American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Restorative Chiropractic Solutions, PC (Applicant)	AAA Case No.	17-18-1087-5492
	Applicant's File No.	GS-611441
- and -	Insurer's Claim File No.	0455506204
	NAIC No.	19232
Allstate Insurance Company (Respondent)		

ARBITRATION AWARD

I, Eileen Hennessy, 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-O.J.

1. Hearing(s) held on 01/09/2019
   Declared closed by the arbitrator on 01/09/2019

   Joseph Padrucco from Law Offices Of Gabriel & Shapiro, LLC. participated in person for the Applicant

   Meghan McDonaugh from Law Offices of John Trop participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 560.75**, was AMENDED and permitted by the arbitrator at the oral hearing.

   The amount in dispute was amended from the original amount of $560.75 to $370.21. Applicant acknowledged the partial payments of $54.74 for date of service 7/31/2017 and $110.10 for dates of service 8/15/2017 through 8/28/2017. The remainder of the bills were reduced in accordance with the applicable Fee Schedule.

   Stipulations WERE made by the parties regarding the issues to be determined.

   The parties stipulated and agreed that (i) Applicant has met its prima facie burden by submitting evidence that payment of no-fault benefits is overdue, and proof of its claims were mailed to and received by Respondent and (ii) Respondent's denials of the subject claims were timely issued.

3. Summary of Issues in Dispute

The record reveals that the Assignor-O.J., a 37-year-old male, reportedly sustained injuries as a pedestrian involved in a motor vehicle accident on 5/5/2017. Applicant billed for chiropractic treatments from 8/2/2017 through 9/12/2017. Respondent partially denied the claims prior to 8/28/2017 based on the bills exceeded the applicable Fee Schedule. Respondent denied the claims for dates of service 8/31/2017 through 9/12/2017 based on a lack of medical necessity per the results of the Independent Medical Evaluation (IME) performed by Dr. John Iozzio, D.C. The issues to be determined are 1) whether the services were billed in accordance with the Fee Schedule and 2) whether the services are medically necessary?

4. Findings, Conclusions, and Basis Therefor

Applicant seeks reimbursement for chiropractic treatments. 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.

Dates of Service 8/2/2017 through 8/28/2017

Fee Schedule

Respondent partially denied the bills for dates of service 8/2/2017 through 8/28/2017 premised upon the 8-unit rule.

It is respondent's burden to come forward with competent evidentiary proof to support its fee schedule defenses. *See* Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co., 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 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 N.Y. Misc. LEXIS 1109 (App. Term, 1 Dep't, per curiam, 2006). A

respondent may interpose a defense in a timely denial that the claim exceeds the fees permitted by the Workers' Compensation schedules, but respondent must, at minimum, establish, by evidentiary proof, that the charges exceeded that permitted by law. Abraham v. Country-Wide Ins. Co., 3 Misc.3d 130A, 787 N.Y.S.2d 678, 2004 N.Y. Misc. LEXIS 544 (App. Term, 2d Dept. 2004).

Furthermore, I take judicial notice of the New York State Workers' Compensation fee schedule. *See*, Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co., 61 A.D.3d 13, 20 (2d Dept. 2009); LVOV Acupuncture, P.C. v. Geico Ins. Co., 32 Misc.3d 144(A) (App Term 2d, 11th & 13th Jud Dists. 2011); Natural Acupuncture Health, P.C. v. Praetorian Ins. Co., 30 Misc.3d 132(A) (App Term, 1st Dept. 2011).

Ground Rule 11 of the Physical Medicine Section of the Medicine Fee Schedule, *Multiple Physical Medicine Procedures and Modalities*, which applies to doctors, physical therapist, and occupational therapists, commonly referred to as the "8-Unit Rule", reads: "When multiple physical medicine procedures and/or modalities are performed on the same day, reimbursement is limited to 8.0 RVUs or the amount billed, whichever is less. The following codes represent the physical medicine procedures and modalities subject to this rule: 97010, 97012, 97014, 97016, 97018, 97022, 97024, 97026, 97028, 97032, 97033, 97034, 97035, 97036, 97039, 97110, 97112, 97113, 97116, 97124, 97139, 97140, 97150, 97530, 97535, 97537, 97542, 97660, 97661, and 97662"

Ground Rule 3 of the Physical Medicine Section of the Chiropractic Fee Schedule, *Multiple Physical Medicine Procedures and Modalities*, which applies to chiropractors, and is also commonly referred to as the "8-Unit Rule", reads: "When multiple physical medicine procedures and/or modalities are performed on the same day, reimbursement is limited to 8.0 RVUs or the amount billed, whichever is less. The following codes represent the physical medicine procedures and modalities subject to this rule: 97010, 97012, 97014, 97024, 97026, 97028, 97032, 97033, 97034, 97035, 97036, 97039, 97110, 97112, 97113, 97116, 97124, 97139, 97140, 97530, 98940, 98941, 98942."

