

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

All City Family Healthcare Center
(Applicant)

- and -

Unitrin Safeguard Insurance Company
(Respondent)

AAA Case No. 17-24-1339-4787

Applicant's File No. n/a

Insurer's Claim File No. 23123625289

NAIC No. 10914

ARBITRATION AWARD

I, Heidi Obiajulu, 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: Injured Party

1. Hearing(s) held on 08/30/2024
Declared closed by the arbitrator on 08/30/2024

Michael Galeno, Esq. from Dino R. DiRienzo Esq. participated virtually for the
Applicant

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

2. The amount claimed in the Arbitration Request, **\$7,898.71**, was AMENDED and permitted by the arbitrator at the oral hearing.

The applicant amended its claim to \$5292.93 to conform to the maximum fee schedule amount and the respondent's fee audit.

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

3. Summary of Issues in Dispute

The applicant seeks reimbursement of charges for ambulatory surgical services for a percutaneous discectomy [CPT code 62287] and IDET procedure [CPT code 22526-59] performed on 09/18/23, following a motor vehicle accident on 04/12/23. The respondent denied the claim based on the peer review by Dr. Ajendra Sohal, MD dated 11/14/23.

4. Findings, Conclusions, and Basis Therefor

The decision is based on the documents in the Modria ADR Electronic Case folder maintained by the American Arbitration Association (hereafter referred to as AAA) as of the hearing.

The applicant, as assignee of the Injured Party, seeks reimbursement, with interest and counsel fees, under the No-Fault Regulations, for ambulatory surgical services for a percutaneous discectomy [CPT code 62287] and IDET procedure [CPT code 22526-59] performed on 09/18/23, in the amended amount of \$5292.93.

The respondent insured the motor vehicle involved in the automobile accident. Under New York's Comprehensive Motor Vehicle Insurance Reparation Act (the "No-Fault Law"), New York Ins. Law §§ 5101 et seq., the respondent was obligated to reimburse the Injured Party (or assignee) for all reasonable and necessary medical expenses arising from the use and operation of the insured vehicle.

This case arises out of a motor vehicle accident occurring on April 12, 2023, in which the Injured Party (JS), a then 49-year-old male passenger sustained multiple injuries including to the neck, back, shoulders, and right knee while occupying the insured vehicle when it was hit on the left side by the adverse vehicle.

On 04/18/23, Trishanna Yankannah, PA initially evaluated the Injured Party and reported that he presented with constant headaches, neck pain [rated 9/10], bilateral shoulder pain [rated 9/10], mid back pain [rated 9/10], lower back pain [rated 8/10], and right knee pain [rated 7/10]. Physical examination revealed tenderness over the semispinalis capitis muscles of the cervical region with pain in cervical facets at C3-C7 with palpable trigger points, a positive Spurling test, and restricted ranges of motion with pain, tenderness over the thoracic paraspinal muscles and facet joint lines with hyperextension of the thoracic spine, pain in the lumbar facets at L3-S1 and over the lumbar intervertebral spaces with tenderness in the bilateral sacroiliac joint area, trigger point tenderness, a positive SLR test at 25 degrees on the right and 60 degrees on the left, and limited range of motion with overhead raising, flexion, and extension of the shoulders with a positive impingement sign and O'Brien's test [only in the right shoulder] and tenderness over the left acromioclavicular joint, posterior deltoid muscle, posterior glenoid rim, and posterior glenohumeral joints, and tenderness in a diffuse pattern on the anterior region of the right knee with limited ranges of motion with guarding. Based on the Injured Party's complaints and clinical findings, the clinical impressions were cervicalgia, cervical paraspinal spasm, bilateral shoulder pain, right knee strain, and thoracic back pain. The PA commenced the Injured Party on conservative care and prescribed DME.

A lumbar spine MRI study revealed L5-S1 HNP.

