

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Psychology 21, PC
(Applicant)

- and -

Integon National Insurance Company
(Respondent)

AAA Case No. 17-23-1330-2022

Applicant's File No. DK23-432832

Insurer's Claim File No. 9XINY07455

NAIC No. 29742

ARBITRATION AWARD

I, Anne Malone, 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 04/28/2025
Declared closed by the arbitrator on 04/28/2025

Jennifer Rabeb, 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, **\$4,471.48**, was AMENDED and permitted by the arbitrator at the oral hearing.

The amount claimed is amended by the applicant to \$1,693.42 to conform to the appropriate fee schedule.

Stipulations WERE NOT made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute

This claim involves two different EIP's with the same name. One is a 48 year old male and the other is his 12 year old son. Both reported involvement in a motor

vehicle accident on July 23, 2023; claimed related injury and underwent psychological evaluation and testing provided by the applicant on August 23, 2023.

The applicant submitted a claim for these psychological services. The respondent made partial payment of the charges for the initial diagnostic evaluations for each of the EIPs pursuant to its calculation of the correct reimbursable amount for these services pursuant to the New York Workers' Compensation Medical Fee Schedule.

Payment of the remainder of the charges for each of the EIPs were timely denied by the respondent based upon peer reviews for both EIPs by Michael Rosenfeld, PSY.D. dated October 16, 2023. In response, the applicant submitted a rebuttal dated March 15, 2025 related to the 12 year old EIP. The submissions did not contain a rebuttal for the 48 year old EIP.

The respondent also asserted a fee schedule defense.

The issues to be determined at the hearing are:

Whether the respondent established that the psychological services at issue were not medically necessary for each of the EIPs.

Whether the respondent established its fee schedule defense.

4. Findings, Conclusions, and Basis Therefor

This hearing was held on Zoom and the decision is based upon the documents reviewed from the Modria File as well as the arguments made by counsel and/or representative at the arbitration hearing. Only the arguments presented at the hearing are preserved in this decision; all other arguments not presented at the hearing are considered waived.

Medical Necessity

To support a lack of medical necessity defense respondent must "set forth a factual basis and medical rationale for the peer reviewer's [or examining physician's] determination that there was a lack of medical necessity for the services rendered." Provvedere, Inc. v. Republic Western Ins. Co., 2014 NY Slip Op 50219(U) (App. Term2d, 11th and 13th Jud. Dists. 2014.)

The Civil Courts have held that a defendant's peer review or report of medical examination must set forth more than just a basic recitation of the expert's opinion. The trial courts have held that a peer review or medical examination 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 specifics as to the claim at issue, is conclusory or vague. See Nir v. Allstate, 7 Misc.3d 544 (N.Y. City Civ. Ct. 2005.)

12 and 48 year old EIPs

To support its contention that the psychological services provided by the applicant were not medically necessary for either the 12 or the 48 year old EIPs, respondent relies upon the peer reviews by Dr. Rosenfeld, who reviewed the medical records of the EIPs, noted the injuries claimed and psychological issues contained in the psychological evaluation of each of the EIPs and the treatment rendered to them. Dr. Rosenfeld considered possible arguments and justification of the need for the psychological services at issue and determined that they were not warranted under the circumstances presented.

Dr. Rosenfeld submitted comprehensive reports in which he discussed the psychological services provided to each EIP and his reasons for determining that they were not medically necessary for each of them.

It was his opinion that the initial diagnostic interviews were necessary and appropriate to evaluate each of the EIPs and to investigate any possible psychiatric disorder related to the subject accident. However, he determined that in this instance, neither of the EIPs required additional psychological testing since they each completed a symptom checklist which provided all of the information necessary, including history and background necessary for the face to face clinical interview.

Dr. Rosenfeld opined that the further testing would not have altered the diagnoses or treatment plans. He also noted that the 12 year old EIP did not sustain any head injury and the although the records he reviewed indicated that the 48 year old EIP may have sustained a mild head injury, the testing was provided too soon after the accident.

Dr. Rosenfeld supported, with relevant medical literature, his opinion that the psychological services provided to each of the EIPs were not medically necessary at the time they were provided.

