American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Herschel Kotkes MD, PC (Applicant)	AAA Case No.	17-23-1282-2764
	Applicant's File No.	LIP-24865
- and -	Insurer's Claim File No.	IVE5110
	NAIC No.	38130
St. Paul Travelers Insurance Co. (Respondent)		

ARBITRATION AWARD

I, Frank Marotta, 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-LC

1. Hearing(s) held on 11/01/2023
   Declared closed by the arbitrator on 11/16/2023

   Usman Nawaz, Esq. from Law Offices of Ilya E Parnas P.C. participated virtually for the Applicant

   Omar Mosqueda, Esq. from Law Offices of Tina Newsome-Lee participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$7,106.77**, was AMENDED and permitted by the arbitrator at the oral hearing.

   The Applicant amended the amount in dispute to $7,036.59 by acknowledging payment for the office visit in the amount of $70.18.

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

3. Summary of Issues in Dispute

   The record reveals that the Assignor-LC, a 53-year-old-female, sustained injuries in a motor vehicle accident on 12/27/21.

The Applicant seeks reimbursement for the services of a surgeon ($6,356.45) and physician assistant ($680.14) in connection with a cervical spine discectomy decompression and intradiscal electrothermal procedure on 6/2/22.

The Respondent denied the claim for the services of the surgeon based on a peer review by Dr. Sammy Dean dated 7/7/22.

The Respondent has not provided any proof of payment or denial of the bill for the Physician Assistant services asserts that the bill was never received.

The issue is whether the Applicant has provided prima facie proof entitling it to a reimbursement of the assigned services of the Physician Assistant and further whether the discectomy decompression and intradiscal electrothermal procedures on 6/2/22 were medically necessary.

4. Findings, Conclusions, and Basis Therefor

The Applicant filed this arbitration in the amount of $7,106.77, amended to $7,036.59 for disputed fees in connection with a cervical spine discectomy decompression and intradiscal electrothermal procedure on 6/2/22.

This hearing was conducted using the documents contained in the Electronic Case Folder (ECF) maintained by the American Arbitration Association. All documents contained in the ECF are made part of the record of this hearing and my decision was made after a review of all relevant documents found in the ECF as well as the arguments presented by the parties during the hearing. In accordance with 11 NYCRR 65-4.5(o)(1), an arbitrator shall be the judge of the relevance and materiality of the evidence and strict conformity of the legal rules of evidence shall not be necessary. Further, the arbitrator may question or examine any witnesses and independently raise any issue that Arbitrator deems relevant to making an award that is consistent with the Insurance Law and the Department Regulations. The parties appeared and the hearing was conducted virtually via zoom.

Prior to the start of the hearing, I informed the Respondent's attorney that Mr. Nawaz and I worked together approximately 10 years ago. I informed Mr. Mosqueda that if this presented an issue for the Respondent, I would continue the case and recuse myself. Mr. Mosqueda advised that he had no issue with me hearing the matter and the case proceeded.

SURGEON BILL ($6,356.45):

As to the services of the surgeon the Applicant's prima facie case is not in dispute as Respondent acknowledges receipt of bill for his services on their denial documents. Viviane Etienne Medical Care, P.C. v. Country-Wide Ins. Co., 114 A.D.3d 33, 977 N.Y.S.2d 292 (2d Dept. 2013), aff'd 25 NY 3d 498 (2015); Mary Immaculate Hospital v. Allstate Ins. Co., 5 A.D.3d 742, 774 N.Y.S.2d 564 (2d Dept. 2004; Ultra Diagnostics

Imaging v. Liberty Mutual Ins. Co., 2005 NY Slip Op 25402, 9 Misc.3d 97 (App. Term 9th & 10th Dists. 2005).

The Respondent denied the claim based on a peer review by Dr. Sammy Dean dated 7/7/22. The Applicant argues that the denial date 30 days after receipt of the bill should be found insufficient to preserve the defense that the services were medically unnecessary without proof of mailing. Having considered Applicant's argument, I find the denial, timely on its face, is sufficient in this forum to find it timely thereby preserving for consideration Respondent's defense based on Dr. Dean's 7/7/22 peer review that the procedures performed on 6/2/22 were not medically necessary.