On 05/22/23, Natela Abramov, PA supervised by Dr. Herschel Kotkes, MD evaluated the Injured Party and reported that he presented with complaints of neck pain, thoracic pain, and lower back pain. He noted that the neck pain radiated to the bilateral shoulders, left hand, and right hand and had worsened. He reported that the pain affected the C3-4, C4-5, C5-6, and C6-7 dermatomal distribution and tingle; the average pain was rated 9/10. Physical examination of the cervical spine revealed tenderness to palpation, facet pain in the C3-C7 region on both sides, restricted ranges of motion, pain with extension of the cervical spine, and a positive Spurling test. The neurological exam of the upper normal sensation, and normal DTRs. He noted that a cervical spine MRI on 05/11/23 revealed C3-C7 bulging discs and C3-C6 disc osteophyte complexes. Based on the Injured Party's subjective complaints, exam findings, and MRI findings, Dr. Kotkes diagnosed cervicalgia, cervical intervertebral disc displacement, cervical radiculopathy, and cervical facet syndrome [regarding injuries to the cervical region]. Based on the complaints regarding the lumbar spine and his exam findings, the PA diagnosed low back pain, lumbar radiculopathy, lumbar intervertebral disc displacement, and lumbar facet syndrome. Regarding the cervical spine, the PA recommended possible injections and a percutaneous cervical discectomy and annuloplasty.

On 05/31/23, Dr. Wendell Joseph Gorum, MD evaluated the Injured Party and reported that he presented with complaints of severe pain in the neck, moderate lower back pain, severe bilateral shoulder pain, and severe right knee pain. Dr. Gorum primarily noted clinical findings regarding his exam of the shoulders and right knee. Physical examination of the right shoulder revealed tenderness over the right anterior glenoid rim, anterior glenohumeral joint, bicipital groove, posterior deltoid muscle, posterior glenoid rim, and rotator cuff with decreased ranges of motion, and positive right shoulder impingement sign, O'Brien's test, Adduction test, and Apprehension sign, with weakness in the supraspinatus muscle. Physical examination of the left shoulder revealed restricted ranges of motion positive impingement test, O'Brien's test, Adduction test, and Apprehension sign. Physical examination of the right knee revealed no tenderness in the anterior knee region with no swelling, ecchymosis, or effusion, restricted ranges of motion, bounce back extension is painful, and a positive apprehension sign. He noted that the cervical and lumbar paraspinal muscles were tender with limited ranges of motion. Based on his exam, he referred the Injured Party for diagnostic testing, prescribed pain cream, and recommended right shoulder surgery.

On 06/05/23, Dr. Kotkes, MD re-evaluated the Injured Party and reported that he presented with complaints of constant, aching, cramping, and sharp tingling pain in the neck with stiffness that radiated to the bilateral shoulders and hands. He noted that the pain was worse by bending, changing position, movement, and turning from side to side. Physical examination of the cervical spine revealed tenderness to palpation, facet pain at the C3-C7 region on both sides, decreased ranges of motion, palpable trigger points in the neck muscle, and positive Compression test and Spurling test. Based on the exam, Dr. Kotkes diagnosed cervicalgia, displacement of the intervertebral disc, and radiculopathy. He recommended ongoing conservative care, trigger point injections, medial branch blocks, and cervical epidural steroid injections. A cervical epidural steroid injection was performed.

On 06/13/23, Trishanna Yankannah, PA re-evaluated the Injured Party and reported that he complained of persisting pain in the cervical spine, shoulder, thoracic spine, knee, and lumbar spine. Overall, the pain was rated 9-10/10. Physical examination of the cervical spine revealed a decreased range of motion with pain, cervical facet pain at C3-C7, tenderness at the paraspinal muscles and facet joint line, and a positive Spurling test on the left. Physical examination of the lumbar spine revealed lumbar facet pain bilaterally at L3-S1 paraspinal region, pain at L3-S1 over the lumbar intervertebral spaces on palpation, and decreased ranges of motion. Physical examination of the shoulders revealed tenderness over the acromioclavicular joints and swelling over the right incisional. Trigger point injections were performed.