Respondent has met its evidentiary burden. The peer review adequately sets forth the factual basis and medical rationale to support the conclusion that the psychological services, other than the diagnostic interview were not indicated for either of the EIPs at the time they were provided. Therefore, pursuant to Bronx Expert Radiology, *supra* the burden shifts to the applicant, which bears the ultimate burden of persuasion to establish that the services at issue were medically necessary.

In response to the peer reviews by Dr. Rosenfeld for both EIPs, the applicant submitted a rebuttal by Dana Savage, Psy.D. related to only the 12 year old EIP.

He disagreed with Dr. Rosenfeld's conclusion that in general psychological testing is necessary to properly treat a patient under these circumstances.

12 year old EIP

Dr. Savage discussed the information provided by this EIP and determined that he was suffering mainly from cognitive problems which required a full psychological evaluation.

He discussed in detail the general benefits and uses of the testing at issue.

Dr. Savage concluded that the psychological treatment was medically necessary for this EIP to reduce the negative impact of the MVA on many aspects of his life.

He cited the ODG guidelines which states the psychological tests can be used in the diagnostic process to provide an objective element to a subjective process. He also cited an article which discussed the treatment of PTSD related to motor vehicle accident and that treatment can be a clinically rewarding experience.

In addition, Dr. Savage noted that New York State no fault regulations allow for referral for psychological testing and that the medical necessity is based on a patient's complaints in the psychological report.

In this instance, the rebuttal meaningfully refers to and rebuts the findings of Dr. Rosenfeld and the psychological reports submitted are sufficient to establish medical necessity for the services at issue for the 12 year old EIP.

A review of the applicant's submissions reveals that it has met the burden of persuasion in rebuttal for the 12 year old EIP. The report of Monica Hartman, LMSW, the treating social worker signed off by Dr. Savage and rebuttal by Dr. Savage submitted in opposition to the findings of Dr. Rosenfeld are sufficient to overcome the burden of production established by the respondent.

Based on the foregoing, I find that the respondent has failed to establish that the psychological services at issue provided to the 12 year old EIP were not medically necessary.

Therefore, an award will be issued in favor of the applicant for the services rendered to the 12 year old EIP pursuant to the appropriate fee schedule.

48 year old EIP

The submissions did not include a rebuttal to the peer review by Dr. Rosenfeld for the 48 year old EIP. However, the applicant relies upon the submissions which include a comprehensive evaluation of this EIP based on the psychological evaluation and testing provided to him.

This report presented a history of the subject accident and the injuries and physical complaints the 48 year old EIP presented to Monica Hartman, LMSW who performed a psychological evaluation and testing of him. The report includes a mental status examination and the results and interpretations of the tests performed.

The report includes the impression by Monica Hartman, LMSW that this EIP was suffering from emotional, behavioral and cognitive problems and that these disorders are causally related to the subject accident.

A review of the applicant's submissions reveals that it has failed to meet the burden of persuasion in rebuttal. The medical records submitted in opposition to the findings of Monica Hartman, LMSW are insufficient to overcome the burden of production established by the respondent.

The applicant did not provide a rebuttal to the peer review. Therefore, it did not respond to the respondent's argument that the psychological testing provided to the EIP was not necessary for this particular EIP at the time it was provided.

Based on the foregoing, I find that the respondent has established that the psychological services at issue were not medically necessary for the 48 year old EIP at the time they were provided.

Therefore, the claim for psychological testing at issue for the 48 year old EIP is dismissed with prejudice.

Fee Schedule

The applicant billed a total of \$4,981.04 (\$2,490.52 each for 2 EIPs) for the psychological services at issue, for which the respondent made partial of \$509.56 (\$254.78 each for 2 EIPs) leaving a total amount in dispute of \$4,471.48. At the hearing, the respondent amended the amount in dispute to \$1,693.42. This includes the charges for the diagnostic evaluation for which the respondent had already made partial payment.

Based on the foregoing, the total amount in dispute is (\$1,285.78 (\$642.89 for each EIP)

The respondent denied payment of the claims for each of the EIPs based on a lack of medical necessity. I have already determined that the respondent did not establish this defense for the 12 year old EIP. I have also determined that the respondent established this defense for the 48 year old EIP.

