

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Gepp Psychological Services PLLC  
(Applicant)

- and -

American Family Connect Insurance Company  
f/k/a Ameriprise Insurance Company  
(Respondent)

AAA Case No. 17-21-1207-4344

Applicant's File No. AF21-121837

Insurer's Claim File No. 2899562C101

NAIC No. 12504

**ARBITRATION AWARD**

I, Eileen Casey, 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

1. Hearing(s) held on 03/24/2022  
Declared closed by the arbitrator on 03/24/2022

Joshua Mak, Esq. from Abrams Fensterman, LLP participated in person for the  
**Applicant**

Matthew Smith, Esq. from Callinan & Smith LLP participated in person for the  
**Respondent**

2. The amount claimed in the Arbitration Request, **\$2,490.50**, 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

The EIP (PD), a 58-year-old male, was the driver of a motor vehicle involved in an accident on December 26, 2020. The amount claimed is \$2,490.50 for psychiatric diagnostic evaluation, psychological testing, neurobehavioral status exam, and neuropsychological testing performed on March 25, 2021. Respondent denied Applicant's claims for psychological testing, neurobehavioral status exam, and neuropsychological testing based on a May 7, 2021 peer review by Dr. Michael Rosenfeld, psychologist. Respondent denied Applicant's claim for the psychiatric diagnostic evaluation based on the 120-day rule. Respondent also raised a fee schedule defense. The issues are whether Respondent established a defense of lack of medical

necessity based on the peer review and/or a defense based on the 45-day rule and/or a fee schedule defense.

#### 4. Findings, Conclusions, and Basis Therefor

This decision is based upon the oral arguments and a review of the documents contained in the ADR Center maintained by the American Arbitration Association. The amount claimed is \$2,490.50 for psychiatric diagnostic evaluation, psychological testing, neurobehavioral status exam, and neuropsychological testing performed on March 25, 2021.

The evidence demonstrates that the EIP (PD), a 58-year-old male, was the driver of a motor vehicle involved in an accident on December 26, 2020.

#### **The Peer Review (Lack of Medical Necessity) Defense**

Lack of medical necessity is a defense to an action to recover no-fault benefits, which an insurer may assert upon a timely denial, based either on a medical examination or a peer review report. *Rockaway Boulevard Medical P.C. v. Travelers Property Casualty Corp.*, 2003 N.Y. Slip Op. 50842(U), 2003 WL 21049583 (App. Term 2d & 11th Dists. Apr. 1, 2003).

Respondent denied Applicant's claims for psychological testing, neurobehavioral status exam, and neuropsychological testing based on a May 7, 2021 peer review by Dr. Michael Rosenfeld, psychologist.

In his report, Dr. Rosenfeld listed the records he reviewed and detailed the EIP's pertinent medical history. Dr. Rosenfeld said that, following the accident, the EIP was seen for psychological/neuropsychological examination and testing on 3/25/21 by Jessica Paulin, MSW and Karin Gepp, PsyD. The EIP reported that the vehicle had been struck at the left front side, he was seat-belted, and he experienced left shoulder pain upon impact. Dr. Rosenfeld said that no head trauma was noted. Dr. Rosenfeld added that current symptoms were noted to include only insomnia due to pain and the EIP reported no prior psychiatric/psychological history. Dr. Rosenfeld also noted that tests administered included mental status exam, BAI, BDI-II, BHS, PCL-5, psychological inflexibility scale and brief symptom inventory. Dr. Rosenfeld added that the psychological evaluation was performed leading to an impression that the EIP had diagnosis of pain disorder with psychological factors. The EIP was reported to be mainly suffering from emotional and behavioral outcomes of the accident which occurred on 12/26/20. Supportive psychotherapy through cognitive behavioral therapy and/or biofeedback was recommended.

Dr. Rosenfeld said that while the March 25, 2021 evaluation for a possible psychiatric disorder was necessary and appropriate, the psychological testing administered was not necessary under the circumstances of this case. Dr. Rosenfeld explained that the

standard of care is that the diagnostic interview alone is the main tool used by psychologists to determine a diagnosis and a treatment plan, which is why this procedure is referred to as a "diagnostic" interview. He added that psychological testing can be useful under certain circumstances to augment the initial interview, but this is typically only necessary when the case is complex and the testing administered will augment findings from the initial interview. Dr. Rosenfeld explained that the case under review was straightforward in that the EIP experienced an obvious precipitant (i.e. the motor vehicle accident) and developed psychological symptoms in response to the stressor. Dr. Rosenfeld said that, in this instance, the case would be considered straightforward and would not require additional psychological testing, particularly in this case where the tests consisted of the EIP completing symptom checklists. In other words, any information provided by these symptom checklists would have been information readily available to the psychologist during the clinical interview. He added that the use of this line of testing would not have altered the diagnosis or treatment plan.

Dr. Rosenfeld find that the neurobehavioral testing /neuropsychological testing was not necessary in this case. He said that this line of testing is indicated in the presence of cognitive sequelae related to a head injury. Dr. Rosenfeld added that the records indicate in this case that the EIP was involved in a traffic accident with no significant head injury, no LOC, or post traumatic amnesia.

