American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Community Medical Imaging P.C. (Applicant)	AAA Case No.	17-18-1088-8091
	Applicant's File No.	102513
- and -	Insurer's Claim File No.	0468635289 2CL
Allstate Fire & Casualty Insurance Company (Respondent)	NAIC No.	29688

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 01/10/2020
   Declared closed by the arbitrator on 01/13/2020

   Naomi Cohn, Esq. from of counsel to Ursulova Law Offices P.C. participated by telephone for the Applicant

   Steven Miranda, Esq. from Law Offices Of Karen L Lawrence participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 1,791.73**, 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 the 42 year-old female driver of a motor vehicle that was involved in an accident on 7/25/17. Following the accident the claimant sought treatment. At issue is the medical necessity of an 8/16/17 cervical spine MRI and an 8/28/17 lumbar spine MRI performed by Applicant that Respondent timely denied reimbursement for based on the 10/18/17 peer review by Isandr Dumesh, M.D.

4. Findings, Conclusions, and Basis Therefor

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.

The claimant was the 42 year-old female driver of a motor vehicle that was involved in an accident on 7/25/17. The claimant reportedly injured her neck, right shoulder, upper back, lower back, and right knee. There was no reported loss of consciousness. There were no reported lacerations or fractures. Following the accident the claimant was transported to Elmhurst Hospital where she was evaluated, treated, and released. On 7/28/17 the claimant presented to Anatoliy Abakin, D.C. of ABA Chiropractic, P.C. with complaints of neck and lumbosacral pain and stiffness radiating to buttocks, sacrum, coccyx, leg, and thigh along with tingling in the right leg. Examination of the cervical spine revealed decreased range of motion in all planes due to pain (quantified), muscle spasm, tenderness, spinal intersegmental restrictions/dysfunctions-instability at C1, C5-C6, and C7-T1. Positive orthopedic tests were Cervical Foraminal Compression, Soto-Hall, Shoulder Depression, Bakody Sing, and Cervical Distraction. Examination of the lumbar spine revealed decreased range of motion in all planes due to pain (quantified), decreased lumbar lordosis, muscle spasm, tenderness, spinal intersegmental restrictions/dysfunctions-instability at L4-L5-S1 and right coccyx and positive Straight Leg Raising test, Braggard's test, Adam's test, Kemp's test, Bilateral Leg Raise test and Yeoman's test. The claimant was initiated on chiropractic treatment. On 7/28/17 the claimant presented to UGP Acupuncture, P.C. and was initiated on acupuncture and cupping. On 7/28/17 the claimant presented to Elmont Rehab PT, P.C. and was initiated on physical therapy. On 7/31/17 the claimant presented to James R. Avellini, M.D. of Corona Medical Plaza, P.C. with complaints of radiating neck pain, back pain, right knee pain, and right ankle pain. Examination of the cervical spine revealed tenderness to palpation at trapezius, positive Cervical Compression test and decreased range of motion in all planes (quantified) due to pain. Examination of the lumbar spine revealed tenderness to palpation and decreased range of motion in all planes (quantified) due to pain. Examination of the right knee revealed tenderness to palpation, decreased range of motion and positive McMurray's sign. **No deficits in muscle strength, sensation, or deep tendon reflexes were documented.** Dr. Avellini supervised Outcome Assessment Testing and the claimant was recommended for physical therapy, MRIs (cervical spine, lumbar spine, and right knee), physical capacity testing; and was prescribed a 5% lidocaine ointment and Mobic 7.5 mg. On 8/2/17 the claimant underwent computerized range of motion and manual muscle testing that suggested 24% cervical spine impairment, 0% thoracic spine impairment, 28% lumbar spine impairment, 45% whole spine impairment, and a 12% lower right extremity impairment. On 8/2/17 Dr. Abakin prescribed a custom fitted lumbosacral orthosis (LSO) with sagittal coronal control. The 8/9/17 right knee MRI ordered by Dr. Avellini and interpreted by Andrew McDonnell,

