American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Avanguard Medical Group, PLLC (Applicant)	AAA Case No.	17-18-1093-9784
- and -	Applicant's File No.	273455, 275605, 278575
	Insurer's Claim File No.	0523919320101040
Geico Insurance Company (Respondent)	NAIC No.	22063

ARBITRATION AWARD

I, Charles Blattberg, 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: Eligible injured person

1. Hearing(s) held on 03/13/2019
   Declared closed by the arbitrator on 04/25/2019

   David Forman, Esq. from Leon Kucherovsky Esq. participated in person for the Applicant

   Christa Varone from Geico Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 1,307.42**, 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 was a 19 year-old female who was involved in a motor vehicle accident on 10/18/15 as a rear seat passenger. Following the accident the claimant suffered injuries which resulted in the claimant seeking treatment. At issue are 12/30/15 bilateral lumbar medial branch blocks and trigger point injections, 1/27/16 bilateral medial branch blocks and trigger point injections and 2/24/16 radio frequency ablation (rhizotomy) of the lumbar facet medial branch and trigger point injections.

4. Findings, Conclusions, and Basis Therefor

THIS HEARING WAS CONDUCTED USING THE ELECTRONIC CASE FOLDER MAINTAINED BY THE AMERICAN ARBITRATION ASSOCIATION. ALL DOCUMENTS CONTAINED IN THAT FOLDER ARE MADE PART OF THE RECORD OF THIS HEARING.

THE ARBITRATOR SHALL BE THE JUDGE OF THE RELEVANCE AND MATERIALITY OF THE EVIDENCE OFFERED.

Based on a review of the documentary evidence, this claim is decided as follows:

An applicant establishes a prima facie case of entitlement to reimbursement of its claim by the submission of a completed NF-3 form or similar document documenting the facts and amounts of the losses sustained and 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. See, *Mary Immaculate Hospital v. Allstate Insurance Company*, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004). I find that Applicant established a prima facie case for reimbursement.

This hearing was held open for Respondent to submit a "peer addendum/re-review by Jason R. Cohen, M.D. and/or Howard Kiernan, M.D., if necessary." Respondent made a post hearing submission of a peer addendum by Dr. Cohen.

The claimant was a 19 year-old female who was involved in a motor vehicle accident on 10/18/15 as a rear seat passenger. There are no medical reports in evidence for the period 10/18/15-12/29/15; except for an 11/10/15 lumbar spine MRI report addressed to Pierre Jean Renelique, M.D. by David R. Payne, M.D. of Southwest Radiology documenting an impression of bulging disc at L3/4 without stenosis and bulging disc at L4/5 without stenosis. On 12/30/15 the claimant presented to Mark Gladstein, M.D. of Metropolitan Medical and Surgical, P.C. with complaints of non-radiating lower back pain rated 8/10. Examination of the lumbar spine revealed pain on lumbar flexion and extension, tender trigger points in the lumbar and gluteal regions bilaterally and positive Facet Loading test bilaterally. The diagnostic impression was lumbar facet syndrome and trigger points/fibromyositis. The patient was recommended bilateral lumbar medial branch blocks for diagnostic purposes and Dr. Gladstein of Avanguard Medical Group, PLLC (Applicant) performed bilateral lumbar medial branch blocks and trigger point injections. On 1/27/16 the claimant returned to Dr. Gladstein for follow-up. The complaints and examination results were substantially similar to 12/30/15 and Dr. Gladstein performed bilateral lumbar medial branch blocks and trigger point injections. On 2/24/16 Dr. Gladstein performed bilateral radio frequency ablation (rhizotomy) of the lumbar facet medial branch and trigger point injections. At issue are the 12/30/15 bilateral lumbar medial branch blocks and trigger point injections, 1/27/16 bilateral medial branch blocks and trigger point injections and the 2/24/16 radio frequency ablation (rhizotomy) of the lumbar facet medial branch and trigger point injections.

