parties.

This award is final and binding unless modified or vacated by a master arbitrator. Insurance Department Regulation No. 68 (11 NYCRR 65-4.10) contains time limits and grounds upon which this award may be appealed to a master arbitrator. An appeal to a master arbitrator must be made within 21 days after the mailing of this award. All insurers have copies of the regulation. Applicants may obtain a copy from the Insurance Department.

ELECTRONIC SIGNATURE

Document Name: Final Award Form
Unique Modria Document ID:
8d8600d8d393e658066f02eecf39414f

Electronically Signed

Your name: Nicholas Tafuri
Signed on: 06/22/2018