American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

All City Family Healthcare Center (Applicant)	AAA Case No.	17-20-1160-8530
	Applicant's File No.	BT20-111558
- and -	Insurer's Claim File No.	0555446889 2NG
Allstate Insurance Company (Respondent)	NAIC No.	19232

ARBITRATION AWARD

I, Hersh Jakubowitz, the undersigned arbitrator, designated by the American Arbitration Association pursuant to the Rules for New York State No-Fault Arbitration, adopted pursuant to regulations promulgated by the Superintendent of Insurance, having been duly sworn, and having heard the proofs and allegations of the parties make the following **AWARD:**

Injured Person(s) hereinafter referred to as: EIP

1. Hearing(s) held on 04/01/2021, 04/14/2021
   Declared closed by the arbitrator on 05/01/2021

   Boris Tadchiev from The Tadchiev Law Firm, P.C. participated for the Applicant

   Meghan McDonough from Law Offices of John Trop participated for the Respondent

2. The amount claimed in the Arbitration Request, **$ 14,821.55**, was NOT AMENDED at the oral hearing.
   Stipulations WERE made by the parties regarding the issues to be determined.

   The Parties stipulated that Applicant had met its prima facie burden of proof and that Respondent's denials were interposed in a timely fashion.

3. Summary of Issues in Dispute

   Was the cervical discectomy and associated proceduresadministered to EIP and performed at the Applicant's facility NOT medically necessary based on the analysis of Respondent's designated peer?

Was Modifier 59 was used appropriately?

Are CPT codes 63076 and 22527 add-on codes, and therefore improper to append modifier 59?

ShouldCPT codes 62291 and 72285 beclassified in EAPG group 999?

4. Findings, Conclusions, and Basis Therefor

This award is predicated upon both a review of the respective submissions of the parties contained within the electronic case file maintained by the American Arbitration Association and the oral argument of the parties.

The dispute arises from an automobile accident on June 25, 20179, in which the EIP, a then 69-year-old male was involved in a motor vehicle accident as a restrained driver.

The EIP, after undergoing a course of physical therapy treatments, injections and medication consulted Dr. Herschel Kotkes, M.D. on November 13, 2019. The EIP complained of low back pain radiating to the buttocks and neck pain which radiated to bilateral shoulders. Examination revealed positive for decreased range of motion, tenderness, muscle spasm, trigger points and compression and Spurling tests. It was Dr. Kotkes' opinion that the EIP was suffering from cervical and lumbar intervertebral disc displacement and cervical and lumbar radiculopathy. Dr. Kotkes' plan was for the EIP to was to be administered epidural injections, trigger point injections, lumbar and cervical discectomy. The MRI of Mr. Khan revealed C2-C3, 2 mm broad-based right paracentral disc herniation impressing on the thecal sac. C3-C4, 2 mm broad-based right paracentral/foraminal disc herniation, annular disc bulge and right-sided uncovertebral spurring impress on the thecal sac with bilateral neural foraminal narrowing, right worse than left. There is resulting impingement of the exiting right C3 nerve roots. C4-C5, 3 mm broad-based central disc herniation and annular disc bulge impressing on the ventral cord with mild central canal stenosis and bilateral neural foraminal narrowing. C5-C6, 4 mm broad-based right paracentral/foraminal disc herniation, annular disc bulge and bilateral uncovertebral spurring flatten the ventral cord with moderate central canal stenosis and bilateral neural foraminal narrowing, right worse than left. There is resulting impingement of the exiting C6 nerve roots bilaterally. C6-C7, 3 mm broad-based right paracentral disc herniation, annular disc bulge and bilateral uncovertebral spurring impressing on the ventral cord with mild central canal stenosis and bilateral neural foraminal narrowing. Disc herniation and disc bulge make contact with the exiting C7 nerve roots bilaterally. C7-T1, annular disc bulge and bilateral uncovertebral spurring impressing on the thecal sac with bilateral neural foraminal narrowing. There is resulting impingement of the exiting C8 nerve roots bilaterally. On November 25, 2019, Dr. Kotkes performed a cervical discectomy and associated procedures at the Applicant's surgical center and the claim for the Applicant's facility fee.

The Applicant established its prima facie case by proof that the prescribed statutory billing forms had been received and that payment of no-fault benefits was not forthcoming. (See, New York & Presbyt. Hosp. v. Countrywide Ins. Co., 44 A.D.3d 729 [N.Y. App. Div. 2d Dep't 2007]). Proof of the receipt of the Applicant's billing is implicit, in the timely denial issued by the Respondent.

The Respondent's denial raised the asserted absence of medical necessity based on the analysis of its designated peer, Dr. Jay M. Weiss, MD. The corresponding report dated January 10, 2020 and addendum has been submitted in support of the Respondent's position.

