American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Herschel Kotkes MD, PC (Applicant)	AAA Case No.	17-23-1301-2949
	Applicant's File No.	LIP-27947
- and -	Insurer's Claim File No.	1111234-03
	NAIC No.	16616
American Transit Insurance Company (Respondent)		

ARBITRATION AWARD

I, Laura E. Villeck, 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: claimant

1. Hearing(s) held on 07/22/2024
   Declared closed by the arbitrator on 07/22/2024

   Lee-Ann Trupia, Esq. from Law Offices of Ilya E Parnas P.C. participated virtually for the Applicant

   Adam Waknine, Esq. from American Transit Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$6,199.90**, 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 claimant, a then 58 year old male, was involved in an accident which occurred on March 6, 2022. Following the accident, the claimant sought treatment for the injuries sustained and on May 17, 2022, the claimant underwent a lumbar percutaneous discectomy, the services at issue herein. The Respondent denied the claim based upon the peer review of Ajendra Sohal, M.D. dated August 23, 2022.

   The issues to be determined are whether the Applicant established entitlement for No-Fault compensation for the treatment rendered to the claimant and whether Respondent properly denied payment based on the peer review.

4. Findings, Conclusions, and Basis Therefor

This hearing was conducted using documents contained in the ADR Center. Any documents contained in the folder are hereby incorporated into this hearing. I have reviewed all relevant exhibits contained in the ADR Center maintained by the American Arbitration Association.

It is now well settled that Applicant establishes "a prima facie showing of their entitlement to judgment as matter of law by submitting evidentiary proof that the prescribed statutory billing forms [setting forth the fact and the amount of the loss sustained] had been mailed and received and that payment of no-fault benefits were overdue." Mary Immaculate Hospital v. Allstate Insurance Company, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2d Dep't. 2004). In the case at bar, Applicant has met this burden.

Medical Necessity

In order to support a lack of medical necessity defense, 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 Jud. Dists. 2014).

Once the Applicant has established its prima facie case, the carrier must prove that the treating doctor's services were not medically necessary. See, e.g., Nir v Allstate Ins. Co., 7 Misc.3d 544 (Civ Ct, Kings County 2005).

In support of its contention that the lumbar percutaneous discectomy was not medically necessary, the Respondent relies on the peer review of Dr. Sohal dated August 23, 2022. Dr. Sohal stated that intradiscal procedure is questionable and not totally safe. He further stated that not providing pharmacotherapy or repeat ESI's is reflective of inadequate conservative treatment.

After reviewing the totality of the credible and admissible evidence, and hearing the arguments of the parties, I find that the peer review failed to sufficiently set forth how and why the services were inconsistent with generally accepted medical and/or professional practices. I find no basis for Dr. Sohal's statements other than his own opinion on the matter. Dr. Sohal's peer review is completely devoid of any standard of care from which Applicant deviated from in performing the percutaneous discectomy. He did not provide any authority to support his contention that pharmacotherapy and ESI's must be performed prior to surgery. Dr. Sohal fails to persuasively provide any supported standard of care for performing a percutaneous discectomy or coherently explain how that standard of care was violated.

Assuming arguendo, that the peer review satisfied Respondent's burden, Applicant's medical records and rebuttal by Dr. Herschel Kotkes sufficiently refute the peer review.

Applicant meaningfully refers to and rebuts the conclusions set forth in the peer review report. High Quality Medical, P.C. v. Mercury Ins. Co., 26 Misc.3d 145(A) (App. Term 2d Dept. 2010).

Therefore, the Applicant's claim is granted.

Fee Schedule

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). See also, Power Acupuncture PC v. State Farm Mutual Automobile Ins. Co., 11 Misc.3d 1065A, 816 N.Y.S.2d 700, 2006 NY Slip Op 50393U, 2006 N.Y. Misc. LEXIS 514 (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 curiam, 2006).

At the hearing, the Respondent alleged that the amount billed was in excess of the fee schedule, however, in this case, they failed to exchange sufficient evidence substantiating its allegation, such as an affidavit from a certified coder, an audit or medical doctor's peer review report.

Therefore, the Applicant's claim is granted in its entirety.

Any further issues raised in the hearing record are held to be moot and/or waived insofar as not raised at the time of the hearing.

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**
	Herschel Kotkes MD, PC	**05/17/22 - 05/17/22**	**$5,600.63**	**Awarded: $5,600.63**
	Herschel Kotkes MD, PC	**05/17/22 - 05/17/22**	**$599.27**	**Awarded: $599.27**
Total			**$6,199.90**	**Awarded: $6,199.90**

B. The insurer shall also compute and pay the applicant interest set forth below. 05/26/2023 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." 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

The insurer shall pay the applicant an attorney's fee, in accordance with 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 Nassau

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

08/05/2024
(Dated)

Laura E. Villeck

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:
5fb8862aa3dd5381c31457722b82c175

Electronically Signed

Your name: Laura E. Villeck
Signed on: 08/05/2024