

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Complete Neuropsychology PC
(Applicant)

- and -

Maya Assurance Company
(Respondent)

AAA Case No. 17-20-1188-3970

Applicant's File No. DK20-111442

Insurer's Claim File No. 200750-03

NAIC No. 36030

ARBITRATION AWARD

I, Bryan Hiller, 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 07/05/2022
Declared closed by the arbitrator on 07/05/2022

Evan Polansky, Esq. from Korsunskiy Legal Group P.C. participated in person for the Applicant

Bryan Visnius, Esq. from De Martini & Yi, LLP participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$1,390.43**, 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 is entitled to reimbursement for the fees associated with psychological testing performed on Assignor on July 30, 2020 connection with injuries sustained in a motor vehicle accident on July 24, 2020 in light of the Respondent's Peer Review performed by Dr. Michael Rosenfeld on September 9, 2020 stating that the service were not medically necessary?

4. Findings, Conclusions, and Basis Therefor

Applicant seeks reimbursement, along with interest and counsel fees, under the No-Fault Regulations, for the costs associated with psychological testing performed on July 30, 2020 in connection with injuries sustained by Assignor in a motor vehicle accident on July 24, 2020. The service was denied following a review of the medical records and a Peer Review report by Dr. Michael Rosenfeld on September 9, 2020 at Respondent's behest after which payment for treatment was denied as not medically necessary. The denial was timely. This decision is based upon the written submissions of counsel for the respective parties as well as oral argument at the hearing conducted on July 5, 2022. I have reviewed the documents contained in the Record as of the date of the hearing. At the hearing, Respondent's representative stated that it was not pursuing a fee schedule issue, so I deem that defense abandoned.

Assignor, a then 38 year old male back seat passenger, was involved in an automobile accident on July 24, 2020. Following the accident, Assignor was taken via ambulance to the local emergency room where she was evaluated, treated and released. Due to a persistence of symptomology, Assignor came under the care of multiple conservative care provider including Applicant Complete Neuropsychology P.C. At the initial examination with Dr. Sara Malagold on July 30, 2020, Assignor's complaints referable to the accident included physical, cognitive, emotional and behavior impairments. Following the evaluation, Dr. Malagold diagnosed anxiety disorder, post-traumatic stress, cognitive disorder and depressive disorder and started the Assignor on a course of care including neuropsychological evaluation, psychotherapy at least once a week and cognitive remediation. The psychological testing on July 30, 2020 at Applicant Complete Neuropsychology PC's facility is at issue in this matter and the notes related to that treatment are attached to the Record.

When an insurer relies upon a peer review report to demonstrate that a particular service was not medically necessary, the peer reviewer's opinion must be supported by sufficient factual evidence or proof and cannot simply be conclusory. As per the holding in Jacob Nir, M.D. v. Allstate Insurance Co., 7 Misc.3d 544 (2005) ("Nir"), the peer reviewer must establish a factual basis and medical rationale to support a finding that the services were not medically necessary, including setting forth generally accepted standards in the medical community. The opinion of the insurer's expert, standing alone, is insufficient to carry the insurer's burden to prove that the services were not medically necessary (see CityWide Social Work & Psychological Services, PLLC v Travelers Indemnity Co., 3 Misc.3d 608, 777 N.Y.S.2d 241 (N.Y. Civ Ct. Kings Co. 2004)).

The claim was submitted to the Respondent and was timely denied based upon a Peer Review of Dr. Michael Rosenfeld dated September 9, 2020. The peer reviewer did review the available medical records and outlined the history of the accident as well as the treatment of the Assignor. Following the review of the records, the Peer Review report was completed by Dr. Rosenfeld and the claim for the treatment was denied as not medically necessary. Dr. Rosenfeld argued that while the initial interview was indeed necessary and reasonable, the testing was not as the main tool for psychological diagnosis and treatment is a comprehensive diagnostic interview. Dr. Rosenfeld argued that while testing can be useful under certain clinical circumstances, the case under

review was straightforward with an obvious relationship between the psychological symptoms and the stressor of a motor vehicle accident. Dr. Rosenfeld concluded that the treatment would thus be duplicative and superfluous and medically unnecessary.