DOS 12/30/15

As to date of service (DOS) 12/30/15 Respondent timely reimbursed $357.10 leaving an unpaid balance of $59.55. Respondent submitted an Empire Stat fee audit as to this DOS. The only code in dispute is CPT code 20553. CPT code 20553 is assigned an RV of .52, which when multiplied by $229.04 (Region IV CV) is $119.10. Pursuant to Surgery Ground Rule 5, with limited exceptions not applicable here, multiple procedures are reimbursed at 50% so CPT code 20553 was properly reimbursed at $59.55, as the fee audit recommends.

DOS 1/27/16 and 2/24/16

As to these bills the burden has shifted to the Respondent as they have raised a medical necessity defense. 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. 20140. Respondent bears the burden of production in support of its lack of medical necessity defense, which if established shifts the burden of persuasion to Applicant. See generally, *Bronx Expert Radiology, P.C. v. Travelers Ins. Co.*, 2006 NY Slip Op. 52116 (App. Term 1st Dept. 2006). As a general rule, reliance on rebuttal documentation will be weighed in light of the documentary proofs and the arguments presented at the arbitration. Moreover, the case law is clear that a provider must rebut the conclusions and determinations of the IME/peer doctor with his own facts. *Park Slope Medical and Surgical Supply, Inc. v. Travelers*, 37 Misc.3d 19 (2012).

Respondent timely denied the 1/27/16 bilateral medial branch blocks and trigger point injections based on the 4/2/16 peer review by Howard A. Kiernan, M.D. After reviewing the claimant's history, treatment, and medical records, Dr. Kiernan opines "these three-level injections were not medically necessary. I quote Orthopedic Knowledge Update, Volume 8, Page 133. Epidural steroid injections, sacroiliac joint injections, zygapophyseal facet joint injections (and that is what this was), discography, and vertebral augmentation are image-guided procedures that are important components of a comprehensive management approach to spine pain syndromes for establishing a diagnosis, directing or administering therapy, and facilitating rehabilitation and functional restoration; and these were three levels that were injected, and this did not help identify the pain generators because of the multiple levels that were injected. These procedures are supposed to contribute to patient management and surgical planning by determining the sources of pain, including the pain generators, and this procedure did not identify the pain generators. The only documentation of the effect of this procedure was that the patient felt better, but this did not in any way help identify the pain generators, and, therefore, did not help in establishing a diagnosis or directing or administering therapy, and should be disallowed."

Respondent timely denied the 2/24/16 radio frequency ablation (rhizotomy) of the lumbar facet medial branch and trigger point injections based on the 5/3/16 peer review by Jason R. Cohen, M.D. Citations have been omitted in consideration of space and readability. After reviewing the claimant's history, treatment, and medical records, Dr. Cohen opines "based upon the medical records presented for independent review