When Respondent has timely raised and established lack medical necessity, the burden of proof then shifts to the Applicant to establish that the disputed services were reasonable and medically necessary. If the insurer medical examination or peer review is not rebutted, the insurer is entitled to denial of the claim. *A Khodadadi Radiology v. New York Central*, 16 Misc.3d 131(A), 841 N.Y.S.2d 824, 2007 N.Y. 51342(U), 2007 WL 1989432 (App. Term 2d & 11th Dists. 2007).

The 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, *Nir v. Allstate Ins. Co.* 7 Misc.3d 544 (N.Y. City Civ. Ct. 2005).

## **Rebuttal**

Applicant submitted a February 19, 2022 rebuttal from Dr. Karin Gepp, the EIP's treating psychologist. Dr. Gepp said that the EIP presented to him for psychological/neuropsychological evaluation on 03/25/2021. At that time, the EIP's physical examination revealed left shoulder pain and insomnia due to pain. He reported limitations for performing the following activities like physical straining, moderate activities, lifting or carrying groceries, bathing or dressing. The EIP administered test/results/interpretations were his suffering mainly from emotional and behavioral problems in addition to physical outcomes of the accident. The EIP was diagnosed with pain disorder with psychological factors and supportive psychotherapy through

cognitive behavioral therapy was recommended. Dr. Gepp said that neuropsychological assessment involves a series of tests in a controlled setting to help assess brain function in the areas of cognition, emotional health, and behavior. He detailed the purpose and benefits of neuropsychological assessment. Dr. Gepp stated that the EIP was involved in motor vehicle accident and presented with physical, emotional and behavioral impairments. The EIP had complaints of left shoulder pain and insomnia due to pain. He reported limitations for performing the following activities like physical straining, moderate activities, lifting or carrying groceries, bathing or dressing. Dr. Gepp noted that the patient administered test/results/interpretations were his suffering mainly from emotional and behavioral problems in addition to physical outcomes of the accident. Dr. Gepp said that these tests augmented the clinical interview and provided more substantive data on the EIP's psychological condition resulting from the motor vehicle accident, and assisted in the evaluation of his psychological and emotional status and in the prescription of the proper treatment for his condition. Dr. Gepp opined that, based upon his examination, the EIUP's psychological impairment and debilitating pain are causally related to the accident in question. Dr. Gepp added that, based upon the review of the aforementioned documents and in accordance with the generally accepted standards of care in the relevant medical community, the psychological testing performed by was medically necessary and well within a reasonable degree of medical certainty.

### **120-Day Rule**

Respondent denied Applicant's claim for the psychiatric diagnostic evaluation based on the 120-day rule.

It is accepted that once presented, a claim for health care benefits must be paid or denied within (30) thirty days of an insurer's receipt thereof. This period may be tolled by requesting additional verification, as provided by 11 NYCRR Section 65-3.8 (a) (1). The insurer must make the verification request within fifteen (15) business days from its receipt of the claim, pursuant to 11 NYCRR Section 65-3.5. If a response to the initial request for additional verification is not received by the carrier within thirty (30) days, then, within ten (10) calendar days after the thirty-day period, the carrier must make a second request. See, 11 NYCRR Section 65 3.6. An insurer is not obligated to pay or deny a claim until it has received all relevant information.

11 NYCRR 65-3.5 (o) provides that an applicant from whom verification is requested shall, within 120 calendar days from the date of the initial request for verification, submit all such verification under the applicant's control or possession or written proof providing reasonable justification for the failure to comply. 11 NYCRR 65-3.8 (b)(3), pertaining to claims for medical services rendered on or after April 1, 2013, provides in pertinent part that "an insurer may issue a denial if, more than 120 calendar days after the initial request for verification, the applicant has not submitted all such verification under the applicant's control or possession or written proof providing reasonable justification for the failure to comply, provided that the verification request so advised the applicant as required in section 65-3.5(o) of this Subpart.

The evidence established that Respondent received the bill in dispute on April 19, 2021. Respondent submitted documents titled "Explanation of Benefits" that it relies upon as requests for additional verification. Respondent sent the initial request for additional verification on May 17, 2021 and a follow-up request on June 18, 2021. The requests asked for IRS Form W9.

The requests contained the required language that Applicant's failure to comply with the verification request by providing all verification under Applicant's control or possession within 120 calendar days after the original request for verification or by providing written proof of reasonable justification for the failure to comply with the verification request may result in the subject claim being denied.

Respondent submitted an affidavit from Kathy Maloney, employed by Respondent as a litigation examiner. Ms. Maloney detailed Respondent's practices and procedures concerning mailing of verification requests and other documents. Ms. Maloney said that the bill was received on April 19, 2021 and verification requests were mailed on May 17, 2021 and June 18, 2021. Ms. Maloney also that no response to the verification demands was received.

There was no evidence of a response to the verification requests from Applicant.

Applicant's counsel argued that the requests for verification issued on documents titled "Explanation of Review" were confusing and improper. Respondent's counsel argued that the requests for verification were proper and clearly gave Applicant notice of the verification requested.