The respondent asserted a fee schedule defense for both claims and a determination must be made regarding the claim for the 12 year old EIP.

The respondent made partial payments of \$254.78 for the initial diagnostic evaluation for each of the EIPs, which were acknowledged in the AR-1. Therefore, the total amount in dispute for the 12 year old EIP is \$2,235.74.

To prevail in a fee schedule defense, the respondent must demonstrate by competent evidentiary proof that applicant's claims were in excess of the appropriate fee schedules, or otherwise respondent's defense of noncompliance with the appropriate fee schedule cannot be sustained. Continental Medical, P.C. v. Travelers Indemnity Co., 11 Misc.3d 145(A) (App. Term 1st Dept. 2006.)

An insurer fails to raise a triable issue of fact with respect to a defense that the fees charged were not in conformity with the Workers' Compensation fee schedule when it does not specify the actual reimbursement rates which formed the basis for its determination that the claimant billed in excess of the maximum amount permitted. See St. Vincent Medical Services, P.C. v. GEICO Ins. Co., 29 Misc.3d 141(A), 907 N.Y.S.2d 441 (App. Term 2d, Dec. 8, 2010.)

A fee schedule defense does not always require expert proof. There are two fee schedule scenarios. The first involves the basic application of the fee codes and simple arithmetic. The second scenario involves interpretation of the codes and often requires testimony and evidence beyond that of a lay individual. I find that the fee schedule issue presented in this case is analogous to the latter scenario and requires an expert's opinion.

The respondent supported its fee schedule defense, with the affidavit of Stephanie Brown, CPC, CPMA, a certified professional coder who submitted a comprehensive review and analysis and determined, based on the applicable New York fee schedule that the correct reimbursable amount for the psychological services at issue is (\$846.71 each for each EIP.) Deducting the amount paid for the services rendered to the 12 year old EIP, the correct reimbursable amount due according to Ms. Brown is \$642.89.

The applicant did not submit an affidavit from a certified professional fee coder, medical professional or other expert to refute the findings of the respondent's expert. The applicant did submit a prior arbitration award, unrelated to this particular claim, which I did not consider because I did not have access to the particulars of that claim and could not determine its relevance to the claim at issue.

Based on the foregoing, the respondent has established its fee schedule defense.

Therefore, the applicant is awarded \$642.89 for the claim of the 12 year old EIP.

Accordingly, the applicant is awarded \$642.89 and the remainder of the claim is dismissed with prejudice.

Any further issues submitted in the record are held to be moot and/or waived insofar as they were not raised at the time of this hearing. This decision is in full disposition of all claims for no-fault benefits presently before 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.

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	Amount Amended	Status
	Psychology 21, PC	08/23/23 - 08/23/23	\$2,235.74	\$846.71	Awarded: \$642.89
	Psychology 21, PC	08/23/23 - 08/23/23	\$2,235.74	\$846.71	Denied
Total			\$4,471.48		Awarded: \$642.89

- B. The insurer shall also compute and pay the applicant interest set forth below. 12/26/2023 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." See 11 NYCRR §64-3.9(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. Where a claim is untimely denied, or not denied or paid, interest shall accrue as of the 30th day following the date the claim is presented by the claimant to the insurer for payment. Where a claim is timely denied, interest shall accrue as of the date an action is commenced or an arbitration requested, unless an action is commenced or an arbitration requested within 30 days after receipt of the denial, in which event interest shall begin to accrue as of the date the denial is received by the claimant. 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 was timely. LMK Psychological Servs. P.C. v. State Farm Mut. Auto. Ins. Co., 12 NY3d 217 (2009.)

C. Attorney's Fees

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

Applicant is awarded statutory attorney's fees pursuant to the no fault regulations. For cases filed after February 4, 2015 the attorney's fee shall be calculated as follows: 20% of the amount of first-party benefits awarded, plus interest thereon subject to no minimum fee and a maximum of \$1,360.00. See 11 NYCRR §65-4.6(d.)

- 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 CT
SS :
County of Fairfield

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

05/21/2025
(Dated)

Anne Malone

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:
be1e3f81951e63d2334a72b373fabefb

Electronically Signed

Your name: Anne Malone
Signed on: 05/21/2025