including follow-up reevaluation by Dr. Gladstein as well as the lack of facet joint pathology identified on radiological studies of the lumbosacral spine, there is no indication for the radiofrequency rhizotomy and trigger point injections performed on 02/24/16. "Trigger-point injection is indicated for patients who have symptomatic active trigger points that produce a twitch response to pressure and create a pattern of referred pain" [*Citation omitted*]. "The decision to treat trigger points by manual methods or by injection depends strongly on the training and skill of the physician as well as the nature of the trigger point itself. For trigger points in the acute stage of formation (before additional pathologic changes develop), effective treatment may be delivered through physical therapy. Furthermore, manual methods are indicated for patients who have an extreme fear of needles or when the trigger point is in the middle of a muscle belly not easily accessible by injection" [*Citation omitted*]. There is no documentation of twitch response or referred pain pattern on palpation of identified trigger points. "There is so far no strong evidence for the effectiveness of trigger point injections, and many physicians consider trigger point injections a little more than, if not equivalent to, placebo effects" [*Citation omitted*]. There is no proven utility to trigger point injections. "Orthoses, transcutaneous electrical nerve stimulation, electromyographic biofeedback, traction, acupuncture, magnet therapy, injections into trigger points, and hydrotherapy are no more effective than sham therapy" [*Citation omitted*]. There is no proven efficacy to trigger point injections." Dr. Cohen continues "the primary indication is to confirm a clinical suspicion of the facet syndrome. Clinical signs include local paraspinal tenderness; pain that is brought about or increased on hyperextension, rotation, and lateral bending; absence of neurologic deficit; absence of root tension signs; and hip, buttock, or back pain when the straight leg is raised. Symptoms of facet syndrome also include cramping leg pain involving the thigh but not radiating below the knee, low back stiffness, and absence of paresthesia. The back stiffness is typically most marked in the morning. Low back pain is brought about or increased by maintenance of certain positions, such as sitting erect for a long period of time. Focal tenderness over a facet joint is a strong indication in the appropriate settings, besides the presence of signs of paravertebral spasm or deformity in patients, with abnormal facet joints on imaging studies. **Cervical** facet pain is often characterized by chronic headaches, restricted motion and axial neck pain, which may radiate sub-occipitally to the shoulders or mid-back" [*Citation omitted*]. There are no abnormal facet joints identified throughout the lumbar spine on lumbar MRI." Dr. Cohen concludes "pain radiating to the buttock or trochanteric region occurred mostly from the L4 and L5 levels, while groin pain was produced from L2 to L5" [*Citation omitted*]. "Distribution of pain provoked from lumbar facet joints and related structures during diagnostic spinal infiltration" [*Citation omitted*]. There is no documentation of lumbar pain radiating towards the hips and buttock region with associated lumbar facet pain from the L4 and L5 levels. "Intermittent or continuous pain with average pain levels of >/= 6 on a scale of 0 to 10 or functional disability AND duration of pain of at least 2 months AND failure to respond to conservative non-operative therapy management. The indications for medical branch nerve blocks are meant to confirm disabling non-radicular low back (lumbosacral) or neck (cervical) pain, suggestive of facet joint origin as documented in the medical record based upon history, consisting of mainly axial or non-radicular pain, and physical examination, with positive provocative signs of facet disease (pain exacerbated by extension and rotation, or associated with lumbar rigidity)" [*Citation omitted*]. There is no documentation of positive provocative signs of lumbar facet

disease with pain exacerbation on extension and rotational maneuvers. "Indications for Facet Joint Denervation (RADIOFREQUENCY NEUROLYSIS) include: Positive response to controlled local anesthetic blocks of the facet joint, with at least 50% pain relief and ability to perform prior painful movements without significant pain but with insufficient sustained relief (less than 2-3 months relief) OR Positive response to prior radiofrequency neurolysis procedures with at least 50% pain improvement for up to 6 months of relief in past 12 months; AND The presence of the following: Lack of evidence that the primary source of pain being treated is from discogenic pain, sacroiliac joint pain, disc herniation or radiculitis; Intermittent or continuous facet-mediated pain [average pain levels of > 6 on a scale of 0 to 10 causing functional disability; Duration of pain of at least 3 months; AND Failure to respond to more conservative non-operative management" [*Citation omitted*]. There is no documentation by Dr. Gladstein on follow-up reevaluation of a positive response to prior lumbar medial branch blocks performed on 12/30/15 and 01/27/16 of at least 50% pain relief with ability to perform prior painful movements. Medical necessity for lumbar facet radiofrequency rhizotomy has not been established."