The sufficiency of Dr. Dean's opinion in connection with the anesthesia relating to the cervical discectomy which was performed on 6-2-22 by Herschel Kotkes, MD and Robert Robenov, PA-C was previously considered in the linked matter Sedation Vacation Perioperative Medicine PLLC a/a/o LC and St. Paul Travelers Insurance Co., AAA Case No. 17-22-1265-6837. In her decision dated 10/23/23 Arbitrator Meryem Toksoy noted:

"*I find the peer review by Dr. Dean to be sufficient for the purpose of establishing Respondent's defense. It adequately sets forth the factual basis and medical rationale to support the conclusion that the surgery performed on 06-02-22 was not indicated for the assignor. That being so, the burden shifts to the Applicant to counter Respondent's showing.*

In this case, Applicant has not submitted a rebuttal. The failure to submit one is not an automatic bar to recovery. There may be instances when the information contained within the medical reports meaningfully address the points that are raised in the peer review. However, when the evidence does not speak to the issues that are voiced by the peer reviewer, the question of medical necessity will preponderate in the insurer's favor.

Here, the evidence does not suffice to refute and overcome Dr. Dean's determination.

Based on the foregoing, I find in favor of the Respondent. The claim is hereby denied in full."

After a review of the documents contained in the ECF and in consideration of the arguments made by the parties at the hearing, I find for the Respondent. I agree with Arbitrator Toksoy that Dr. Dean's peer review is sufficient for the Respondent to meet its prima facie burden in support of its defense that the surgical procedures performed on 6-2-22 were not medically necessary as the peer review sets forth a factual basis and medical rationale in support of its conclusion. See Provvedere, Inc. v. Republic Western Ins. Co., 2014 NY Slip Op 50219 (U) (App. Term 2nd, 11th and 13th Jud. Dists. 2014); Jacob Nir, M.D. v. Allstate Ins. Co., 7 Misc.3d 544, 546-47 (Civ. Ct. Kings Co. 2005).

When a Respondent presents sufficient evidence to establish a defense based on the lack of medical necessity, the burden shifts to the Applicant who must then present its own evidence of medical necessity. See West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co., 13 Misc.3d 131(A), 2006 N.Y. Slip Op. 51871(U) at 2 (App. Term 2d & 11th

Dists. Sept. 29, 2006) citing Prince, Richardson on Evidence §§ 3-104, 3-202 [Farrell 11th ed])." See also Lynbrook Medical of New York, PC v Praetorian Ins. Co., 48 Misc. 3d 139(A); 2015 NY Slip Op 51226(U) (App. Term, 2d, 11th and 13th Jud Dists 2015); Alfa Medical Supplies v. Geico General Ins. Co.,2013 NY Slip Op 50064(U),38 Misc. 3d 134(A) (App. Term, 2d, 11th and 13th Jud Dists 2013).

In the instant matter the Applicant submits a peer review rebuttal by Herschel Kotkes, MD dated 10/11/23, however, the rebuttal is unsigned and therefore is of no probative value. Although a formal rebuttal is not required, the medical record relied on to overcome the opinion of a peer reviewer must meaningfully refute the conclusions set forth in the peer review. Jaga Med. Servs., P.C. v American Tr. Ins. Co., 2017 NY Slip Op 50954(U), 56 Misc. 3d 134(A) (2d, 11th & 13th Jud Dists July 21, 2017); Pan Chiropractic, P.C. v. Mercury Ins. Co., 24 Misc.3d 136(A), 2009 N.Y. Slip Op. 51495(U) (App Term 2d, 11th & 13th Dists. July 9, 2009). In the absent of any arguments contrary to those raised in the peer review it is unrebutted and finding should be made in Respondent's favor. A Khodadadi Radiology, P.C. v. NY Central Mutual Fire Ins. Co., 16 Misc.3d 131(A), 841 N.Y.S.2d 824 (Table), 2007 N.Y. Slip Op. 51342(U), 2007 WL 1989432 (App. Term 2d & 11th Dists. July 3, 2007). Since no such contrary evidence has been provided by Applicant the claim for the services of the surgeon must be denied. Lynbrook Medical of New York, PC v Praetorian Ins. Co., 48 Misc. 3d 139(A); 2015 NY Slip Op 51226(U) (App. Term 2d, 11th & 13th Jud Dists. 2015).

