

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Opus Psychological Services, P.C.
(Applicant)

- and -

Geico Insurance Company
(Respondent)

AAA Case No.	17-17-1067-2734
Applicant's File No.	None
Insurer's Claim File No.	0471847180101028
NAIC No.	22063

ARBITRATION AWARD

I, Evelina Miller, 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: SC

1. Hearing(s) held on 09/04/2018
Declared closed by the arbitrator on 09/04/2018

Walter Pissary Esq from The Law Offices of Hillary Blumenthal P.C. participated in person for the Applicant

Alexandra Brancato Esq from Geico Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 1,019.52**, was NOT AMENDED at the oral hearing.
Stipulations WERE NOT made by the parties regarding the issues to be determined.
3. Summary of Issues in Dispute

Whether Applicant established entitlement to No-Fault compensation for fees associated with psychological testing performed on Assignor

Whether Respondent made out a prima facie case of lack of medical necessity, and if so, whether Applicant rebutted it.

4. Findings, Conclusions, and Basis Therefor

Applicant was represented by Walter Pissary Esq., who presented oral arguments and relied upon documentary submissions. Alexandra Brancato Esq., appeared on behalf of Respondent and presented oral arguments and relied upon documentary submissions I have reviewed the submissions contained in MODRIA. These submissions are the record in this case.

The dispute arises from the underlying automobile accident of August 14, 2015, in which the Assignor (SC), a 62-year-old-female was the driver. Thereafter, Assignor sought private medical attention and was eventually referred to Applicant for psychological assessment. Patient was nervous and irritable after the accident. Patient was recommended to undergo psychological testing. The bill in dispute is for psychological testing performed on the patient on 10/2/15 through 10/9/15.

I find that Applicant establishes its prima facie showing of entitlement to recover first-party no-fault benefits by submitting evidentiary proof that the prescribed statutory billing forms, setting forth the fact and amount of the loss sustained, had been mailed and received and that payment of no-fault benefits were overdue. See *Mary Immaculate Hospital v. Allstate Insurance Co.*, 5 A.D.3d 742, (2d Dept., 2004).

Applicant's proof is also in Respondent's denials, which acknowledged receipt of the bill. Since Applicant establishes its prima facie showing of entitlement to recover first-party no-fault benefits, the burden then shifts to the Respondent to demonstrate a lack of medical necessity for the items at issue. See, *Citywide Social Work & Psychological Services, PLLC v. Allstate Ins. Co.*, 8 Misc 3d 1025 A (2005).

Respondent issued timely denial for psychological testing performed on Assignor on 10/2/15 through 10/9/15, based on a Peer Review by Dr. Yakov Burstein Ph.D. performed on 11/4/15. Upon review of the medical records, Dr. Burstein determined that there was no medical necessity for the psychological testing performed on Assignor on 10/2/15 through 10/9/15.

Medical Necessity:

A denial premised on a lack of medical necessity must be supported by competent evidence such as an independent medical examination, a peer review or other proof which sets forth a factual basis and a medical rationale for denying the claim. *Healing Hands Chiropractic, P.C., v. Nationwide Assur. Co.*, 5 Misc., 3d 975, 787 N.Y.S. 2d 645 (Civ.Ct., New York County, 2004); *King's Med. Supply Inc. v. Country Wide Ins. Co.*, 5Misc. 3d 767, 783 N.Y.S. 2d 448.

The civil courts have held that a defendant's peer review or medical evidence must set forth more than just a basic recitation of the expert's opinion. The trial courts have held that a peer review 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 medical practice as a medical rationale for his findings; and 3) the peer review report fails to provide specifics as to the claim at issue, is conclusory or vague. See generally, *Nir v. Allstate*, 7 Misc.3d 544 (N.Y. City Civ. Ct. 2005); See also, *All Boro Psychological Servs. P.C. v. GEICO*, 2012 NY Slip Op 50137(U) (N.Y. City Civ. Ct. 2012).

PEER by Dr. Yakov Burstein Ph.D.

On November 4, 2015, Dr. Yakov Burstein performed a peer review on behalf of Respondent regarding the medical necessity of psychological testing performed on Assignor. Dr. Burstein reviewed medical records of the Assignor and concluded that based on Assignor's medical history as well as recognized medical guidelines, medical necessity for the testing has not been established.

Dr. Burstein states that the testing wasn't necessary as formal testing is only necessary where the diagnosis cannot be determined in any other manner. Here, the diagnosis could have been made based on history and mental state. This testing is a self-administered questioner, and could have been completed upon intake, rather than as a separate procedure. Claimant was seen in psychotherapy to reduce reported symptoms on 9/24/15. Psychotherapy is an accepted intervention to deal with anxiety and depression. Finally, he states that the test is done in 15 minutes and does not take the amount of time that was billed by the Applicant.