In considering the issue presented, I note that as part of its prima facie showing, the Applicant is not required to show that the contents of the statutory no-fault forms themselves are accurate or that the medical services documented therein were actually rendered or necessary. Stated another way, the Applicant is not required to establish the merits of the claim to meet its prima facie burden. (Viviane Etienne Med. Care, P.C. v Country-Wide Ins. Co., 114 A.D.3d 33, 46, aff'd 25 NY3d 498)

On the contrary, "[m]edical necessity is presumed upon the timely submission of a no-fault claim (see All County Open MRI & Diagn. Radiology P.C. v. Travelers Ins. Co ., 11 Misc. 3d 131[A], 815 N.Y.S.2d 493, 2006 NY Slip Op 50318[U] [App Term, 9th & 10th Jud Dists 2006]). Thus, ordinarily it falls to the defense to establish that the billed-for services were not medically necessary." (Park Slope Med. & Surgical Supply, Inc. v. Progressive Ins. Co., 34 Misc. 3d 154[A] [N.Y. App. Term 2012] [concurring opinion, Golia, J.]; see, also, Kings Med. Supply Inc. v. Country-Wide Ins. Co., 5 Misc. 3d 767, 771 [N.Y. Civ. Ct. 2004 ["It is by now firmly established that the burden is on the insurer to prove that the medical services or supplies in question were medically unnecessary {citation omitted}."])

The Respondent, to establish the validity of its denial on a prima facie level and put the Applicant to its proof, must, as a minimum, demonstrate both a factual predicate and medical rationale for the asserted absence of medical justification for the specific service provided to the EIP, and must premise its contention upon uncontroverted evidence of generally accepted medical standards of care. (See, Nir v. Allstate Ins. Co., 7 Misc. 3d 544, 547 [N.Y. Civ. Ct. 2005])

Thus, the focus falls squarely on the Weiss report.

Critical of the challenged discectomy and associated services, Dr. Weiss, citing supportive medical literature, and based on his analysis of the EIP's medical records, opined that the clinical findings and reported symptoms did not rise to a level sufficient to justify the discectomy and associated services performed on November 25, 2019 at the Applicant's facility.

In pertinent part, Dr. Weiss criticizing the cervical discectomy and associated services performed November 25, 2019 at the Applicant's facility, notes: "It was reported there

was neck pain radiating to both shoulders, however, there was no report of persistence of radiation of pain below the level of the shoulders in any specific distribution. There were also no focal abnormalities of strength, sensation or reflexes, but strength was 4/5 for all muscles tested in all four extremities. Radiculopathy is a lesion of one nerve as it leaves the spine, and this would give symptoms in one limb. If it was severe enough that one would consider interventional procedures such as epidural injection or any type of discectomy, it would be expected there would be evidence of nerve involvement, that is weakness in the motor distribution of the nerve on one side and sensory distribution of the same nerve on the same side. No such focal findings were noted. Furthermore, the criteria for performing any type of discectomy is the above mentioned findings along with imaging findings that would confirm a lesion at the level and side predicted by the clinical picture. There was no focal nerve root compression on any one side that would correspond with specific clinical lesions. In fact, EMG was negative for evidence of cervical radiculopathy. Given this entire clinical picture, there would be no indication for discectomy let alone percutaneous discectomy.

The rebuttal by Dr. David Gamburg, with supportive medical literature, however, specifically states "EIP presented with clear signs and symptoms that showed evidence of cervical radiculopathy. EIP presented with constant aching and shooting neck pain, that radiated to bilateral shoulders, associated with tingling. On average pain was 5/10 and was made worse by movement, sitting a long time, and turning side to side. Upon physical examination there was decreased range of motion and decreased strength. Palpation of the cervical facet revealed pain in C3-C7 region on both sides and tenderness along the cervical spine bilaterally. Palpable trigger points were noted in the muscles of the head and neck. There was a positive Compression test and positive Spurling's test. These findings are significant proof of radiculopathy.

EIP also exhibited positive Spurling's Test upon physical examination. Please note, a Spurling's test is a "root tension sign." **In Shabat's study, the Spurling's test was 95% sensitive and 94% specific diagnosing nerve root pathology, ie., radiculopathy**. (Shabat, Shay; Leitner, Yossi, David, Rami, Folman, Yoram (September 2011)."The Correlation between Spurling Test and Imaging Studies in Detecting Cervical Radiculopathy." *Journal of Neuroimaging.* Similarly, please see: " **The result of a positive Spurling test is a reproduction of cervical radiculopathy symptoms. . . The Spurling test is a well-recognized provocative test that is routinely used in the evaluation of neck pain and cervical radiculopathy**. If used appropriately in conjunction with other history and exam findings, the Spurling test can help determine the cause of cervical radiculopathy and guide further workup and imaging studies." *Jones, S. J., & Miller, J.- M. (2019). Spurling test. In State-Pearls [internet]. Treasure Island, FL: StatPearls Publishing.* **The literature clearly states that a positive response to the Spurling's Test is a supportive finding of the diagnosis of cervical radiculopathy.**