Applicant submitted a 1/25/19 peer rebuttal by Mark Gladstein, M.D. After reviewing the claimant's history, treatment, and medical records, Dr. Gladstein asserts "Dr. Cohen argued that there is no documentation of twitch response or referred pain pattern on palpation of identified trigger points. However, as evident from the medical record, the patient had persistent nonradiating lower back pain, decreased range of motion and positive tender trigger and was diagnosed with trigger points/fibromyositis. All these findings were sufficient to perform the trigger point injections. [*The claimant*] had myofascial pain for which the trigger point injections were given appropriately. Trigger point injection (TPI) is currently used to treat a wide variety of pain syndromes and other painful conditions. A common application for TPI is treatment of myofascial pain syndrome, a chronic musculoskeletal pain condition in which painful trigger points develop within muscle and fascia, resulting in local and referred pain, restricted range of motion, and autonomic nervous system dysfunction. A number of studies suggest that TPIs may improve quality of life in patients who experience pain as a result of myofascial pain syndrome. For example, a study in 91 patients with myofascial pain in different locations reported pain relief in 93.3% of the patients following ultrasound-guided TPI without medications [*Citations omitted*]. The use of trigger point "dry" needling under ultrasound guidance for the treatment of myofascial pain [*Citation omitted*]. Comparison of high-power pain threshold ultrasound therapy with local injection in the treatment of active myofascial trigger points of the **upper trapezius** muscle [*Citation omitted*]. As evident from the patient's medical records; the evaluation noted pain, restricted range of motion, tender trigger points and tenderness of facet joints upon palpation. These symptoms failed to respond to conservative treatment for more than three months. Hence, the patient was administered trigger point injections as a course of treatment. Dr. Cohen stated that there is no proven efficacy to trigger point injections. However, this is not true. There is ample evidence to suggest that TPI can be effective as a treatment of chronic pain and bodies such as the American College of Occupational and Environmental Medicine recommend the use of Trigger point injections using local anesthetic as an option for treating trigger points that are not resolving [*Citation omitted*]. TPI is generally considered a medical necessity in several scenarios including where: Trigger points have been identified by physical examination

and palpation; and Symptoms have persisted for a significant period of time; and Medical management therapies such as bed rest, exercises, physical therapy, nonsteroidal anti-inflammatory medications (unless contraindicated) and muscle relaxants have failed to control pain" [*Citation omitted*]. Dr. Gladstein continues "Dr. Cohen stated that there are no abnormal facet joints identified throughout the lumbar spine on lumbar MRI. It should be noted that the decision of lumbar rhizotomy was not solely based on the reviews of the MRI report; it was also based on the positive clinical findings throughout the physical examination of the patient. The patient had a combination of subjective complaints and positive clinical findings, which demonstrated the need for the lumbar rhizotomy. Further, the decision of performing the lumbar rhizotomy was taken as the patient was noted to have two positive lumbar blocks. [*The claimant*] complained of symptoms that were suggestive of facet involvement with lumbar muscle spasm in non-dermatomal radiculopathy and her pain exacerbated with bilateral rotation, extension and lateral flexion. Facet related pain is mostly over the axial spine itself and mostly directed over the region of the affected joints. Its most important feature is that the pain is in axial spine and less so in the extremities. Often patients with facet related pain have unremarkable imaging [*Citation omitted*]. In this case, the patient's examination indeed revealed various positive findings suggestive of pain being in facet origin. She had complaints of worse nonradiating lower back pain along with pain on lumbar flexion and extension, tender trigger points in the lumbar and gluteal regions bilaterally and positive Facet Loading test bilaterally. All these findings of the patient certainly indicated lumbar facet disease which was positive to two prior medial branch blocks indicating future radiofrequency rhizotomy. Lastly, Dr. Cohen argued that there is no documentation of positive response to prior lumbar medial branch blocks performed on 12/30/2015 and 1/27/2016 of at least 50% pain relief with ability to perform prior painful movements. It seems Dr. Cohen has not reviewed the patient's medical records carefully. [*The claimant*] indeed had 100% pain relief with the prior medial branch blocks, therefore, was preceded with lumbar radiofrequency rhizotomy. Radiofrequency Rhizotomy is a minimally invasive procedure used to treat pain by sending radio waves through a needle to the selected medial branch nerves causing pain in order to interrupt the pain signals. Radiofrequency Rhizotomy is indicated if a diagnostic procedure called medial branch block is successful in confirming the patient's back pain is originating from the facet joints. If the pain is relieved after the medial branch block, this indicates that the origin of the pain is the medial branch nerves that were numbed. Treating physician may then recommend a radiofrequency ablation or a rhizotomy to relieve the pain for a longer period of time. With the radiofrequency technique, the nerves regenerate over time and the pain returns after a few months. With the endoscopic technique, a section is cut from the nerve, preventing the nerve from being able to regenerate. The advantages of the Endoscopic Rhizotomy include short recovery time and minimal scarring in addition to it being a minimally invasive procedure. Many other advantages of this procedure include high success rates, none or minimal blood loss, and maintained spinal ability. The use of the endoscopic view can reduce radiation exposure from other real time imaging techniques such as X-Ray or CT scans." Dr. Gladstein concludes "forty-eight of the 50 from the initial pilot study was used to provide information for the design of an IRB approved cohort to more robustly determine patient inclusion criteria positive response would likely include the effect of medial branch blocks with and without steroid. 10 percent (5/50) of the pilot study partially regressed at one year follow-up, but none were worse. None requested, nor