These sections of the New York Workers' Compensation Fee Schedule contain CPT codes which appear in both sections and both sections provide that when multiple physical medicine procedures and/or modalities are performed on the same day, reimbursement is limited to 8.0 RVUs or the amount billed, whichever is less.

Additionally, these services are governed by a conversion rate of 8.45 for medical physicians, 7.70 for physical and occupational therapists who are self-employed, and 5.78 for chiropractors and licensed acupuncturists.

I have stated in the past I believe that if a treating physical therapist and chiropractor both bill for the CPT modalities that can be performed by either a licensed physical therapist or chiropractor on the same date, the carrier is not required to pay both bills and the limitation of a combined eight RVU applies.

As noted by Arbitrator Glen Wiener in *Goodheart Chiropractic, PC v Geico Insurance Co.*, AAA Legacy 412013101975 (February 20, 2014), in discussing whether there is a

limitation to eight units based on specialist or CPT modalities, "…I respectfully decline to follow the holding of District Court Judge Hackeling who held only each provider is limited to reimbursement of 8 units per day. *See* Doctor of Medicine in the House v. Allstate Ins. Co., 41 Misc. 3d 983, 975 N.Y.S.2d 591 (3D District Ct. Suffolk Co Sept. 30, 2013). Judge Hackeling's holding is a misinterpretation of Ground Rule 11 which clearly limits reimbursement to all providers performing physical medicine services on the same day. To hold otherwise would allow an acupuncturist, chiropractor, medical doctor, and massage therapist to bill for and receive reimbursement for a plethora of physical medicine treatments conducted on one individual on a single day (and many times out of the same location-as herein)."

I agree with Arbitrator Wiener's analysis. If a provider can render a licensed service but chooses not to then the 8-unit limitation will apply. Therefore, the modalities listed above, which can be performed by either a physical therapist or chiropractor are subject to the 8-unit limitation.

Notwithstanding this point, it is further worth mentioning this limitation would not apply when a treating provider is unable to perform the services rendered by another provider based upon licensing restrictions. Therefore, when a treating practitioner is not licensed to provide a specific physical medicine modality (such as chiropractic manipulation or acupuncture), and another healthcare practitioner then provides this service the "8-Unit Rule" should not be imposed to bar recovery. An injured individual should never be precluded from receiving subsequent non-traditional treatment such as chiropractic manipulation or acupuncture when the initial provider was neither licensed nor skilled in this service.

I am guided by a recent email, dated 1/30/2018, from Heather MacMaster, Deputy General Counsel, NYS Workers' Compensation Board to Chris Maloney of the Department of Financial Services, Ms. MacMaster stated that: "The 8 RVU limitation is per patient per day regardless of how many body parts are treated or how many practitioners treat. The only exception is with chiro and PT. If a chiro renders manipulation only (98940-98943) and does not bill any of the other physical medicine codes, the injured worker could receive chiro and PT on the same day. This scenario is usually performed by a chiro who is affiliated with the Chiropractic Council. They only perform manipulation. The physical medicine codes that are impacted by the 8 RVU limitation are in the chiro physical medicine fee schedule but the codes for spinal manipulation are not in the general physical medicine fee schedule."

Although Ms. MacMaster's advisory may not be an official position, nonetheless, I am guided by Ms. MacMaster's email and defer to the Workers' Compensation Board. I find that the WCB interpretation is entitled to deference. *See* Matter of 427 W. 51st St. Owners Corp. v. Division of Hous. & Community Renewal, 3 N.Y.3d 337, 342 (2004) ("[T]he interpretation given to a regulation by the agency which promulgated it and is responsible for its administration is entitled to deference if that interpretation is not irrational or unreasonable.").

I note that I do not apply payments made for code 98940-98943 towards the 8.0 unit maximum contained in Ground Rule 11 of the Physical Medicine Section of the New York State Workers' Compensation Medical Fee Schedule.