On 06/19/23, Dr. Kotkes, MD re-evaluated the Injured Party and reported that he presented with complaints of constant neck pain described as stiff, aching, cramping, sharp, and tingling rated as 10/10 associated with radiation to the bilateral shoulder and bilateral hand. Pain in cervical dermatomes and pain worsened by bending, changing position, movement, and turning side to side. Dr. Kotkes also reported that the Injured Party had 60% relief for a week from the cervical epidural steroid injections but that the pain returned with radicular shooting pain. Physical examination revealed tenderness to palpation of the cervical facet in the C3-C7 region on both sides, decreased ROM with pain, palpable trigger points in the muscle of the neck, positive Compression test and Spurling test, and decreased muscle strength. Based on his exam, Dr. Kotkes diagnosed Cervicalgia and cervical intervertebral disc displacement. He opined that the Injured Party failed conservative care and recommended the cervical discectomy. Dr. Kotkes, MD, assisted by Vyacheslav Gulkarov, NP, performed the percutaneous cervical discectomy and annuloplasty.

On 06/27/2023, the patient presented to Dr. Olga Gibbons for neurological consultation with the chief complaints of 9/10 neck pain with weakness, numbness, and paresthesia, right shoulder pain, and 9/10 lower back pain with weakness, numbness, and paresthesia. Examination of the cervical spine revealed a painful range of motion, tenderness, and muscle spasms. Neurological examination revealed decreased muscle strength of the bilateral hands. Examination of the shoulder revealed a positive Impingement sign and Supraspinatus test on the left. Examination of the lumbar spine revealed a restricted range of motion with pain in all planes. Based on the exam, Dr. Gibbons diagnosed the patient with cervical and lumbar sprain of ligaments, cervicalgia, and low back pain. Therefore, Dr. Gibbons recommended the patient to continue physical therapy and also referred for EMG/NCV studies of the Upper and Lower Extremities which revealed normal results.

On 07/11/23, Trishanna Yankannah, PA re-evaluated the Injured Party and reported that he presented with persisting constant low back pain rated 9/10 on the pain scale. Physical examination revealed lumbar facet pain at L3-S1 bilaterally, pain at L3-S1 dermatomes, tenderness in the erector spinae muscles, multifidus muscles, latissimus dorsi muscles, and quadratus lumborum muscle, decreased and painful range of motion, trigger point tenderness over multiple muscles and a positive SLR test. Ongoing conservative treatment was recommended.

On 07/31/23, Natela Abramov, PA re-evaluated the Injured Party and reported that he presented with constant and stiff pain in the lower back [rated 8/10] radiating to the buttock region and the pain affected the L5-S1 dermatomal distribution and was associated with tingling. Physical examination revealed lumbar facet pain at the L3-S1 region bilaterally with a decreased and painful range of motion, decreased muscle strength, and a positive SLR test and Kemp's test. Ongoing conservative care was recommended.

On 08/07/23, Dr. Herschel Kotkes MD re-evaluated the Injured Party and reported that he presented with constant lower back pain radiating to the buttock region, left lower extremity, left leg, and left foot. He rated the pain as 10/10 at its worst and generally at 8/10 on the pain scale. The pain was associated with tingling. Physical examination revealed lumbar facet pain on both sides at the L3-S1 region, a positive SLR test, a positive Kemp's test, pain with lumbar extension and left and right lateral flexion, decreased muscle strength, and a normal sensory exam. Based on the exam and diagnoses of lumbar radiculopathy, lumbar intervertebral disc displacement, and low back pain, he recommended and performed lumbar epidural steroid injections under ultrasonic guidance and trigger point injections.

On 08/28/23, Natela Abramov, PA re-evaluated the Injured Party and reported that he presented with persisting neck pain, middle back pain, and lower back pain. The lower back pain was described as radiating to the buttock region. He indicated the pain was 2/10 at its worst but on average 1/10. The lumbar epidural steroid injection reportedly greatly improved the severity of the pain. Physical examination of the lumbar spine revealed lumbar facet pain at the bilateral L3-S1 region, negative SLR test, restricted ranges of motion, and motor deficits in the lower extremities [graded 4/5], normal sensation, and normal DTRs. Based on his exam, he discussed possible trigger point injections, medial branch block injections, epidural steroid injections, and the disputed percutaneous lumbar discectomy and annuloplasty.

