

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Aron Rovner MD PLLC  
(Applicant)

- and -

Country-Wide Insurance Company  
(Respondent)

AAA Case No. 17-20-1172-6175

Applicant's File No. N/A

Insurer's Claim File No. 344029-002

NAIC No. 10839

**ARBITRATION AWARD**

I, Gillian Brown, 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 12/01/2021  
Declared closed by the arbitrator on 12/01/2021

Dino DiRienzo, Esq., from Dino R. DiRienzo Esq. participated in person for the Applicant

Cody Robar, Esq., from Jaffe & Velazquez, LLP participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 9,759.40**, was AMENDED and permitted by the arbitrator at the oral hearing.

The parties stipulated to an amended amount in dispute of \$5333.20, to conform to the fee schedule.

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

3. Summary of Issues in Dispute

The EIP was involved in a motor vehicle accident on 4/6/19. On 10/21/19, the EIP underwent left shoulder arthroscopy. Reimbursement has been denied based on a peer review prepared by Dr. Julio Westerland, MD, dated 11/21/19.

#### 4. Findings, Conclusions, and Basis Therefor

Pursuant to 11 NYCRR §65-4.5(o)(1), the arbitrator shall be the judge of the relevance and materiality of the evidence offered and strict conformity to legal rules of evidence shall not be necessary. The arbitrator may question any witness or party and independently raise any issue that the arbitrator deems relevant to making an award that is consistent with the Insurance Law and Department regulations. This hearing was conducted using documents contained in the ADR Center. Any documents contained in the ADR Center folder for this matter are hereby incorporated into this hearing. I have reviewed all relevant exhibits contained in the ADR Center maintained by the American Arbitration Association.

Decided herewith are two linked matters, both involving reimbursement for the same surgery. The matters include the surgeon's bill, the facility fee and anesthesia. The matters are 17-20-1172-6175 (claimant Aaron Rovner, MD, PLLC, and 17-20-1158-3641 (claimant SCOB LLC, Premier Anesthesia Associates PA). The denial of reimbursement is based on the same peer review in both matters.

The record shows that the EIP was a 38-year-old male who was involved in a motor vehicle accident on 4/16/19. He was the restrained driver of a vehicle, whose vehicle was struck on the driver's side when he tried to merge into traffic from the service lane. He was seen at a hospital emergency department, where he complained of left shoulder pain. He sustained no fractures, and he was discharged the same day.

Records indicate that he began a course of conservative care, including acupuncture, EMG/NCV testing, physical therapy and chiropractic. He was prescribed medication. An MRI study of his left shoulder was performed. With worsening pain in his left shoulder, he sought a consultation with orthopedic surgeon Aaron Rovner. At his second appointment with Rovner on 8/27/19, the doctor recommended that he undergo a "diagnostic left shoulder arthroscopy." His recommendation was based on his opinion that the EIP's pain was worsening, that he had failed all methods of conservative care, and that the MRI of his left shoulder was consistent with "edema in the left distal clavicle, and adjacent acromion with fluid in adjacent acromioclavicular joint." The EIP's left shoulder exhibited clicking on range of motion testing, reduced ranges of motion, and positive orthopedic tests.

The surgery was performed on 10/21/19. Reimbursement has been denied based on a peer review prepared by Dr. Julio Westerband, MD, dated 11/21/19.

Once a claimant has established a prima facie case of entitlement to no-fault benefits, the burden then shifts to the insurer to prove that the disputed services were not medically necessary. To meet this burden, the insurer's denial(s) of the Applicant's claim(s) must be based on a peer review, IME report, or other competent medical evidence that sets forth a clear factual basis and a medical rationale for the denial(s). Amaze Medical Supply, Inc. v. Eagle Ins. Co., 2 Misc. 3d 128A (App. Term, 2nd & 11th Jud. Dist., 2003); Tahir v. Progressive Cas. Inc. Co., 12 Misc. 3d 657 (NYC Civ.

Ct., NY Co., 2006); Healing Hands Chiropractic, P.C. v. Nationwide Assurance Company, 5 Misc. 3d 975 (NYC Civ. Ct., NY Co., 2004); Acupuncture Prima Care, P.C. v State Farm Mutual Auto Ins., 17 Misc. 3d 1135 (A)(Dist. Ct., 1<sup>st</sup> Dist., Nassau Co. 2007).

"To find treatment or services are not medically necessary, it must be reasonably shown by medical evidence, in consideration of the patient's condition, circumstances, and best interest of the patient, that the treatment or services would be ineffective or that the insurer's preferred healthcare treatment or lack of treatment would lead to an equally good outcome." See: Fifth Avenue Pain Control Center v. Allstate Ins. Co., 196 Misc. 2d 801, 766 (Civ. Ct. Queens Co. 2003).

Dr. Westerband bases his conclusion on his opinion that the EIP had not exhausted all conservative care modalities. He further states that, "no reason is provided to justify this rush to surgical intervention." He states that there was no evidence of a full thickness tear, and that the EIP should have been treated for a partial thickness tear with pain, and that if, after "judicious use of steroid injections," the EIP did not improve, then surgery would have been appropriate. However, the citations he provides do not state that the standard of care is what Dr. Westerband says that it is. In fact, he provides a citation which specifically states that, "A recent survey of [orthopedic surgeons] indicated considerable variations in practice patterns relating to the care of patients with rotator cuff tears."

Moreover, the surgeon, Dr. Rovner, has submitted a rebuttal in these matters. He addresses each of Dr. Westerband's points, and notes that steroid injections do not provide long-lasting or permanent pain relief, and that there have been reports of steroid toxicity on rotator cuff tendons. I find as a matter of fact that the Rovner rebuttal is a meaningful rebuttal to the Westerband peer, and that the Westerband peer at best represents a difference of opinion between the two practitioners, and not a clearly defined standard of care which was not followed in this matter.

I find that to the limited extent that the peer was sufficient to shift the burden of proving medical necessity to the claimant, it has been rebutted by the Rovner rebuttal.

Additionally, claimant argues that the denials in these matters are facially insufficient. Claimant notes that boxes 25, 26, 27 and 32 are blank on the denial, and the omitted information (the date of service, the date of the bill, the date the bill was received and the amount in dispute) is necessary for the denial to be valid. I agree that the denials are facially insufficient, but the issue is moot, as I have already found that the denials cannot be sustained.

I find for the claimant in the stipulated amounts in both of these matters.

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
	Aron Rovner MD PLLC	10/21/19 - 10/21/19	\$9,759.40	\$5,333.20	Awarded: \$5,333.20
Total			\$9,759.40		Awarded: \$5,333.20

- B. The insurer shall also compute and pay the applicant interest set forth below. 07/27/2020 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

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). 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(b).

- 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 New York

SS :

County of Erie

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

12/18/2021  
(Dated)

Gillian Brown

**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:**  
c284ec64e3000a19b1dda82a34a28dc6

### Electronically Signed

Your name: Gillian Brown  
Signed on: 12/18/2021