PHYSICIAN ASSISTANT BILL ($680.14):

The Applicant seeks $680.14 for the services of a physician assistant in connection with the services. In their submission letter Respondent asserts that it was not paid or denied but never received. Respondent further acknowledges that that Applicant has provided an "Affidavit of Faxing" and further that a payment for the Physician Assistant services was being issued. The matter was held open for two weeks for the Respondent to upload proof that the Physician Assistant bill was paid. No proof of payment was provided; therefore, the Applicant is awarded its fee for the Physician Assistant's services in the amount of $680.14.

The Applicant's "Affidavit of Faxing" indicates that the bill was faxed to the Respondent on 6/15/22. An insurer is required to pay, in whole or in part, a claim for no-fault benefits within 30 days. Insurance Law §5106(a); 11NYCRR 65- 3.8 (c). Where, as here, no denial has been issued and no payment has been made, interest runs from the thirty-first day after the claim was presented to the carrier for payment. See New York Presbyterian Hospital v. Allstate Insurance Company, 30 A.D.3d 492, 819 N.Y.S.2d 268, 2006 N.Y. Slip Op. 04815 (2nd Dept 2006). Hempstead General Hospital v. Insurance Company of North America, 208 A.D.2d 501, 617 N.Y.S.2d 478 (2nd Dept 1994). In this matter interest runs from 7/16/22.

CONCLUSION:

The Applicant is awarded $680.14 for the Physician Assistant services.

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**
	Herschel Kotkes MD, PC	**06/02/22 - 06/02/22**	**$680.14**		**Awarded: $680.14**
	Herschel Kotkes MD, PC	**10/13/22 - 10/13/22**	**$70.18**		**Withdrawn with prejudice**
	Herschel Kotkes MD, PC	**06/02/22 - 06/02/22**	**$6,356.45**		**Denied**
Total			**$7,106.77**		**Awarded: $680.14**

B. The insurer shall also compute and pay the applicant interest set forth below. 07/16/2022 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest is governed by 11 NYCRR §65-3.9. Where a motor vehicle accident occurs after April 5, 2002, 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 (c) indicates that "*If an applicant does not request arbitration … with 30-days after the receipt of a denial of claim or payment of benefits … interest shall not accumulate … until such action is taken.*" The Superintendent and the New York Court of Appeals has interpreted this provision to apply regardless of whether the denial at issue was timely. LMK Psychological Servs., P.C. v. State Farm Mut. Auto. Ins. Co., 12 N.Y.3d 217 (2009). Where no denial has been issued and no payment has been made, it is clear from the statute that the claim is overdue, and interest runs from the thirty first day after the claim was presented to the carrier for payment. New York Presbyterian Hospital v. Allstate Insurance Company, 30 A.D.3d 492, 819 N.Y.S.2d 268, 2006 N.Y. Slip Op. 04815 (2nd Dept 2006). Hempstead General Hospital v. Insurance Company of North America, 208 A.D.2d 501, 617 N.Y.S.2d 478 (2nd Dept 1994).

C. Attorney's Fees

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

The insurer shall also pay the applicant for attorney's fees as set forth below Applicant is awarded statutory attorney fees pursuant to the no-fault regulations. See, 11 NYCRR §65-4.5(s)(2). The award of attorney fees shall be paid by the insurer. 11 NYCRR §65-4.5(e). Accordingly, "the attorney's fee shall be limited as follows: 20 percent of the amount of first-party benefits, plus interest thereon, awarded by the arbitrator or the court, subject to a maximum fee of $850." Id. The minimum attorney fee that shall be awarded is $60. 11 NYCRR §65-4.5(c). However, if the benefits and interest awarded thereon is equal to or less than the 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 (i). For claims that fall under the Sixth Amendment to the regulation the following shall apply: "If the claim is resolved by the designated organization at any time prior to transmittal to an arbitrator and it was initially denied by the insurer or overdue, the payment of the applicant's attorney's fee by the insurer shall be limited to 20 percent of the total amount of first-party benefits and any additional first-party benefits, plus interest thereon, for each applicant with whom the respective parties have agreed and resolved disputes, subject to a maximum fee of $1,360." 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 NY
SS :
County of Suffolk

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

11/27/2023
(Dated)

Frank Marotta

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:
1ba78ffdda972d8d6414fb6a424d5421

Electronically Signed

Your name: Frank Marotta
Signed on: 11/27/2023