Occupational Medicine Practice Guideline, published by ACOEM, second edition, lists the following criteria to perform discectomy:

All of the following indications should be present: 1. Radicular pain syndrome with current dermatomal pain and/or numbness, or myotome muscle weakness, all consistent with a herniated disc; 2. Imaging findings by MRI, or CT with or without myelography that confirm persisting nerve root compression at the level and on the side predicted by the history and clinical examination; and 3. Continued significant pain and functional limitation after 4 to 6 weeks of time and appropriate conservative therapy. (Hegmann K, Occupational Medicine Practice Guidelines, 2nd Ed (2008 Revision) - p. 851). **In this case EIP demonstrated physical exam findings consistent with radicular pain syndrome (positive Compression and positive Spurling's test), had positive MRI findings (C2-C7 disc herniation, C7-T1 disc bulge), indicating radiculopathy/nerve root compression, and had failed extensive conservative treatment, and thus discectomy treatment was entirely warranted as per the *OMP Guidelines*…EIPs cervical MRI found disc herniations and disc bulges. Please note there's an abundance of medical literature establishing percutaneous discectomy is effective and recommended for treatment of cervical disc herniation**. For example, "**Surgical intervention represents the most efficacious clinical alternative for CDH (cervical disc herniation) cases** that fail to respond to conservative treatments." *Wen H, Wang X, Liao W, et al. Effective Range of Percutaneous Posterior Full-Endoscopic Paramedian Cervical Disc Herniation Discectomy and Indications for Patient Selection. BioMed Res Int. 2017;2017:3610385.* Similarly, *Clinical Spine Surgery* states: "**The ideal selection criteria are patients with symptomatic single-level contained cervical disk herniations (CDH)** and minimally degenerated disks. *PS, Soria van Hoeve JS, Huygen FJ, Aukes HA, Harhangi BS. Percutaneous Nucleoplasty for the Treatment of a Contained Cervical Disk Herniation.Clin Spine Surg. 2017;30(9):389-391.The European Spine Journal similarly* states: " **Percutaneous cervical discectomy (PCD) has been developed as an effective treatment option for soft cervical disc herniation**." *Li J, Yan DL, Zhang ZH. Percutaneous cervical nucleoplasty in the treatment of cervical disc herniation. Eur Spine J. 2008;17(12):1664-1669.* Thus, it is well documented in medical literature that percutaneous discectomy is effective and recommended to treat disc herniation.

There is no requirement for a patient to experience a specific dermatomal distribution to be diagnosed with radiculopathy and necessitate the service in dispute… That neurological deficits are not a required criteria to perform discectomy…As such, a lack of neurological deficits cannot be considered a valid basis to establish the lack of medical necessity of the provided treatment for EIP… That EMG testing has the potential to confirm the presence of a radicular component, **a negative EMG does not unequivocally prove there is no radiculopathy present.** For example, the *Turkish Journal of Neurology* conducted a study comparing EMG with MRI in evaluating radiculopathy and concluded: "Based on these data, it is important to understand that **a negative EMG or MRI study for radiculopathy does not rule out the presence of disease,** and that clinical findings, particularly in motor deficits." *Correlation of Electromyography and Magnetic Resonance Imaging Findings in the Diagnosis of Suspected Radiculopathy, Turk J Neurol 2016;22:55-59."*

Indeed, Dr. Gamburg's Rebuttal makes a strong case that there was no deviation from generally accepted medical guidelines in the decision to proceed with the subject discectomy and associated services. Dr. Gamburg brings strong evidence to rebut each and every criticism articulated by Dr. Weiss.

Where, as here, there are dueling reports from physicians each raising a factual basis and medical rationale for respective opinions there becomes a question of fact for me to resolve regarding causation and/or medical necessity. See State Farm Mut. Auto. Ins. Co. v. Stack, 55 A.D.3d 594, 869 N.Y.S.2d 536 (2nd Dept. 2008); Radiology Today PC v. Travelers Ins., 39 Misc.3d 146(A) (App. Term 2nd Dept. May 14, 2013); Westcan Chiropractic PC v. Elco Admin. Services, 2018 NY Slip Op. 51045(U) (App. Term 2nd Dept. June 28, 2018). As the trier of fact, I am free to accept or reject opinions on credibility grounds. See Webster Ave. Pavilion PC v. Allstate Ins. Co., 42 Misc.3d 148(A) (App. Term 1st Dept. March 19, 2014); AP Orthopedic v. Allstate Ins. Co., 49 Misc.3d 144(A) (App. Term 2nd Dept. Nov. 12, 2015.).

