American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:		
Infinity Psychological Services, P.C. / **Applicant_ 1** (Applicant)	AAA Case No. AAA Assessment No. Applicant's File No.	412010005557 17 991 10526 10
- and -		
Liberty Mutual Fire Insurance Company (Respondent)	Insurer's Claim File No.	115434504

ARBITRATION AWARD

I, Glen A. Wiener, 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:Assignor

1. Hearing(s) held on
☒06/22/10
and declared closed by the arbitrator on 6/22/10.

Nadezhda Ursulova, Esq participated in person for the Applicant.
Herman Buchanan participated in person for the Respondent.

2. The amount claimed in the Arbitration Request, **$1,664.01**, was AMENDED and permitted by the arbitrator at the oral hearing. (Amendments, if any, set forth below).

Amended to $1,103.34. Applicant is only seeking reimbursement for the services noted below.

STIPULATIONS were not made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute

What must Respondent establish to properly deny a claim for lack of medical necessity?

Did Respondent's peer review establish the services/supplies provided were not medically necessary?

4. Findings, Conclusions, and Basis Therefor

The decision below is based on the documents on file in the Electronic Case Folder maintained by the American Arbitration Association as of the date of this hearing and on oral arguments of the parties. No witness testimony was produced at the hearing.

Assignor KWL was involved in an automobile accident on April 24, 2009. Applicant, Infinity Psychological Services, P.C., as assignee of KWL seeks $1,103.34 reimbursement, with interest and counsel fees, under the No-Fault Regulations, for psychological testing and psychotherapy provided to Assignor.

Respondent **Liberty Mutual Fire Insurance Company** insured the motor vehicle involved in the automobile accident. Under New York's Comprehensive Motor Vehicle Insurance Reparation Act (the "No-Fault Law"), New York Ins. Law §§ 5101 et seq., Respondent was obligated to reimburse the injured party (or its assignee) for all "reasonable and necessary expenses" and "medical expenses" arising from the use and operation of the insured vehicle. Respondent partially paid Applicant for the psychotherapy and denied Applicant's claim seeking reimbursement for the psychological testing based upon a peer review conduced by Andrew M. Elmore, Ph.D. who reviewed Assignor's records and opined the studies in question were not medically necessary.

THE PSYCHOTHERPY

Applicant seeks $76.88 additional reimbursement for psychotherapy performed on May 11, 2009. Respondent does not dispute the medical necessity of the claim. Respondent denied the claim alleging the CPT code indicated by Applicant on its proof of claim did not exist. Respondent is correct, CPT 90805 does not exist and Applicant incorrectly billed $114.58 for 20 minutes of psychotherapy under CPT 90805. The correct CPT code for 20 minutes of psychotherapy is 90804. Under CPT 90804 Applicant would be entitled to $76.88, the amount now requested by Applicant herein. Respondent should have re-coded the claim to reflect the proper code and reimbursed Applicant the correct amount. If there were any doubts as to what was being claimed. Respondent should have requested additional verification. Instead it elected to deny the claim outright due to this clerical error listing the wrong CPT code. This is not a sifficient basis for denying Applicant's otherwise valid claim. Accordingly, Applicant is awarded $76.88 reimbursement for the 20 minutes of psychotherapy performed on May 11, 2009.

THE PSYCHOLOGICAL TESTING

Applicant seeks another $1,026.46 reimbursement for the psychological testing conducted on assignor on May 13, 2009. Respondent denied the claim based upon the peer review performed by Dr. Elemore. In opining the testing was not medically necessary Dr. Elemore stated:

> *Available medical records contain no medical documentation of any significant head trauma. Available medical records contain no medical documentation of any significant, functionally disabling cognitive or emotional sequelea, and no recommendation or referral for psychological evaluation based upon specific medical examination findings of significant, functionally disabling cognitive or emotional sequelae casually related to the motor vehicle accident of 4/24/09.*

The above quoted statements, although not delineated as such, set forth a generally accepted medical practice for prescribing the psychological testing. The peer reviewer also properly integrates the facts of the case to demonstrate Applicant violated the standard. He even notes that certain "vague and clinically meaningless complaints are not specified as to the degree of significant, functional impairment, if any, they create for the claimant." "These 'complaints' are attributed to a checklist, the "Personal Injury Questionnaire. It is not a standard practice in the profession of Psychology to perform psychological evaluation, testing, or treatment based solely on checklist data."

The peer reviewer provided a sufficient factual basis and medical rationale for his opinion that the testing billed for was not medically necessary and therefore established prima facie the trsting billed for was not medically necessary. *See, Delta Diagnostic Radiology, PC v. Progressive Casualty Ins. Co.*, 21 Misc.3d 142A, 2008 Slip Op 52450(U), (App Term 2nd and 11th Jud. Dist. 2008); *Crossbridge Diagnostic Radiology, PC v. Progressive Casualty Ins. Co.*, 20 Misc.3d 143A, 2008 Slip Op 51761(U), (App Term 2nd and 11th Jud. Dist. 2008).

