American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Aron Rovner MD PLLC (Applicant)	AAA Case No.	17-19-1149-2403
	Applicant's File No.	NA
- and -	Insurer's Claim File No.	0499454171
	NAIC No.	19232
Allstate Insurance Company (Respondent)		

ARBITRATION AWARD

I, Alana Barran, 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: Patient

1. Hearing(s) held on 11/11/2021
   Declared closed by the arbitrator on 11/11/2021

   Kim Gitlin from Dino R. DiRienzo Esq. participated for the Applicant

   Josh Eidsvaag from Law Offices of James F. Sullivan, PC participated for the Respondent

2. The amount claimed in the Arbitration Request, **$ 4,955.28**, was AMENDED and permitted by the arbitrator at the oral hearing.
   The Applicant amended the amount in dispute to $3,410.41 to reflect the fee schedule amount for the services at issue.

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

3. Summary of Issues in Dispute
   The Patient, BL, is a 24 year old female that was involved in an accident on 4/22/18. This is a claim for surgeon's bill related to knee surgery performed on 4/15/19. The claim was denied based on the IME of Dr. Dorothy Scarpinato. The issue raised is whether the services at issue were medically necessary.

4. Findings, Conclusions, and Basis Therefor

My decision is based on the arguments of the representatives for both parties and those documents contained in the ADR Center for this case. The Applicant amended the amount in dispute to $3,410.41 to reflect the fee schedule amount for the services at issue.

The Respondent relied on the IME of Dr. Dorothy Scarpinato on 8/9/18 in denying the bill at issue for lack of medical necessity. Dr. Scarpinato reviewed medical records. Her examination revealed normal findings of the cervical spine, left shoulder, lumbar spine with "subjective complaint of paraspinal tenderness", bilateral knee with "subjective complaint of anterior tenderness". She concludes that the injuries are resolved and that no further treatment is medically necessary. I find that there is no persuasive rationale for determination that the complaints were subjective and why the positive findings would not warrant further treatment. I find the IME to be unpersuasive and insufficient to meet the Respondent's burden of proof to sustain its defense of lack of medical necessity.

The Respondent relied on the peer review of Dr. Dorothy Scarpinato on 6/13/19 in denying the bills at issue for lack of medical necessity. Dr. Scarpinato reviewed medical records. She states that there is no record of any rehabilitation to the left knee; that based on her completely normal physical evaluation four months post-accident and eight months prior to the surgery in question, the left knee surgery was not medically necessary as it relates to the accident of record.She concludes that the injuries are resolved and that no further treatment is medically necessary. I find that there is no persuasive rationale for determination that the complaints were subjective and why the positive findings would not warrant further treatment. I find the peer review findings to be general, conclusory, unpersuasive and insufficient to meet the Respondent's burden of proof to sustain its defense of lack of medical necessity.

The records in submission include evaluations 4/15/19, 9/20/18, 3/14/19, 4/23/18, 7/19/18, 6/25/18, 5/9/18 with positive findings; progress notes; operative report of the left knee dated 4/15/2019; hospital records. I find that the records in submission are persuasive and sufficient to rebut the findings of the Dr. Scapinato as they contain positive findings both before and after the IME, as well as demonstrate that the patient had received conservative care.

The applicant has established its initial entitlement to no fault benefits. The burden then shifts to the respondent. The respondent's denial for lack of medical necessity must be supported by a peer review or other competent medical evidence which sets forth a clear factual basis and medical rationale for denying the claim. Healing Hands Chiropractic, P.C. v. National Assurance Co., 5 Misc. 3d 975; Citywide Social Work, et. al v. Travelers Indemnity Co., 3 Misc. 3d 608. The issue of whether treatment is medically unnecessary cannot be resolved without resort to meaningful medical assessment, Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co., 2009 NY Slip Op 00351 (App Div. 2d Dept., Jan. 20, 2009); Channel Chiropractic, P.C. v. Country-Wide Ins. Co., 2007 Slip Op 01973, 38 A.D.3d 294 (1st Dept. 2007); Bronx Radiology, P.C. v. New York Cent. Mut. Fire Ins. Co., 2007 NY Slip Op 27427, 17 Misc.3d 97 (App Term 1st Dept., 2007).

In order for an applicant to prove that the disputed expense was medically necessary, it must meaningfully refer to, or rebut, the conclusions set forth in the peer review. Yklik, Inc. v. Geico Ins. Co., 2010 NY Slip Op. 51336(U) (App Term 2d, 11th& 13th Dists. July 22, 2010); High Quality Medical, P.C. v. Mercury Ins. Co., 2010 N.Y. Slip Op. 50447(U) (App Term 2d, 11th & 13th Dists. Mar. 10, 2010); 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).

I find that the IME and peer review findings of Dr.Dorothy Scarpinatohave failed to set forth a sufficient factual basis and medical rationale for the opinion that the disputed services were not medically necessary and therefore has not established, *prima facie*, a lack of medical necessity for those services rendered by applicant. The burden has not shifted to the Applicant and has nevertheless been rebutted. Therefore, the claimis granted.

Comparing the relevant evidence presented by both parties against each other and the above referenced standards, based on the foregoing, the Applicant is awarded the amended sum of $3,410.41.

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	**04/15/19 - 04/15/19**	**$4,955.28**	**$3,410.41**	**Awarded: $3,410.41**
Total			**$4,955.28**		**Awarded: $3,410.41**

B. The insurer shall also compute and pay the applicant interest set forth below. 11/26/2019 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

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. (11 NYCRR 65-3.9(c)). The end date for the calculation of interest shall be the date of payment of the claim. In calculating interest, the date of accrual shall be excluded from the calculation. Where a motor vehicle accident occurs after April 5, 2002, interest shall/be calculated at the rate of two percent per month, simple, calculated on a pro rata basis using a 30-day month. (11 NYCRR 65-3.9(a)). Where the claim is submitted electronically after the close of business or on the weekend, I find that the claim is deemed received on the next day of business following the electronic submission, and interest is awarded as of the next day of business following the electronic submission of the claim.

C. Attorney's Fees

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

For cases filed prior to February 4, 2015, 20 percent of the amount of first party benefits awarded herein, plus interest thereon, subject to a minimum of $60 and a maximum of $850. For cases filed on or after February 4, 2015, 20 percent of the amount of first party benefits awarded herein, plus interest thereon, subject to no minimum and a maximum of $1360.(11NYCRR65-4).

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 Nassau

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

01/14/2022
(Dated)

Alana Barran

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:
7cede0562d5c87452690c64a1358b172

Electronically Signed

Your name: Alana Barran
Signed on: 01/14/2022