American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Psychology 21, PC (Applicant)	AAA Case No.	17-23-1306-2238
	Applicant's File No.	DK23-362024
- and -	Insurer's Claim File No.	9XINY03178-03
	NAIC No.	29742
Integon National Insurance Company (Respondent)		

ARBITRATION AWARD

I, Robyn McAllister, 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 12/03/2024
   Declared closed by the arbitrator on 12/03/2024

   Jennifer Raheb, Esq. from Korsunskiy Legal Group, P.C. participated virtually for the Applicant

   Maureen Knodel, Esq. from Law Offices of Eric Fendt participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$2,235.74**, 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 Respondent properly partially denied Applicant's claim for performing diagnostic interview and psychological testing for Assignor (ML), a 41 year-old male passenger, in connection with treatment of injuries sustained in a motor vehicle accident on March 22, 2023, based on a peer review by Michael Rosenfeld, Psy.D., and the Workers' Compensation Fee Schedule.

4. Findings, Conclusions, and Basis Therefor

Applicant sought reimbursement in the amount of $2235.74 for the balance owed for performing diagnostic interview and psychological testing on March 28, 2023 for Assignor (ML), a 41 year-old male passenger, in connection with treatment of injuries sustained in a motor vehicle accident on March 22, 2023. Respondent timely and partially denied Applicant's claim based on a peer review dated May 25, 2023 by Michael Rosenfeld, Psy.D., and the Workers' Compensation Fee Schedule.

This decision is based on the oral arguments of counsel or other representative at the hearing and the documents submitted. I have reviewed the documents contained in the ADR Center as of the date of this award. Applicant established its prima facie case since Respondent's denial acknowledged receipt of Applicant's bill. *See Viviane Etienne Medical Care, P.C. v. Country-Wide Ins. Co.,* 25 N.Y.3d 498 (2015); *AR Medical Rehabilitation v State-Wide Insurance Company*, 49 Misc.3d 919 (Civil Ct., Kings Co. 2015).

At the hearing, Respondent argued that it properly partially denied Applicant's claim based on the Fee Schedule. I agree. It was Respondent's burden to establish a prima facie showing that the bill was incorrect, *see Cornell Medical P.C. v. Mercury Casualty Co.,* 24 Misc.3d 58 (App. Term 2d, 11th & 13th Dists. 2009), and I find that Respondent satisfied its burden.

Applicant billed $305.74 under CPT code 90791 and attached modifier 1B. Respondent paid Applicant $254.78 and denied the remainder of the claim based on the peer review by Dr. Rosenfeld. Respondent asserted that modifier 1B was improperly applied to Applicant's bill.

The same issue was previously addressed by Arbitrator Cifarelli in *Psychology 21, PC v. Integon National Insurance Company*, 17-23-1306-2764. In that case, the Arbitrator stated as follows:

Applicant billed $305.74 for code 90791. Respondent issued partial payment in the amount of $254.78. To support its reduction, Respondent relied on an affidavit by Stephanie Brown, CPC. Ms. Brown concluded that Respondent issued reimbursement in excess of the allowable fee schedule, applying a 20% reduction as the service was performed by a Social Worker pursuant to the Behavioral Health Fee Schedule Ground Rules.

Code 90791 has a relative value of 25.84.

- 25.84 x $9.86 conversion factor = $254.78

Applicant billed using Modifier 1B.

Modifier 1B "Provides a 20 percent reimbursement increase for E/M and Medicine services when rendered by providers with the following WCB assigned provider rating codes: PN-P (Psychiatry), PN-ADP (Addiction Psychiatry), PN-PM (Pain Management) and PSY (Psychology).

The plain reading of the fee schedule as well as 11 NYCRR 68.1(b) provides "The charges for services specified in Insurance Law section 5102(a)(1) and any further health service charges that are incurred as a result of the injury and that are in excess of basic economic loss, shall not exceed the charges permissible under the schedules prepared and established by the chair of the Workers' Compensation Board for industrial accidents that are in effect for purposes of no-fault at the time the charges are incurred. However, references to workers' compensation reporting and procedural requirements in such schedules do not apply to no-fault, e.g., requirements that provide for authorization to perform surgical procedures. The general instructions and ground rules in the workers' compensation fee schedules apply, but those rules that refer to workers' compensation claim forms, pre-authorization approval, time limitations within which health services must be performed, enhanced reimbursement for providers of certain designated services, durable medical equipment being provided by a New York State Medicaid-enrolled supplier, and dispute resolution guidelines do not apply, unless specified in this Part."