M.D. of Applicant's office produced an impression of an interstitial tear of the ACL is seen, disorganization of the fibers is noted without evidence of attenuation or laxity and the PCL is unremarkable; there is a prominent soft tissue contusion overlying the patellar tendon and tibial tuberosity; and there is a joint effusion without evidence of a loose body. The 8/16/17 cervical spine MRI ordered by Dr. Avellini and interpreted by Andrew McDonnell, M.D. of Applicant's office produced an impression of midline and paramedian herniation at the C5-C6 level which is greater at the right paramedian with prominent partial effacement of the anterior subarachnoid space, disc bulges are seen prominently at the C4-C5 and C5-C6 disc levels, and straightening of the mid and upper cervical lordosis consistent with severe muscular spasm. The 8/28/17 lumbar spine MRI ordered by Dr. Avellini and interpreted by Andrew McDonnell, M.D. of Applicant's office produced an impression of prominent straightening of the lumbar lordosis consistent with severe spasm, a protrusion is noted at the midline at the L5-S1 disc level, a focal stress reaction is suspected posteriorly at the right pedicle of L5 but no fracture is seen, and disc bulges are seen at the L3-L4, L4-L5 and L5-S1 levels. At issue are the 8/16/17 cervical spine MRI and the 8/28/17 lumbar spine MRI.

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).

An insurance carrier can assert its lack of medical necessity defense against a radiologist who is deemed as an assignee of the injured party. See *Long Island Radiology v. Allstate Ins. Co.*, 36 AD3d 763,765 (App Div, 2d Dept 2007) (where plaintiff-radiologist argued that defendant-insurer improperly denied a claim based on lack of medical necessity because radiologists performing MRIs upon prescription do not assess medical necessity, and thus such defense is not applicable; the court held that the defense applied to radiologists because radiologists accept assignments of no-fault benefits).

The medical necessity of a diagnostic test must be proven to justify payment for it. The patient must make subjective complaints consistent with the information sought by the testing. Physical examination must demonstrate measurable objective findings of abnormalities of the same body part or system. The medical provider must state the purpose of the diagnostic test clearly before the test is done. The results sought by the test must be of the type that would be considered when evaluating further treatment of the patient and must actually be considered.

Respondent timely denied the subject imaging studies based on the 10/18/17 peer review by Isandr Dumesh, M.D. After reviewing the claimant's history, treatment, and medical records, Dr. Dumesh asserts the claimant "sustained sprain/strain injuries to the spine, right knee and right ankle in the above motor vehicle accident. The standard of care for similar injuries would be physical therapy and rehabilitation treatments for a period of three to four months, possibly supplemented by NSAID medications and muscle relaxers. A diagnostic test, such as a spinal MRI, would be necessary if it potentially enhances the treatment or assists with future diagnostic and treatment-related decisions. In regards to the MRIs of the Cervical and Lumbar Spine, the following should be noted. In general, a spinal MRI could be considered in cases of persistent pain in the cervical and/or lumbar spine area present for a period of one month or longer, despite a standard conservative therapy regimen (such as physical therapy, NSAID medication, and/or chiropractic treatments), and especially when any alternative therapy approach, such as neurosurgical intervention, is being considered. As per the article: "Appropriate Use of MRI for Evaluating Common Musculoskeletal Conditions" by Donald C. Pompan, MD, FAAOS, Salinas, California. Am Fam Physician. 2011 Apr 15;83(8):883-884. "The use of magnetic resonance imaging (MRI) has become routine in the evaluation of musculoskeletal conditions. Originally, MRI was used mainly as a preoperative planning tool for patients thought to have surgical pathology based on history and physical examination. In recent years, however, MRI often has been used solely to establish a diagnosis, in many cases before any conservative treatment has been instituted. This practice raises the following questions: Is MRI overused in patients with musculoskeletal conditions? What are the indications for MRI? For most patients with neck, back, knee, or shoulder pain, a diagnosis can be made with a history, physical examination, and plain film radiography; surgery is not indicated. Neck and back pain have many causes, but the majority of patients will improve with conservative management....The treatment for these common conditions- which usually involves muscle strengthening and stretching, and possibly physical therapy-would not be dependent on MRI results. Most patients will improve within a few weeks or months. MRI often identifies pathology that may have no relationship to a patient's symptoms. Approximately 30 to 40 percent of asymptomatic young and middle-aged patients have changes in the intervertebral disks, such as a protrusion or desiccation, and these structural abnormalities increase with aging...MRI may provide information that is confusing to the patient and physician, and does not necessarily identify the source of pain. The patient may be referred to an orthopedist with the expectation of being "fixed" quickly, even though the problem may have been treated successfully without surgery. In these cases, the patient becomes more of a passive bystander, rather than actively participating in a stretching-strengthening program. A surgeon may be willing to perform surgery to satisfy the patient and referring physician, although the procedure may not be curative. The patient may be exposed to unnecessary risks, and the cost of care is increased. The indications for and timing of MRI will depend on whether the problem is emergent, acute, or chronic. Musculoskeletal emergencies that require an immediate MRI are limited primarily to spinal conditions such as suspected cauda equina syndrome and infection. There are certain acute neck, back, shoulder, and knee conditions for which MRI should be considered after four to six weeks of conservative care if the findings could alter treatment. In patients who have neck and back pain with persistent radiculopathy or those who have loss of balance and gait problems indicative