Applicant failed to introduce sufficient evidence refuting the peer reviewer's contentions. "Applicant did not meaningfully refer to, or discuss the determination of [Respondent's] doctors." *Pan Chiropractic P.C. v. Mercury Ins. Co.*, 2009 NY Slip Op 51495U, 24 Misc.3d 136A (App Term 2009). Applicant's request for reimbursement is therefore denied.

THE BURDEN OF PROOF

Applicant establishes "a prima facie showing of their entitlement to judgment as matter of law by submitting evidentiary proof that the prescribed statutory billing forms [setting forth the fact and the amount of the loss sustained] had been mailed and received 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 (2nd Dept. 2004).

Once Applicant has established a prima facie case the burden is on the insurer to prove that the medical treatment was not medically necessary. *See, Citywide Social Work & Psychological Services, PLLC a/a/o Gloria Zhune v. Allstate Ins. Co.*, 8 Misc.3d 1025A, 806 N.Y.S.2d 444 (App. Term 1st Dept. 2005); *.A.B. Medical Services, PLLC v. Geico Ins. Co.*, 2 Misc 3d 26, 773 N.Y.S.2d 773 (App Term 2nd & 11th Jud Dist 2003). If the insurer presents sufficient evidence establishing the lack of medical necessity, then the burden shifts to the Applicant to present its own evidence of medical necessity. *West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co.*, 13 Misc.3d 131(A), 824 N.Y.S.2d 759 (App Term 2nd & 11th Jud Dist. 2006).

Neither the Insurance Law nor the Regulations provide a definition of "medical necessity." Over the years, various trial courts have struggled with the definition of "medical necessity." *Sunrise Medical Imaging, P.C. a/a/o Patricia Downie v. Liberty Mutual Ins. Co.* 2001 NY Slip op. 40091U, 2001 N.Y. Misc. Lexis 725 (Dist. Ct. Nassau Co. 2001)(Serving a valid medical purpose.); *Fifth Ave. Pain Control Center a/a/o Gladys Quintero v. Allstate Ins. Co.*, 196 Misc. 2d 801, 766 N.Y.S.2d 748 (Civ. Ct. Queens Co. 2003)("To find treatment or services are not medically necessary, it must first be reasonably shown by medical evidence, inconsideration of the patient's condition, circumstances, and best interest of the patient, that the treatment or services would be ineffective or that the insurer's preferred health care treatment or lack of treatment would lead to an equally good result."); *Medical Expertise, P.C. a/a/o Irina*

Moukha v. Trumbull Insurance Company, 196 Misc. 2d 389, 765 N.Y.S2d 171 (Civ. Ct. Queens Co. 2003)(Based on the physician's objectively reasonable belief that it will further the patient's diagnosis and treatment and the use of the treatment, procedure, or service must be warranted by the circumstances and its medical value be verified by credible and reliable evidence."); *Behavioral Diagnostics a/a/o Maria Arevalo v. Allstate Ins*., 3 Mic3d 246, 246 N.Y.S.2d 178 (Civ. Ct. Kings Co. 2004)(Within the standard of care for accepted medical practice or the treating physician made a reasonable judgment the services would assist in formulating an accurate diagnosis and treatment plan.).

A review of the extensive case law reveals that most courts have evaluated medical necessity based on whether or not the services provided were in accord with the "generally accepted medical/professional practice." *Citywide Social Work & Psychological Services, PLLC a/a/o Tremayne Brow v. Travelers Indemnity Co.,* 3 Misc.3d 608, 777 N.Y.S.2d 241 (Civ. Ct. NY Co. 2004); *See, Expo Medical Supplies Inc. v. Clarendon Ins. Co.,* 12 Misc. 3d 1154A (Civ. Ct. Kings Co. 2006).; *American Chinese Acupuncture, PC v. State Farm Mut. Auto. Ins. Co.,* 18 Misc.3d 1125A, 859 N.Y.S.2d 892 (Civ. Ct. Richmond Co. 2008).

"Generally accepted practice is that range of practice that the professional will follow in the diagnosis and treatment of patients in light of the standards and values that define its calling." *Citywide Social Work & Psychological Services, PLLC a/a/o Tremayne Brow v. Travelers Indemnity Co.,* 3 Misc.3d at 616. This is the standard that will be applied herein.

Therefore, to prove that the services were not medically necessary experts must provide medical rationale for their opinion the services were not medically necessary. Using the definition set forth in *Citywide Social Work*, the "medical rationale" would be a departure from the "generally accepted medical practice" or standards.