This regulation specifically provides that No Fault claims are not subject to rules regarding "enhanced reimbursement for providers of certain designated services."

Based on the above, I find that the plain reading of the regulations is sufficient to establish that Applicant is not entitled to reimbursement with Modifier 1B.

Likewise, in the instant case, for the reasons noted above, I am persuaded by Arbitrator Cifarelli's analysis and adopt it herein. Therefore, I find that Respondent properly partially denied Applicant's claim for the diagnostic interview and Applicant is not entitled to any additional reimbursement.

Respondent further argued that it properly denied Applicant's the remainder of Applicant's claim since the psychological testing was not medically necessary. I agree. I was persuaded by the peer review report by Dr. Rosenfeld, submitted by Respondent in support of its denial.

In order to support a defense of lack of medical necessity, the respondent must "set forth a factual basis and medical rationale for the peer reviewer'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 2nd, 11th and 13th Dist. 2014). It is the respondent's burden to demonstrate lack of medical necessity, which, if established, shifts the burden of persuasion to the applicant. *See Bronx Expert Radiology, P.C. v. Travelers Ins. Co.*, 2006 NY Slip Op 52116 (App. Term 1st Dept. 2006); *A. Khodadadi Radiology, P.C. v. NY Central Mutual Fire Ins. Co.,* 16 Misc.3d 131 (A), 2007 N.Y. Slip Op. 51342(U) (App. Term 2d & 11th Dist. 2007).

Furthermore, a respondent's peer review must set forth more than just a conclusory or basic recitation of the expert's opinion. It is well-settled that a peer review is deficient when it fails to set forth the generally accepted medical practice and how the provider deviated from those standards. *See Elmont Open MRI & Diagnostic Radiology, P.C. v. Progressive Casualty Ins. Co.,* 23 Misc.3d 1110(A)(Dist. Ct. Nassau Co. 2009)*; Nir v. Allstate,* 7 Misc.3d 544 (Civ. Ct. Kings Co. 2005).

Dr. Rosenfeld noted that Assignor "was the unrestrained right back seat passenger of a car that was impacted by another vehicle. There is no head trauma or loss of consciousness noted. Emergency services were called, but did not show up. He went home and took ibuprofen for pain. Subsequently, on March 28, 2023, [Assignor] was evaluated by Psychology 21, P.C. He reported experiencing symptoms, including pain, increased fatigue, paresis, increased rigidity, insomnia, change in weight/appetite, anger/outbursts, paranoia, anxiety, irritability, isolation, withdrawal, easy agitation, mood swings, worries and change in attention/concentration. Testing administered included BDI-II, BHS, BAI, SBT, PTSD, PDI, HSQ, PIS and BSI. [Assignor] is diagnosed with cognitive disorder and acute stress disorder. A neuropsychological evaluation, psychotherapy and cognitive remediation are recommended."

Dr. Rosenfeld opined as follows:

The diagnostic interview was necessary and appropriate to evaluate the claimant for any possible psychiatric disorder due the accident. However, I find that the psychological testing was not necessary under the circumstances of this case. That is, 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. It should be noted that the diagnostic interview is an untimed procedure, is comprehensive in nature, and includes gathering of clinical and background infom1ation, such as the presenting complaints, social, medical, and psychiatric history, as well mental status information. Furthermore, while psychological testing can be useful under certain clinical circumstances to augment the initial interview, this is typically only necessary when the case is complex, and the testing administered will augment findings from the initial interview. However, the case under

review was straightforward in that the claimant experienced an obvious precipitant (i.e., the motor vehicle accident) and developed psychological symptoms in response to the stressor. Thus, 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 claimant completing pre-formatted symptom checklists. In other words, any information provided by these symptom checklists would have been readily available to the psychologist during the face-to-face clinical interview. Thus, the use of this line of testing would not have altered the diagnosis or treatment plan.

Dr Rosenfeld stated that "In this case, a psychological diagnosis 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. 1n other words, in this case, the diagnostic interview, if conducted in accordance with current psychological standards of practice, would have been sufficient to establish the diagnosis and treatment plan (if a genuine psychiatric diagnosis was in fact present). Therefore, the use of these checklists provided redundant information because any information obtained from these checklists would have been information readily available to the psychologist from the face-to-face interview."