of cervical myelopathy, MRI can detect disk herniations or spinal stenosis that may benefit from more aggressive treatment." Dr. Dumesh continues "as per Worker's Compensation Board New York Neck Injury Medical Treatment Guidelines, Third Edition, September 15, 2014, page 3 "Clinical information obtained by history taking and physical examination should be the basis for selection and interpretation of imaging procedure results. All diagnostic procedures have variable specificity and sensitivity for various diagnoses." As per Worker's Compensation Board New York Neck Injury Medical Treatment Guidelines, Third Edition, September 15, 2014, page 13 "Certain findings, "red flags," raise suspicion of potentially serious and urgent medical conditions. Assessment (history and physical examination) should include evaluation for red flags. In the cervical spine these findings or indicators may include: acute fractures, acute dislocations, infection, tumor, progressive neurological deficit, cauda equina syndrome, and extra-spinal disorders. Further evaluation/consultation or urgent/emergency intervention may be indicated and the New York Neck Injury Medical Treatment Guidelines incorporate changes in clinical management triggered by the presence of "red flags. Imaging of the cervical spine may be obtained as deemed clinically appropriate. Basic views are the anteroposterior (AP), lateral, right, and left obliques, swimmer's, and odontoid. CT scans may be necessary to visualize C7 and odontoid in some patients. Lateral flexion and extension views are done to evaluate instability but may have a limited role in the acute setting. MRI or CT is indicated when spinal cord injury is suspected." Dr. Dumesh opines "the mechanism of injury and specific indications for the imaging should be listed on the request form to aid the radiologist and x-ray technician. Alert, non-intoxicated patients, who have isolated cervical complaints without palpable midline cervical tenderness, neurologic findings, or other acute or distracting injuries elsewhere in the body, may not require imaging." As per Worker's Compensation Board New York Neck Injury Medical Treatment Guidelines, Third Edition, September 15, 2014, page 16 "MRI is useful in suspected nerve root compression, in myelopathy to evaluate the spinal cord and/or differentiate or rule out masses, infections such as epidural abscesses or disc space infection, bone marrow involvement by metastatic disease, and/or suspected disc herniation or cord contusion following severe neck injury. MRI should be performed immediately if there is a question of infection or metastatic disease with cord compression. MRI is contraindicated in patients with certain implanted devices. In general, the high field, conventional, MRI provides better resolution. A lower field scan with lower magnetic intensity may be indicated when a patient cannot fit into a high field scanner or is too claustrophobic despite sedation." As per Worker's Compensation Board New York Mid and Low Back Injury Medical Treatment Guidelines, Third Edition, September 15, 2014, page 15 "MRI is considered the gold standard in diagnostic imaging for defining anatomy because it has the greatest resolution of any test currently available. While CT remains an important analytical tool especially for evaluating bony or calcified structures of the spine, due to the greater resolution of MRI, particularly with respect to soft tissue of the spine (nerve root compression, myelopathy to evaluate the spinal cord and/or differentiate/rule out masses), there is less need for using CT at the current time. Ferrous material/metallic objects in tissue is a contraindication for the performance of an MRI. Inadequate resolution on the first scan may require a second MRI using a different technique. A subsequent diagnostic MRI may be a repeat of the same procedure when the rehabilitation physician, radiologist or surgeon documents that the study was of inadequate quality to make a diagnosis. All questions in this regard should be discussed