received repeat rhizotomy the first year. Pre- and post-op VAS score decreased from 6.2 to 2.5 and Oswestry scores decreased from 48 to 28. No patient was worse. Duration of pain relief lasted over one year in the two year follow up period with ablation of more nerves in the vicinity of the transverse process lateral to the mammillary body. All were satisfied with their decision to have the rhizotomy even if some of the initial relief began to fade. Modified MacNab criteria was determined by the follow-up surgeon, into good, excellent or poor at the last visit prior to discharge, based the patient volunteering their satisfaction that they would return if their back recurred. [*The claimant*] was completely asymptomatic regarding her lower back prior to the MVA. After the traumatic injuries, she sustained severe lower back pain. Despite receiving all this conservative care, her complaints of pain persisted. She also received two LMBB for her facetogenic pain with reported 100% relief in her lower back pain. I, therefore, recommended her lumbar rhizotomy procedure as per the standards of care. I believe each and every piece of information is strongly evident that the treatment given to the patient was appropriate and medically warranted. The patient had a combination of subjective complaints and positive clinical findings which demonstrated the high likelihood of the diagnosis necessitating the need for the procedure. The treating physician who is responsible for the care and treatment of the patient is in the best position to determine the need for continued treatment. The peer reviewer, on the other hand, who was retained by the insurance carrier, has no responsibility for the patient's best interests."

Respondent submitted a 3/19/19 peer addendum by Jason R. Cohen, M.D. After reviewing the claimant's history, treatment, and medical records, Dr. Cohen asserts "this dictation serves as addendum to prior peer report 5/3/16 regarding lumbar radiofrequency ablation and trigger point injections performed 2/24/16. I am in receipt of an appeal letter forwarded by Dr. Gladstein on 1/25/19 stating the history, symptomatology, and physical examination I acknowledge in my peer report 5/3/16. Additionally, Dr. Gladstein references Am J Phys Med Rehabilitation, Archive Phy Med Rehabilitation, American College of Occupational and Environmental Medicine 2008." Dr. Cohen opines "however, Dr. Gladstein fails to adequately address and resolve the lack of any active trigger points with reproducible twitch response or referred pain pattern identified on palpation examination. Dr. Gladstein fails to produce evidence from randomized- controlled trials surrounding efficacy of trigger point injections. Dr. Gladstein fails to produce evidence on imaging studies of any facet joint pathology in the lumbosacral spine. Furthermore, Dr. Gladstein fails to produce evidence on examination of positive provocative signs of lumbar facet disease with pain exacerbation upon extension and rotational maneuvers only. Finally, there is no resolution by Dr. Gladstein of any documented 50% relief status post multiple prior lumbar medial branch blocks 12/30/15 and 1/27/16 prior to radiofrequency ablation."