> *"A peer review report's medical rationale is insufficient if it is unsupported by or controverted by evidence of medical standards. For example, the medical rationale may be insufficient if not supported by evidence of the generally accepted medical professional practice." Jacob Nir, M.D. a/a/o Josapphat Etienne v. Allstate Ins. Co., 7 Misc 3d 544, 796 N.Y.S.2d 857 (Civ. Ct. Kings Co. 2005).*

Once the generally accepted practice (the medical rationale) is articulated, the expert must apply the facts of the case and only then may she properly conclude the services in issue were not medically necessary due to the provider's violation of the generally accepted medical standards. *Healing Hands Chiropractic, P.C. a/a/o Cleeford Franklin v. Nationwide Assurance Company*, 5 Misc. 3d 975, 787 N.Y.S. 645, (Civ. Ct NY Co. 2004)("Lack of medical necessity must be supported by competent evidence such as an independent medical examination, peer review or other proof which sets forth a *factual basis and medical rational* for denying the claim.")(Emphasis added)

Significantly, "the opinion of the insurer's expert, standing alone, [that being devoid of any generally accepted medical practice] is insufficient to carry the insurer's burden of proving that the services were not medically necessary." *Citywide Social Work & Psychological Services, PLLC a/a/o Tremayne Brow v. Travelers Indemnity Co.,* 3 Misc.3d 608, 609 (Civ. Ct. Kings Co. 2004) "Without reference to the authority of generally accepted practice, the judge's conclusion would appear to be yet another professional medical judgment but one uninformed by

the standards and values of the profession." *Citywide Social Work & Psychological Services, PLLC a/a/o Tremayne Brow v. Travelers Indemnity Co.,* 3 Misc.3d at 616.

For example in *Citywide Social Work & Psychological Services, PLLC v. Allstate Ins. Co.*, 2008 NY Slip Op 51601U, 20 Misc.3d 1124A (Sup. Ct. Nassau Co. 2008), the expert peer reviewer testified "that the general accepted medical professional standard for conducting the initial interview is six (6) weeks post accident . . ." Thereafter the expert concluded the services were against the generally accepted medical professional standards because the initial interview was conducted only thirteen days post accident. The medical provider did not submit any evidence disputing this standard and hence the insurance carrier prevailed. Had the expert peer reviewer merely stated the services were unnecessary or premature without testifying as to the generally accepted medical standards, it is unlikely the insurer would have prevailed. *See also, Andrew Carothers, MD, PC, v. Geico*, 2008 NY Slip Op 50456U, 18 Misc.3d 1147A (Civ. Ct. Kings Co. 2008) (Expert/peer reviewer testified the MRI's performed one month after the accident were inconsistent with accepted medical standards and practice.); *Williamsbridge Radiology & Open Imaging v. Travelers Ins. Co.*, 14 Misc.3d 1231A, 836 N.Y.S.2d 496 (Civ. Ct. Kings Co 2007)("Defendant submitted no objective testimony or evidence to establish that his opinion is what is generally accepted in the medical profession."; *Vladimir Zlatnick, M.D., P.C. a/a/o Angela Reynolds v. Travelers Ins. Indemnity Co.*, 12 Misc. 3d 128A (App. Term 1st Dept. 2006)(The report relied on by the insurer was conclusory in nature and lacking a detailed basis and medical rationale for the denial of benefits and was clearly insufficient to sustain the insurer's evidentiary burden.)

CONCLUSION

For the reasons enunciated above, Respondent's denial dated July 10, 2009 is partially vacated and Applicant is awarded $76.88 for the 20 minutes of psychotherapy provided to Assignor on May 11, 2009. Respondent's denial dated July 14, 2009 is sustained and Applicant's request for $1,026.46 reimbursement for the psychological testing conducted on May 11, 2009 and explanation of results performed on May 12, 2009 is denied.

This award is in full disposition of all No-Fault benefit claims submitted to 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.

Accordingly, the applicant is AWARDED the following:

A.

Benefits	Amount Claimed	Amount Awarded
Health Service Benefits	1103.34	76.88

Totals:	$1,103.34	$76.88

B. The insurer shall also compute and pay the applicant interest as set forth below. (The filing date for this case was 02/04/2010, which is a relevant date only to the extent set forth below.)

Since the motor vehicle accident occurred after Apr. 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). If an applicant does not request arbitration or institute a lawsuit within 30 days after receipt of a denial of claim form or payment of benefits calculated pursuant to Insurance Department Reguslations, interest shall not accumulate on the disputed claim or element of claim until such action is taken. 11 NYCRR 65-3.9 (c).

In accordance with 11 NYCRR 65-3.9(c), interest shall be paid on the claim(s) totalling $76.88 from 2/4/10, 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.

In accordance with 11 NYCRR 65-4.6(e), the insurer shall pay Applicant an attorney's fee equal to 20% of the total amount awarded in this proceeding plus interest, with the minumun fee set at $60 and the maximun fee capped at $850.

Given that the within arbitration request was filed on or after Apr. 5, 2002, if the benefits and interest awarded thereon is equal to or less than 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 New York.

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

7/20/10
(Dated) (Glen A. Wiener)

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.