"Even when a claimant believes it need not comply with a verification request, the claimant still has a duty to communicate with the insurer regarding the request (see, *Dilon Medical Supply Corp. v. Travelers Insurance Co.*, 7 Misc 3d 927). It is well established that the purpose of the No Fault statute is to ensure prompt resolution of claims by accident victims. The parties' obligations are centered on good faith and common sense. Any questions concerning a communication should be addressed by further communication, not inaction. (see, *Dilon Medical Supply Corp. v. Travelers Insurance Co.*, supra). [¶] If a Plaintiff deems a Verification Request to be defective and or unreasonable, it is incumbent on that Plaintiff to convey that information to the Defendant and to state the reasons thereof, thereby giving the Defendant the opportunity to respond accordingly. The Defendant should not be put in a position to second guess the reason or reasons why the Plaintiff has failed to respond to the request." *Canarsie Chiropractic, P.C. v. State Farm Mutual Automobile Ins. Co.*, 27 Misc.3d 1228(A), 911 N.Y.S.2d 691 (Table), 2010 N.Y. Slip Op. 50950(U) at 2, 2010 WL 2105860 (Civ. Ct. Kings Co., Sylvia G. Ash, J., May 25, 2010).

### **Fee Schedule Defense**

Respondent also raised also raised a fee schedule defense.

11 NYCRR 65-3.8(g)(1), in effect as of April 1, 2013, provides that proof of the fact and amount of loss sustained pursuant to Insurance Law section 5106 (a) shall not be deemed supplied by an applicant to an insurer and no payment shall be due for such claimed medical services under any circumstances for those claimed medical service fees that exceed the charges permissible pursuant to Insurance Law sections 5108(a) and (b) and the regulations promulgated thereunder for services rendered by medical providers.

Respondent has the burden of coming forward with competent evidentiary proof to support its fee schedule defenses. See, *Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co.*, 2006 NY Slip 26240, 13 Misc.3d 172, 822 N.Y.S.2d 378, 2006 N.Y. Misc. LEXIS 1519 (Civil Ct, Kings Co. 2006).

If Respondent fails to demonstrate by competent evidentiary proof that a plaintiff's claims were in excess of the appropriate fee schedules, defendant's defense of noncompliance with the appropriate fee schedules cannot be sustained. See, *Continental Medical PC v. Travelers Indemnity Co.*, 11 Misc.3d 145A, 819 N.Y.S.2d 847, 2006 NY Slip Op 50841U, 2006 N.Y. Misc. LEXIS 1109 (App. Term, 1st Dep't, per curium, 2006).

Judicial notice may be taken of the Workers' Compensation Medical Fee Schedule. *Natural Acupuncture Health, P.C. v. Praetorian Ins. Co.*, 30 Misc.3d 132(A), 958 N.Y.S.2d 647 (Table), 2011 N.Y. Slip Op. 50040(U), 2011 WL 135241 (App. Term 1st Dept. Jan. 14, 2011).

Applicant billed \$2,490.50 (\$305.73 under CPT code 90791-1B for psychiatric diagnostic evaluation; \$1,160.48 under CPT code 96101-1B for psychological testing; \$324.07 under CPT code 96116-1B for neurobehavioral status exam; and \$700.22 under CPT code 96118-1B for neuropsychological testing).

Respondent's counsel argued that the proper reimbursement should be \$1,992.40. Respondent's counsel argued that since the testing was performed by a social worker reimbursement should be reduced by 20% based on Ground Rule 12, Behavioral Health Provider Enhanced Reimbursement. Applicant's counsel argued that a 20% reduction is not appropriate as the evidence show that Dr. Gepp, a licensed psychologist supervised the evaluations and testing.

## **Findings**

Based on the foregoing, as to Applicant's claims for psychological testing, neurobehavioral status exam, and neuropsychological testing, I am faced with conflicting medical opinions. Weighing the evidence, I am persuaded by the peer review of Dr. Rosenfeld and find that he established an adequate factual basis and medical rationale to support his opinion that the exam and testing in dispute failed to conform to generally accepted medical standards and was not medically necessary. I did not find the rebuttal to be convincing. Dr. Gepp noted that the EIP had complaints of left shoulder

pain and insomnia due to pain. Dr. Gepp did not adequately address the issues raised in the peer review and failed to demonstrate that the EIP's clinical findings and complaints justified the psychological testing, neurobehavioral status exam, and neuropsychological testing. Therefore, the denial based on the peer review is sustained.

As to Applicant's claim for the psychiatric diagnostic evaluation, I find that Respondent's requests for verification were proper and clearly apprised Applicant of the verification requested. There is no prescribed form for a request for verification. I also find that Respondent established timely mailing of the verification requests to Applicant. There was no evidence submitted to show that Applicant responded to the requests. Therefore, the denial based on the 120-day rule is sustained.

Accordingly, Applicant's claim is denied in its entirety.

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 claim is DENIED in its entirety

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

04/23/2022  
(Dated)

Eileen Casey

### **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**

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### **Electronically Signed**

Your name: Eileen Casey  
Signed on: 04/23/2022