On 09/18/23, Dr. Kotkes, MD re-evaluated the Injured Party and reported he complained of persisting radiating lumbar spine pain that on average was rated 5/10 but 6/10 at its worst. He noted the pain affected the L5-S1 dermatomal distribution. His physical examination of the lumbar spine was essentially unchanged. Dr. Kotkes, MD, assisted by Robert Robenov PA-C, performed the lumbar percutaneous discectomy with nucleus pulposus ablation and annuloplasty. In his operative report, he stated that the surgery was indicated due to persisting discogenic pain and failed conservative care, i.e., physical therapy.

The applicant performed the disputed associated ambulatory surgical services for the lumbar percutaneous discectomy and IDET.

Thereafter, the applicant submitted its claim form to the respondent seeking reimbursement of no-fault benefits.

Within 30 days of its receipt of the applicant's claim form, the respondent denied reimbursement based on the peer review by Dr. Ajendra Sohal, MD dated 11/14/23.

After it received the respondent's denial, the applicant commenced this arbitration seeking reimbursement of its claim.

At the outset, I find that the applicant established its prima facie case with the submission of its claim form and the copy of the respondent's denial of claim form, which demonstrates that the respondent received the applicant's claim form, that more than 30 days elapsed since its receipt of same, and that the respondent denied reimbursement of the applicant's claim, which shows that the applicant's claim is now due and owing. See Insurance Law section 5106 [a]; Viviane Etienne Medical Care, PC v. County-Wide Ins. Co 25 N.Y.3d. 498, (NY, June 10, 2015), Westchester Medical Center v. Nationwide Mut. Ins. Co., 78 A.D.3d. 1168, (N.Y.A.D. 2nd Dept., November 30, 2010).

Once an applicant establishes a prima facie case, the burden shifts to the insurer to prove its defense.

However, even before determining whether the respondent met its burden of proof, it must first be determined whether the respondent's defense survives preclusion.

I find the respondent's lack of medical necessity defense is preserved based on the uncontested timely and legally sufficient denial asserting that defense.

Therefore, the issue is whether the respondent met its burden of proof in establishing its defense.

To establish its lack of medical necessity defense, the respondent relies on the peer review by Dr. Ajendra Sohal, MD dated 11/14/23. To rebut that defense, the applicant relies on the arguments of its attorney that in the linked award [with AAA Case No. 17-23-1325-2133] involving the medical necessity of the underlying surgical procedures [the lumbar percutaneous discectomy and IDET], I found an almost identical peer review by Dr. Sohal [dated 10/12/23] to be unpersuasive.

Reviewing the relevant evidence in the record and considering the oral arguments made by the parties, I find as follows:

In determining whether an insurer met its burden of proof in establishing its lack of medical necessity defense, the courts have found that an insurer must submit an IME report/peer review with a detailed basis and medical rationale for the denial of benefits to prevail. See Vladimir Zlatnick, M.D., P.C. v. Travelers Ins. Indemnity Co., 12 Misc.3d 128A (App. Term 1stDept. 2006) and Nir v. Allstate, 7 Misc.3d 544, 546-47 (Civ. Ct., Kings County. 2005). ("At a minimum, (the respondent) must establish a factual basis and medical rationale for the lack of medical necessity of (applicant's) services"). Once the respondent submits an IME report or peer review with a sufficient factual basis and medical rationale, the courts have routinely found that the respondent has established its prima facie defense that the disputed medical service is medically unnecessary. A Khodadadi Radiology, P.C. v. NY Cent. Mut. Fire Ins. Co., 16 Misc.3d 131(A), (N.Y. Sup. App. Term Jul 03, 2007). Then, the burden of persuasion regarding