As my colleague, Arbitrator Antonietta Russo, in AAA Case Number 17-16-1039-3636 stated:

Eight units are eight units unless treatment is rendered by a medical doctor/physical therapist/occupational therapist and chiropractor on the same day. In that circumstance, the chiropractor may be reimbursed a maximum of 8 units of spinal manipulation (CPT codes 98940-98943) even when a medical doctor/physical therapist/occupational therapist has already been reimbursed 8 units.

Respondent denied the bills for five dates of service from 8/2/2017 through 8/17/2017, stating: "On the dates of service billed, only 0 RVU's of physical medicine procedures are available for reimbursement, as 8 RVU's have already been reimbursed to an Acupuncturist. In addition to the foregoing reason for denial, the amount charged and sought to be reimbursed exceeds the amount permitted under the applicable Workers' Compensation Fee schedule and is not reimbursable as billed." Respondent provides copies of EOBs and cancelled checks indicating that payment was issued to an acupuncturist for the same dates of service for CPT codes 97810, 97811, and 97799. These codes are not included in Ground Rule 11 of the Physical Medicine Section of the Medicine Fee Schedule or Ground Rule 3 of the Physical Medicine Section of the Chiropractic Fee Schedule and the 8-unit rule should not be imposed. Therefore, Applicant is entitled to be reimbursed in the amended amount of $202.87 for dates of service 8/2/2017 through 8/17/2017.

For the bill for 3 dates of service from 8/21/2017 through 8/28/2017, Applicant billed $46.24 for each date of service; $34.68 for CPT code 98941 and $11.56 for CPT code 97139. Respondent paid CPT code 98941 in full and $2.02 for CPT code 97139. Respondent denied the remainder and stated "On the dates of service billed, only .35 RVU's of physical medicine procedures are available for reimbursement, as 7.65 RVU's have already been reimbursed to a Physical Therapist. In addition to the foregoing reason for denial, the amount charged and sought to be reimbursed exceeds the amount permitted under the applicable Workers' Compensation Fee schedule and is not reimbursable as billed." Respondent provides copies of EOBs and cancelled checks indicating that payment was issued for each of the 3 dates of service in the amount of $58.90 (7.65 units) to a physical therapist for CPT codes 97010, 97124, and 97014. Therefore, 0.35 units were available for each date of service, which Respondent paid Applicant in the amount of $2.02 (0.35 X 5.78). As Respondent paid a total of 8 units to Applicant and a physical therapist for each of the 3 dates of service from 8/21/2017 through 8/28/2017, no additional reimbursement is warranted, and Applicant's claim is denied.

Applicant's claim for dates of service 8/2/2017 through 8/28/2017 is granted in the reduced amount of $202.87.

Dates of service 8/31/2017 through 9/12/2017

IME CUTOFF

Legal Standards for Determining Medical Necessity

Once applicant has established a prima facie case, the burden then shifts to respondent to establish a lack of medical necessity with respect to the benefits sought. *See*, Citywide Social Work & Psychological Services, PLLC v. Allstate Ins. Co., 8 Misc3d 1025A (2005). A denial premised on lack of medical necessity must be supported by competent evidence such as an IME, peer review or other proof which sets forth a factual basis and medical rational for denying the claim. *See*, Healing Hands Chiropractic, P.C. v. Nationwide Assur. Co., 5 Misc3d 975 (2004).