When an insurer relies upon a peer review report to demonstrate that a particular service was not medically necessary, the peer reviewer's opinion must be supported by sufficient factual evidence or proof and cannot simply be conclusory. As per the holding in Jacob Nir, M.D. v. Allstate Insurance Co., 7 Misc.3d 544 (2005) ("Nir"), the peer reviewer must establish a factual basis and medical rationale to support a finding that the services were not medically necessary, including setting forth generally accepted standards in the medical community. The opinion of the insurer's expert, standing alone, is insufficient to carry the insurer's burden to prove that the services were not medically necessary (see CityWide Social Work & Psychological Services, PLLC v Travelers Indemnity Co., 3 Misc.3d 608, 777 N.Y.S.2d 241 (N.Y. Civ Ct. Kings Co. 2004)).

Applicant's counsel submitted a rebuttal by treating physician Dr. Sara Malagold dated May 30, 2022. Dr. Malagold argued that the testing was necessary to determine the full extent of the problem and their impact on the individual to establish an appropriate treatment plan as some issues could not be elucidated through a diagnostic interview alone. The testing allows for the patient to more fully perceive and articulate their specific anxieties and fears regarding their physical symptoms, sleep difficulties and anxiety. Dr. Malagold explained how this was not a straight or standard case and the Assignor was dealing with a lot of cognitive issues that Dr. Rosenfeld was not acknowledging or diminishing. Lastly, Dr. Malagold noted that an interview alone cannot yield quantitative measures to help assess a treatment program and quantitative psychometric measures allow for more precise determinations on how the current discomforts are related to the accident and how much change the treatment is allowing for. As such, Dr. Malagold concluded that the psychological testing was medically necessary for this patient.

Comparing the relevant evidence presented by both parties against each other and the above referenced medical necessity standard, I find the Applicant is entitled to reimbursement for the treatment provided to the Assignor. I find the rebuttal testimony sufficient to meet the Applicant's burden in establishing the medical necessity of the treatment after the Respondent's peer review shifted the burden. The rebuttal by Dr. Malagold meaningfully referred to and rebutted the conclusions set forth in the peer review report (see High Quality Medical, P.C. v. Mercury Ins. Co., 26 Misc.3d 145(A), 2010 N.Y. Slip.Op. 50447(U)(Sup. Ct. App. Term 2nd Dept 2010)). Specifically, in this matter, Dr. Malagold thoroughly addresses each complaint made in the peer review and refers to the medical literature and specific examination findings with respect to this Assignor that made it necessary. Dr. Malagold elucidated the specifics with this Assignor that would have made it difficult to just use a diagnostic interview to determine the issues at hand. As such, Applicant's claims for treatment on July 30, 2020 are granted in full in the amount of \$1,390.43.

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
	Complete Neuropsychology PC	07/30/20 - 07/30/20	\$1,390.43	Awarded: \$1,390.43
Total			\$1,390.43	Awarded: \$1,390.43

- B. The insurer shall also compute and pay the applicant interest set forth below. 12/28/2020 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Applicant is awarded interest pursuant to the no-fault regulations. See generally, 11 NYCRR §65-3.9. Interest shall be calculated "at a rate of two percent per month, calculated on a pro rata basis using a 30 day month." 11 NYCRR §65-3.9(a). A claim becomes overdue when it is not paid within 30 days after a proper demand is made for its payment. However, the regulations toll the accrual of interest when an applicant "does not request arbitration or institute a lawsuit within 30 days after the receipt of a denial of claim form or payment of benefits calculated pursuant to Insurance Department regulations." See, 11 NYCRR 65-3.9(c). The Superintendent and the New York Court of Appeals has interpreted this provision to apply regardless of whether the

particular denial at issue was timely. LMK Psychological Servs., P.C. v. State Farm Mut. Auto. Ins. Co., 12 N.Y.3d 217 (2009).

C. Attorney's Fees

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

After calculating the sum total of the first-party benefits awarded in this arbitration plus the interest thereon, Respondent shall pay Applicant an attorney's fee equal to 20% of that sum total, subject to no minimum and a maximum of \$1360.00. However, if the benefits and interest awarded thereon is equal to or less than the Respondent's written offer during the conciliation process, 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, Bryan Hiller, do hereby affirm upon my oath as arbitrator that I am the individual described in and who executed this instrument, which is my award.

07/05/2022
(Dated)

Bryan Hiller

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:
5dd427fbc4337a29948f3afd2bd65f59

Electronically Signed

Your name: Bryan Hiller
Signed on: 07/05/2022