with the MRI center and/or radiologist. Recommendations: C.I.b.i MRI is not recommended for acute back pain or acute radicular pain syndromes in the first 6 weeks, in the absence of red flags. C.l.b.ii MRI is recommended for patients with acute back pain during the first 6 weeks if they have demonstrated progressive neurologic deficit, cauda equina syndrome, significant trauma with no improvement in atypical symptoms, a history of neoplasia (cancer), or atypical presentation (e.g., clinical picture suggests multiple nerve root involvement). C.l.b.iii MRI is recommended for acute radicular pain syndromes in the first 6 weeks if the symptoms are severe and not trending towards improvement and both the patient and the physician are willing to consider prompt surgical treatment, assuming the MRI confirms ongoing nerve root compression. Frequency/Duration: Repeat MRI imaging without significant clinical deterioration in symptoms and/or signs is not recommended. C.l.b.iv MRI is recommended for patients with non-acute radicular pain syndromes lasting at least 6 weeks, in whom the symptoms are not trending towards improvement, if both the patient and surgeon are considering prompt surgical treatment, assuming the MRI confirms ongoing nerve root compression. C.l.b.v In cases where an epidural glucocorticosteroid injection is being considered for temporary relief of acute or subacute radiculopathy, MRI at 3 to 4 weeks (before the epidural steroid injection) may be reasonable (see Section D.6, Injections: Therapeutic). C.l.b.vi MRI is recommended as an option for the evaluation of select non-acute back pain patients in order to rule out concurrent pathology unrelated to injury. This should rarely be considered before 3 months and failure of several treatment modalities (including NSAIDs, aerobic exercise, other exercise, and considerations for manipulation, and/or acupuncture). C.l.b.vii Standing or weight-bearing MRI is not indicated for any back or radicular pain syndrome or condition. In the absence of studies demonstrating improved patient outcomes, this technology is currently considered experimental/investigational." Dr. Dumesh concludes "in this particular case, the claimant sustained musculo-skeletal injuries as a result of the motor vehicle accident. According to the initial evaluation, the claimant was started on a proper and sufficient course of conservative therapy. The claimant was referred for the spinal MRIs following the same initial evaluation. The studies were conducted approximately two to four weeks later. However, according to the records reviewed, there was no indication that the claimant was failing on the conservative therapy course and any alternative therapy approach or surgical intervention was considered at that time that would depend on the above spinal MRI results. There was no indication that the above Cervical and Lumbar Spine MRIs could somehow influence the planned therapy course or affect future treatment decisions. Therefore, I consider the spinal MRIs not medically necessary."

Where the Defendant insurer presents sufficient evidence to establish a defense based on lack of medical necessity, the burden shifts to the Plaintiff which must then present its own evidence of medical necessity (see Prince on Evidence section 3-104, 3-202). *West Tremont Medical Diagnostic PC v. Geico,* 13 Misc.3d 131, 824 N.Y.S. 2d 759.

Applicant submitted a 10/12/18 peer rebuttal by Andrew McDonnell, M.D. After reviewing the claimant's history, treatment, and medical records, Dr. McDonnell opines "Dr. Dumesh stated that the MRIs of the cervical and lumbar spine was ordered and performed early with no indication of any alternative therapy approach or surgical intervention at that time, in response to this I would submit as under: First, it should be noted that the MRI of the lumbar spine though prescribed early, was not performed until