In evaluating the medical necessity of services with proof of each party, particularly where the conclusion is contradictory; consideration must be given to the evidentiary burdens. Respondent must prove first that the services were not medically necessary. The issue of whether treatment is medically unnecessary cannot be resolved without resort to meaningful medical assessment. Kingsborough Jewish Med. Ctr. v. All State Ins. Co., 61 A.D. 3d. 13 (2d. Dep't, 2009), *See also* Channel Chiropractic PC v. Country Wide Ins. Co., 38 AD 3d. 294 (1st Dep't, 2007). An IME doctor must establish a factual basis and medical rationale for his asserted lack of medical necessity for future health care services. *E.g.*, Ying Eastern Acupuncture, P.C. v. Global Liberty Insurance, 20 Misc.3d 144(A), (App. Term 2d & 11th Dists. Sept. 3, 2008). Where the defendant insurer presents sufficient evidence to establish a defense based on the lack of medical necessity, the burden shifts to the plaintiff which must then present its own evidence of medical necessity. West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co., 13 Misc.3d 4(App. Term 2d & 11th Dists. Sept. 29, 2006). For an applicant to prove that the disputed expense was medically necessary, it must meaningfully refer to, or rebut, respondent's evidence. *See*, Yklik, Inc. v. Geico Ins. Co., 28 Misc3d 133A (2010). The case law is clear that a provider must rebut the conclusions and determinations of the IME doctor with his own facts. Moreover, the Appellate Term, 2d, 11th & 13th Dists., stated: "Assuming the insurer is successful in satisfying its burden, it is ultimately plaintiff who must prove, by a preponderance of the evidence, that the services or supplies were medically necessary." Park Slope Medical and Surgical Supply, Inc. v. Travelers Ins. Co., 37 Misc.3d 19, 22 (App. Term 2d, 11th & 13th Dists. 2012). Where an IME report provides a factual basis and medical rationale for an opinion that services were not medically necessary, and the claimant fails to present any evidence to refute that showing, the claim should be denied, as the ultimate burden of proof on the issue of medical necessity lies with the claimant. *See* Insurance Law § 5102; AJS Chiropractic, P.C. v. Mercury Ins. Co., 22 Misc.3d 133(A), (App. Term 2d & 11th Dist. Feb. 9, 2002); Wagner v. Baird, 208 A.D.2d 1087 (3d Dept. 1994).

Application of Legal Standards

I note the validity of denials based upon negative IME findings have been recognized by several Courts. See e.g. Innovative Chiropractics P.C. v. Mercury Ins. Co., 25 Misc3d 137 (App. Term 2d & 11th Dists. 2009); B.Y. M.D., P.C. v. Progressive Casualty Ins.

Co., 26 Misc3d 125 (App. Term 9th & 10th Dists. 2010). An IME report can be the basis of a termination of benefits if ultimately found to be persuasive. Whether an IME report is persuasive, and meets the carrier's burden is a factual decision, which must be rendered on a case by case basis. Therefore, when, as here, an insurer interposes a timely denial of claim that sets forth a sufficiently detailed factual basis and adequate medical rationale for the claim's rejection, the presumption of medical necessity and causality attached to the applicant's properly completed claim is rebutted and the burden shifts back to the claimant to refute the IME findings and prove the necessity of the disputed services and the causal relationship between the injuries and the accident. See, CPT Med. Servs., P.C. v. New York Cent. Mut. Fire Ins. Co., 18 Misc.3d 87 (App. Term 1st Dept.); A.Khodadadi Radiology, P.C. v. NY Cent. Mut. Fire Ins. Co., 16 Misc. 3d. 131 (A) (App Term 2d Dept.).

In support of its contention that further treatment was not medically necessary Respondent relies upon the chiropractic and acupuncture examination report of Dr. John Iozzio, D.C., which was conducted on 8/2/2017. Chiropractic treatment is in dispute and the chiropractic IME is relevant to the bills at issue. While Dr. Iozzio noted decreased muscle strength and decreased range of motion in the left shoulder, a review of the chiropractic examination report of the cervical, thoracic, lumbar, and hips reveals all tests were objectively negative. Notably, the chiropractor was not treating the Assignor's shoulders. Dr. Iozzio diagnosed resolved cervical, thoracic, lumbar, left hand, and bilateral hips sprain. Based upon Dr. Iozzio's examination, all chiropractic No-fault benefits were denied effective 8/22/2017. The results of the examination presented a cogent medical rationale as to why further benefits were terminated in support of Respondent's defense. Therefore, the burden shifts to the Applicant to establish the services billed were medically necessary.

There is no formal rebuttal to the IME report. Applicant relies on an initial examination from David Hershkowitz, DC, dated 7/31/2017, and chiropractic progress notes from 7/31/2017 through 9/12/2017. Respondent submits the records reviewed by the IME doctor including, but not limited to, emergency room records, an initial chiropractic evaluation and treatment notes from AEL Chiropractic, P.C., dated 5/8/2017 through 6/12/2017, MRI reports of the cervical and lumbar spine, computerized range of motion and manual muscle testing, physical therapy records, and acupuncture records.

In this matter, I am faced with conflicting opinions concerning the medical necessity for the disputed services. There are no legal issues to resolve. This dispute involves solely an issue of fact, that is, whether the services billed was medically necessary. Resolution of that fact is determined by which opinion is accepted by the trier of fact.