Once Respondent submits an IME report or peer review that has a sufficient factual basis and medical rationale, then the courts have routinely found that Respondent has established its prima facie defense that the disputed medical service is medically unnecessary. *A Khodadadi Radiology, P.C. v. NY Cent. Mut. Fire Ins. Co.*, 16 Misc.3d 131(A), 841 N.Y.S.2d 824 (Table, Text in WESTLAW), Unreported Disposition, 2007 WL 1989432, 2007 N.Y. Slip Op. 51342(U) (N.Y. Sup. App. Term Jul 03, 2007). See also, *Amaze Medical Supply Inc. v. Eagle Insurance Company*, 2003NY Slip Op 51701 (U), 2 Misc.3d. 128 (App. Term 2d & 11 Dist.-2003).

In order for an applicant to prove that the disputed expense was medically necessary, it must meaningfully refer to, or rebut, the conclusions set forth in the peer review. *High Quality Medical, P.C. v. Mercury Ins. Co.*, 2010 N.Y. Slip Op. 50447(U) (App Term 2d, 11th & 13th Dists. Mar. 10, 2010); *Pan Chiropractic, P.C. v. Mercury Ins. Co.*, 24 Misc.3d 136(A), 2009 N.Y. Slip Op. 51495(U) (App Term 2d, 11th & 13th Dists. July 9, 2009).

Rebuttal by Applicant

Applicant submits a rebuttal by Dr. Cajetan Uchendu PhD. Dr. Uchendu states that the patient presented with subjective complaints that were more extensive than described by Dr. Burstein. He also states that the medical literature cited by Dr. Burstein is

inapplicable to the type of injury sustained by the Assignor. Furthermore, Dr. Uchendu states that the duration of the test in this case is over one hour per test. He states that it is different than the testing described by Dr. Burstein as he attributes only 15 minutes to the test. Dr. Uchendu states that the testing also includes the interpretation of the test, not just the administration of it. Finally he states that the provider himself performs the test and not a technician, as such the duration of the test and the amount billed for the test is appropriate in this case. Dr. Uchendu then cites to medical literature which speaks to the efficacy of the testing for the specific symptoms sustained by the Assignor in the accident.

Conclusion

After consideration of all the documents submitted, as well as oral arguments presented at the hearing I find the following. I find that Respondent has been able to establish its prima facie burden that the services at issue were medically unnecessary. The crux of Dr. Burstein's peer report is that formal testing is only necessary where the diagnosis cannot be determined in any other manner. Here, the diagnosis could have been made based on history and mental state. This testing is a self-administered questioner, and could have been completed upon intake, rather than as a separate procedure. Applicant submits a rebuttal by Dr. Uchendu. He describes the extent of the patient's symptoms and states that this particular testing was appropriate in this case. He also argues that it was billed appropriately as well. He cites to medical literature to support his opinion regarding the medical necessity of the testing. He also describes the test and concludes that due to the duration of the test and the preparation of the report, the services at issue have been properly billed.

Based on the above, I find that Applicant has been able to adequately rebut the conclusion of the Peer doctor.

Accordingly, Applicant's claim for reimbursement is granted.

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
	Opus Psychological Services, P.C.	10/02/15 - 10/09/15	\$1,019.52	Awarded: \$1,019.52
Total			\$1,019.52	Awarded: \$1,019.52

B. The insurer shall also compute and pay the applicant interest set forth below. 07/05/2017 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Since the motor vehicle accident occurred after April 5, 2002, interest shall be calculated at the rate of two percent per month, simple, calculated on a pro rata basis using a 30 day month. 11 NYCRR 65-3.9(a). In accordance with 11 NYCRR 65-3.9c, interest shall be paid on the claims totaling \$1,019.52 from the date the arbitration was commenced.

C. Attorney's Fees

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

Respondent shall pay Applicant an attorney's fee upon the amount awarded plus the interest, as calculated in section "B" above, and in accordance with 11 NYCRR 65-4.6(e), i.e., 20 percent of the amount of first party benefits, plus interest thereon. The minimum attorney's fee payable shall be in accordance with 11 NYCRR 65-4.6c. For cases filed after February 4, 2015, there is no minimum attorney's fee but there is a maximum fee of \$1,360.00. However, if the benefits and interest awarded thereon is equal to or less than the respondent's written offer during the conciliation process, then the attorney's fee shall be based upon the provisions of 11 NYCRR 65-4.6(b)."

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

10/02/2018
(Dated)

Evelina Miller

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:
ab4f5c44f5ccfb68257c89d9a653974d

Electronically Signed

Your name: Evelina Miller
Signed on: 10/02/2018