As to 1/27/16 bilateral medial branch blocks and trigger point injections I find Dr. Kiernan's peer review to be scant in analysis, as it does not discuss claimant-specific examination findings or diagnoses. I am not persuaded by Dr. Kiernan's arguments or find that he sufficiently set forth a foundational standard of care or demonstrated that the services deviated from a proffered standard of care. It is the peer reviewer's burden to persuasively establish a standard of care, supported by credible sources and correlate

such standard to the facts at hand to conclude whether or not there was a deviation. I do not find that Dr. Kiernan meets this burden therefore the burden did not shift to Applicant. Accordingly, I find in favor of the Applicant and award this claim.

As to 2/24/16 radio frequency ablation (rhizotomy) of the lumbar facet medial branch and trigger point injections I find that Dr. Cohen's peer review is sufficient to meet Respondent's burden of proof of lack of medical necessity. The burden therefore shifts back to Applicant to present competent medical proof as to the medical necessity for the injections and related services at issue by a preponderance of the credible evidence. *West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co.*, 13 Misc.3d 131(A), 2006 N.Y. Slip Op. 51871(U) at 2 (App. Term 2d & 11th Dists. Sept. 29, 2006). *A. Khodadadi Radiology, P.C. v. N.Y. Central Fire Mutual Insurance Company*, 16 Misc. 3d 131[A], 841 N.Y.S.2d 824, 2007 WL 1989432 (App. Term 2d & 11th Dists. 7/3/08). Ultimately, the burden of proof rests with the applicant (See Insurance Law Section 5102). I find that Applicant satisfied its burden of rebutting the peer reviewer's assertions. The rebuttal by Dr. Gladstein, the treating doctor, meaningfully refers to and rebuts the conclusions set forth in the peer review. *High Quality Medical, P.C. v. Mercury Ins. Co.*, 26 Misc.3d 145(A), 2010 N.Y. Slip Op. 50447(U) (Sup. Ct. App. Term 2d Dep't 2010). Dr. Cohen's addendum does not sufficiently address Dr. Gladstein's arguments. Accordingly, I find in favor of the Applicant and award this claim.

Respondent also argues that Applicant excessively billed for the services performed on 1/27/16 and 2/24/16. Respondent submitted the fee audits of TechSource, in support of its argument that the proper total amount for these services is $580.61. I find the Respondent's argument and proof to be persuasive and sufficient to sustain the Respondent's fee schedule defense which is unrebutted. Therefore, I find that Respondent has sustained its defense that the proper amount for these services is $580.61.

Accordingly, Applicant is awarded $580.61.

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**
	Avanguard Medical Group, PLLC	**12/30/15 - 12/30/15**	**$59.55**	**Denied**
	Avanguard Medical Group, PLLC	**01/27/16 - 01/27/16**	**$416.65**	**Awarded: $332.10**
	Avanguard Medical Group, PLLC	**02/24/16 - 02/24/16**	**$831.22**	**Awarded: $248.51**
Total			**$1,307.42**	**Awarded: $580.61**

B. The insurer shall also compute and pay the applicant interest set forth below. 05/04/2018 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest runs from 5/4/18 (the date that arbitration was requested) until the date that payment is made at two percent per month, simple interest, on a pro rata basis using a thirty day month.

C. Attorney's Fees

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

Pursuant to 11 NYCRR §65-4.6 (d), ". . . the attorney's fee shall be limited as follows: 20 percent of the total amount of first-party benefits and any additional first-party benefits, plus interest thereon for each applicant for arbitration or court proceeding, subject to a maximum fee of $1,360."

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

06/04/2019
(Dated)

Charles Blattberg

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:
599c71b22d401738e5bfaaca42695be2

Electronically Signed

Your name: Charles Blattberg
Signed on: 06/04/2019