the patient completed more than three weeks of conservative care. According to the Diagnostic Imaging Utilization Management 2011 - 2012 Program Guidelines, "an MRI of the spine should be ordered when a patient fails to respond to conservative therapy over a three to four week period." So, it is a standard of care that the MRI of the spine may be performed if the symptoms do not improve after 3 to 4 weeks of conservative treatment, which is the case here. Secondly, with regards to cervical spine MRI, I would state that this patient tested positive for Cervical Compression test at the time of the initial evaluation. Patients with positive Spurling test or Cervical Compression test have probable nerve root pressure and should be sent for further imaging studies. (The correlation between Spurling test and imaging studies in detecting cervical radiculopathy) (http://www.ncbi.nlm.nih.gov/pubmed/21883627). Also, early detection often leads to prompt and accurate diagnosis, expeditious management, and avoidance of unnecessary procedures. (J Craniovertebr Junction Spine 2011 Jan-Jun; 2(1): 17-26). MRI allows the radiologist to directly evaluate the soft tissues of the spine and is therefore crucial in the evaluation of the patient with ligamentous injury and thus, instability. Recognition of soft-tissue injuries impacts patient management and outcome. (MRI in acute spinal trauma, Michael C Hollingshead, MD and Mauricio Castillo, MD FACR published in applied radiology, Volume 36, Number 8, August 2007). MRI should be the primary modality for evaluating possible ligamentous injuries in acute spine trauma. (American College of Radiology ACR Appropriateness Criteria Suspected Spine Trauma Date of origin; 1999 Last review date 2012). Third, surgery and red flags signs are not the only indications for warranting a spinal MRI. The ACR guidelines clearly state that trauma is one of the indicators for the performance of MRI of the spine. As such, MRI plays an important role in the determination and assessment of ligamentous integrity. The ACR reports that there is an agreement in the literature that MRI is most appropriate for adult patients with suspected spinal trauma. The need for the MRI was based on the claimant's history and physical findings during the examination. Also, the red flag signs usually indicate the immediate necessity for the MRI, rather than denying the indication for an MRI in their absence." Dr. McDonnell continues "Dr. Dumesh stated that for most patients with neck and back pain, a diagnosis can be made with a history, physical examination and plain film radiography. In response to this I would state that injuries from whiplash trauma are difficult to identify objectively. X-ray examination cannot typically reveal minor injuries. Consequently, reports of the pathoanatomical injuries are underestimated (Review spine lesions after road traffic accidents: a systematic review Uhrenholt L Grunnet-Nilsson N, Hartvigsen J Spine (Phila Pa 1976). 2002 Sep 1; 27 (17): 1934-41; discussion 1940). Panjabi reported soft tissue injuries associated with whiplash often may not be visualized on routine radiographs or CT scans. Soft tissues involved in low velocity whiplash seldom tear completely and are often stretched beyond the elastic limits, resulting in incomplete injuries (Simulaton of whiplash trauma using a whole spine specimens Panjabi MM, Cholewicki J, Nibu K, Babat LB, Dvorak J Spine (Phila Pa 1976). 1998 Jan 1;23(1): 17-24). In contrast to physical exam and plain film x-rays, MRI would aid in formulating the treatment plan for the patient. (Croft AC: Treatment paradigm for acceleration/deceleration injuries (whiplash). Am ChiroAssoc J Chirol993, 30 (1): 41-45). The MRI of the cervical and lumbar spine was medically necessary in this case based on the clinical findings made by the treating provider and criteria mentioned in American College of Radiology (ACR), Expert panel on musculoskeletal imaging. The patient suffered a traumatic neck and low back injury. This imaging study

(MRI) was necessary to diagnose the presence of herniations, bulging of disc and any other abnormality that might not been seen on physical examination and/or x-ray imaging alone. An MRI was indicated for further evaluation of the spinal cord and to determine the nature and extent of the injury." Dr. McDonnell concludes "finally, again I would like to state that regardless of whether the treating or testing physician explicitly lists how exactly the test results will be used, the fact is that patient's complaints, the history and the findings on examination justified the MRI testing of the cervical and lumbar spine performed and the results can be beneficial for determining and confirming the diagnosis, the extent of treatment and the prognosis… MRI of the cervical spine performed on 08/16/2017 and MRI of the lumbar spine performed on 08/28/2017 by our office Community Medical Imaging, PC was medically necessary and the findings further confirm and reinforce my opinion. Based on the above mentioned literature, I believe that Dr. Dumesh's decisions to deny reimbursement of the MRI of the right knee and cervical and lumbar spines should be overruled."

I find in favor of the Respondent. Dr. Dumesh sets forth a persuasive standard that a "spinal MRI could be considered in cases of persistent pain in the cervical and/or lumbar spine area present for a period of one month or longer, despite a standard conservative therapy regimen." In this instance the cervical MRI was performed a little over two weeks after the initial evaluation and the lumbar spine MRI was rendered within four weeks of the initial evaluation, and there was no indication that the claimant was not responding to conservative therapy or that alternate treatment options were being considered. It also seems as if Dr. McDonnell acknowledges that the cervical spine MRI (performed on 8/16/17) was premature, since he states "it should be noted that the MRI of the lumbar spine (performed on 8/28/17) though prescribed early, was not performed until the patient completed more than three weeks of conservative care." Dr. McDonnell's argument that the fact that the claimant "tested positive for Cervical Compression test" justifies early performance of the cervical spine MRI because it suggests "probable nerve root pressure" is rendered less persuasive since Dr. Avellini did not test for or document any muscle strength, sensation, or deep tendon reflex deficits. Based on the foregoing, I find that Applicant did not meet its burden of persuasion. Accordingly, I find in favor of the Respondent and uphold the denial of the claims.

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 claim is DENIED in its entirety

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.

01/19/2020
(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:
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Electronically Signed

Your name: Charles Blattberg
Signed on: 01/19/2020