the medical necessity of the medical services shifts to the applicant to submit competent medical evidence to refute the respondent's prima facie defense that the disputed medical service/test was medically unnecessary. Compare Pan Chiropractic PC v. Mercury Ins. Co., 24 Misc.3d. 136 (A) (July 9, 2009). However, as Judge Aaron Maslow determined in the case of American Tr. Ins. Co. v. Right Choice Supply, Inc., 2023 N.Y. Slip Op 23039, (N.Y. Sup., Kings County, February 9, 2023), Pan Chiropractic, PC, et. al, supra. is not controlling in arbitrations because that case applies to summary judgment motions and not no-fault arbitrations. He reasoned no-fault arbitrations "...entail final determinations, akin to a bench trial where the trial court hears the evidence and makes its own findings of fact..."

Applying the above case law and criteria to the medical evidence in the record, I find in favor of the applicant, for two reasons. First, in my linked decision Herschel Kotkes MD, PC v. [Respondent], with AAA Case No. 17-23-1325-2133, I found the underlying surgical services were medically necessary. Therefore, the law regarding the medical necessity of the underlying surgical services is that they were medically necessary. Notably, the peer reviewer relied on his argument that the underlying surgical services were medically unnecessary to find that the associated ambulatory surgical services were medically unnecessary. Second, even if I decided on the medical necessity of the underlying surgical services de novo, based on the totality of the medical evidence in the record I find those services and the disputed associated ambulatory surgical services were medically necessary, for the following reasons. I am not persuaded by Dr. Sohal's arguments that there was no objective evidence of classical radiculopathy, that the Injured Party was improving, and that there was no discogenic pain. Deference is afforded the treating provider's [Dr. Kotkes'] opinion that the Injured Party was diagnosed with lumbar radiculopathy and disc displacement causing discogenic pain. Also, I find that based on the medical evidence in the record, the Injured Party failed conservative care. In my linked decision involving the same parties with AAA Case No. 17-23-1326-7684, I found credible and persuasive Dr. Kotkes' opinion that the Injured Party failed conservative care and had causally related lumbar radiculopathy. Additionally, I am also not persuaded by the peer reviewer's arguments outlined in his peer review report dated 11/14/23 that "*If discectomy is undertaken tissue is normally sent for histopathological report*" and that IDET is not usually recommended because those opinions are conclusory given he did not cite medical authority to support his position.

So, the bottom line is that based on the totality of the medical evidence in the record, I am persuaded by the treating surgeon Dr. Kotkes that the disputed ambulatory surgical services associated with the underlying surgical services were medically necessary.

Accordingly, for the above reasons, I find in favor of the applicant in the amount of \$5292.93, as reimbursement of its entire claim.

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
	All City Family Healthcare Center	09/18/23 - 09/18/23	\$7,898.71	\$5,292.93	Awarded: \$5,292.93
Total			\$7,898.71		Awarded: \$5,292.93

- B. The insurer shall also compute and pay the applicant interest set forth below. 03/07/2024 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

The applicant's award of \$5292.93 shall bear interest at a rate of two percent per month, calculated on a pro-rata basis using a 30-day month from 03/07/24, the date the applicant initiated arbitration, to the date of the payment of the award, under 11 NYCRR 65-3.9 (a) and LMK Psychological Servs. P.C. v. State Farm Mut. Auto Ins. Co., 12 N.Y.3d 217, (N.Y., April 02, 2009) since Applicant did not commence this Arbitration proceeding within 30 days after receiving the subject denial(s).

C. Attorney's Fees

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

As this matter was filed **after** February 4, 2015, this case is subject to the provisions promulgated by the Department of Financial Services in the Sixth Amendment to 11 NYCRR 65-4 (Insurance Regulation 68-D). Accordingly, the insurer shall pay the applicant an attorney's fee, under 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 NJ

SS :

County of Union

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

08/30/2024
(Dated)

Heidi Obiajulu

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:
ad1a8cba09469740134b88ec07bb5447

Electronically Signed

Your name: Heidi Obiajulu
Signed on: 08/30/2024