He added that "I also find that the neuropsychological testing/neurobehavioral status examination were not medically necessary. In this case, the records indicate that the claimant was involved in a traffic accident with no severe head trauma or loss of consciousness." He set forth the DSM-V criteria for testing and asserted that Assignor failed to meet the criteria.

Dr. Rosenfeld concluded that "even if the neuropsychological evaluation had been indicated, the psychologist administered the evaluation prematurely. According to leading experts in neuropsychological assessment: " ... neuropsychological assessment of head-injured patients should be deferred until after the post-acute stage o injury. The dynamic nature of symptoms over the days and weeks immediately following injury makes assessment during this time invalid for most purposes ... A 6-week waiting period is usually adequate ... " (p. 255)… In this case, the testing was administered only six days after the MVA, which is premature. That is, in the immediate days and weeks following such an injury monitoring by a physician or a neurologist is all that would be necessary at that point in time. If the symptoms persisted beyond 6 to 8 weeks, then testing may have been necessary at that point in time."

I find that Dr. Rosenfeld's peer review was sufficient to support Respondent's defense of lack of medical necessity. Thus, the burden shifted to Applicant to rebut Dr. Rosenfeld's assertions. *See A. Khodadadi Radiology, P.C. v. NY Central Mutual Fire Ins. Co., supra*.

In support of its claim, Applicant submitted the documents contained in the ADR Center including the testing report and rebuttal to the peer review dated October 16, 2024 by

Dana Savidge, Psy.D. I was not persuaded by the medical evidence that the psychological testing was warranted.

Dr. Savidge stated that "I disagree with Dr. Rosenfeld's conclusion since the type of test performed on this patient, together with the face-to-face evaluation and mental status exam provides a more accurate picture of the patient's overall psychological condition, which in tum, enables the treating psychologist to properly treat the patient and help him cope with his emotions, thoughts, concerns and fears."

She argued that "The patient presented for a psychological examination with complaints of angry/outbursts, paranoid ideation, anxiety, irritability, isolation/withdrawal, easy agitation, mood swings, and worried. His cognitive symptoms were change in attention/concentration and concrete thinking. He reported that he has nervousness or shakiness inside, feels easily annoyed or irritated, and feels afraid in open spaces or on the streets, he is suddenly scared for no reason, has temper outbursts that he could not control, feels no interest in things, and feels that he is being watched or talked about by others, he reports he has trouble falling asleep and gets into frequent arguments. Impressions: Patient is suffering from emotional, cognitive problems besides any other physical outcomes. Diagnosis: cognitive disorder, not otherwise specified and acute stress disorder. Based on these findings, the patient was recommended a full psychological evaluation."

Dr. Savidge added that "It must also be noted that a diagnostic interview examination does not (and cannot) yield quantitative measures to help assess progress through treatment; only psychological testing can provide such measures."

She further argued that "The testing administered was in accordance with the standards of the ODG-Official Disability Guidelines publication "'ODG Integrated/Disability Duration Guideline," published 2008 by Work Loss Data, Inc., which recommends that "psychological tests can be used as an important adjunct to the diagnostic process, specifically for the purpose of introducing an objective element to a process that is otherwise completely subjective."

Dr. Savidge added that "Individuals who experience a motor vehicle accident (MVA) are at increased risk for psychological problems, particularly Posttraumatic Stress Disorder (PTSD)... MVAs can have serious psychological consequences."

She further asserted that "Under New York State No-Fault regulations, a patient may be referred for psychological testing due to concerns about mood and behavior following the motor vehicle accident, and medical necessity of such psychological service is based upon the patient's own complaints as verified in the psychological report itself, as well as in supporting documents."

After careful consideration of the arguments presented, I was not persuaded that this case was complicated and warranted further immediate psychological or neurobehavioral testing to make a diagnosis or treatment plan. I note that the testing was performed six days after the accident. Furthermore, Dr. Savidge performed the same exact testing for all of the three individuals involved in the accident, which detracted from her arguments. I find that Dr. Rosenfeld's opinion was more credible. Therefore, I find that Respondent properly denied that portion of Applicant's claim.

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 NY
SS :
County of Westchester

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

12/08/2024
(Dated)

Robyn McAllister

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
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Electronically Signed

Your name: Robyn McAllister
Signed on: 12/08/2024