Comparing the relevant evidence presented by both parties, and upon consideration of the arguments of counsel, I find that Respondent has submitted sufficient evidence to sustain its burden of demonstrating that the services at issue were not medically necessary. I find respondent's IME report credible. I am persuaded by Dr. Iozzio that further chiropractic treatment was not reasonable or medically necessary. Based on the records submitted by the Respondent, the Assignor commenced chiropractic treatment at AEL Chiropractic, P.C. on 5/8/2017 and received chiropractic treatment at this facility through at least 6/12/2017. Applicant submitted an initial examination, dated 7/31/2017,

conducted nearly three months after the motor vehicle accident, which recommends chiropractic treatment and refers the Assignor for MRIs of the cervical, thoracic, and lumbar spine. The examination is a checkmark handwritten examination that is incomplete as multiple orthopedic tests were not conducted. Furthermore, Dr. Hershkowitz does not obtain a treatment history including what chiropractic treatment the Assignor received between the accident and the date of the initial examination or review any records to assess the Assignor's progress over the previous three months. The Assignor was referred for multiple MRIs at the second initial examination that he had been previously been referred for and received months earlier. Applicant began treating the Assignor without reviewing the results of these MRIs. I note that the patient's VAS pain scale in the cervical spine was an 8/10 and the thoracic and lumbar spine was a 6/10 at the first initial examination on 5/8/2017, while at the second initial examination with Applicant on 7/31/2017, nearly 3 months later, the pain scale in the cervical, thoracic and lumbar spine was a 7/10, showing a lack of improvement. Applicant did not review these records and therefore there is no indication whether the appropriate chiropractic standard of care was utilized in referring for further chiropractic treatment. The weight, credibility, and persuasiveness of the evidence favors Respondent. Applicant's medical records are insufficient to rebut the Respondent's IME objective examination. Therefore, Applicant's claims for dates of service 8/31/2017 through 9/12/2017 ($138.72) are denied.

Applicant's claim is granted in the reduced amount of $202.87. The remainder of the claim is denied. This decision is in full disposition of all claims for No-Fault benefits presently before this arbitrator.

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
	Restorative Chiropractic Solutions, PC	**07/31/17 - 07/31/17**	**$54.74**	**$0.00**	**Withdrawn with prejudice**
	Restorative Chiropractic Solutions, PC	**08/02/17 - 08/07/17**	**$110.39**	**$110.39**	**Awarded: $110.39**
	Restorative Chiropractic Solutions, PC	**08/15/17 - 08/28/17**	**$256.90**	**$121.10**	**Awarded: $92.48**
	Restorative Chiropractic Solutions, PC	**08/31/17 - 09/12/17**	**$138.72**	**$138.72**	**Denied**
Total			**$560.75**		**Awarded: $202.87**

B. The insurer shall also compute and pay the applicant interest set forth below. 02/21/2018 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 denial at issue was timely. LMK Psychological Servs., P.C. v. State Farm Mut. Auto. Ins. Co., 12 N.Y.3d 217 (2009). Based on the regulations, interest shall accrue from the date the applicant requested arbitration in this matter. *See*, 11 NYCRR 65-3.9(c).

C. Attorney's Fees

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

Applicant is entitled to an attorney's fee pursuant to Insurance Law §5106(a). After calculating the sum total of the first-party (No-Fault) benefits awarded in this arbitration plus interest thereon, Respondent shall pay Applicant an attorney's fee equal to 20 percent of that sum total, subject to the following limitations: In the event the above filing date was prior to Feb. 4, 2015, the attorney's fee is subject to a minimum of $60.00 and a maximum of $850.00, per 11 NYCRR 65-4.6(e). In the event the above filing date was on or after Feb. 4, 2015, the attorney's fee is subject to a maximum of $1,360.00, per 11 NYCRR 65-4.6(d). In the event the above filing date was on or after Feb. 4, 2015 and first-party (No-Fault) benefits are awarded to more than one Applicant herein, the attorney's fee shall be calculated separately for each Applicant, each Applicant's attorney fee being subject to the $1,360.00 maximum.

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

01/25/2019
(Dated)

Eileen Hennessy

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:
b3afeecaf42324e5c63aad2dee4c661e

Electronically Signed

Your name: Eileen Hennessy
Signed on: 01/25/2019