Lastly, "[i]n the face of a course of treatment that has not been shown to have no medical purpose or performed towards no medical objective, this [forum] is not prepared to second guess a treating doctor who decides that a medical [service] is necessary for his/her diagnosis and treatment (see also A.B. Med. Serv. v. New York Central Mut. Fire Ins. Co., supra; Alliance Med. Office, P.C. v. Allstate Ins. Co., 196 Misc. 2d 268, 764 N.Y.S.2d 341 [Civ Ct. Kings Co. 2003];see also Citywide Social Work &Psy. Serv. P.L.L.C v. Travelers Indemnity Co., supra])." (A.R. Med. Art, P.C. v. State Farm Mut. Auto. Ins. Co.,11 Misc. 3d 1057[A] [N.Y. Civ. Ct.2006]; see also, Matter of Integrated Neurological Assoc., PC v 21st Century North America Insurance Company, AAA No. 412013086392 [Arbitrator Moritz])

Accordingly, I find that Respondent's denial is not sustained.

FEE SCHEDULE

Insurance Law § 5102(a)(1) defines "basic economic loss" as including "all necessary expenses incurred for…professional health services" subject to the limitations of Insurance Law § 5108. Insurance Law § 5108 limits the amounts to be charged by providers of health services, and states that charges for services specified in Insurance Law § 5102(a)(1) "shall not exceed the charges permissible under the schedules prepared and established by the chairman for the workers' compensation board…except where the insurer…determines that unusual procedures or unique circumstances justify the excess charge." 11 NYCRR § 65-3.16(a) provides that "[p]ayment for medical expenses shall be in accordance with fee schedules promulgated under section 5108 of the Insurance Law and contained in Part 68 of this Title (Regulation 83)." 11 NYCRR § 68.1 provides that the "existing fee schedules prepared and established by the chairman of the Workers' Compensation Board…are hereby adopted by the Superintendent of Insurance with appropriate modifications so as to adapt such schedules for use pursuant to section 5108 of the Insurance Law."

The Respondent has the burden of coming forward with competent evidentiary proof to support its fee schedule defenses. Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co., 2006 NY Slip 26240 (Civil Ct. Kings Co. 2006). If the Respondent fails to demonstrate by competent evidentiary proof that an Applicant's claims were billed in excess of the appropriate fee schedules, the defense of noncompliance with the fee schedule cannot be sustained. See, Continental Medical PC v. Travelers Indemnity Co., 11 Misc.3d 145A (App. Term 1st Dept. per curiam, 2006).

Respondent submitted an affidavit by Jeffrey Futoran, a certified professional coder, wherein he indicated that he reviewed the documents submitted by Applicant regarding the services, under code 63075, 63076-59, 22526-59, 22527-59, 62291 and 72285 rendered to EIP. He opines that the following is the maximum fee allowed:

CPT Code 63075 - Primary Procedure-Diskectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace. - EAPG Maximum Fee $5,292.93.

CPT Code 63076-59- Intra-service work associated with primary procedure-Diskectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, each additional interspace-Modifier 59 is not appropriate-consolidated with CPT 63075-Maximum Fee $0.00.

CPT Code 22526-59- Primary Procedure - Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level-Modifier 59 is not appropriate- consolidated with CPT 63075-Maximum Fee $0.00.

CPT Code 22527-59- Intra-service work associated with primary procedure-Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; 1 or more additional levels- Modifier 59 is not appropriate-consolidated with CPT 22526-Maximum Fee $0.00.

CPT Code 62291- CPT codes 62291 and 72285 group to "no payment" EAPG 999 and are not reimbursed-Maximum Fee $0.00

CPT Code 72285- CPT codes 62291 and 72285 group to "no payment" EAPG 999 and are not reimbursed-Maximum Fee $0.00

Total correct fee is 5,211.56.

Modifier 59 was used inappropriately on all the billed codes because all services were performed on the C4-C5 and C5-C6 levels of the cervical spine.

Codes 63076 and 22527 are add-on codes, and it is therefore improper to append modifier 59.

CPT codes 62291 and 72285 are classified in EAPG group 999 for which no payment is due.

Applicant submits a rebuttal to Respondent coder's affidavit by Alpa Prajapati, a certified fee coder, who disagrees with Jeffrey Futoran's calculations.

CPT Code 63075 - Primary Procedure-Diskectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace. -EAPG Base Weight 17.6103 x Base rate $295.94- EAPG Maximum Fee $5,292.93.

CPT Code 63076-59- Intra-service work associated with primary procedure- Diskectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, each additional interspace-Modifier 59 is appropriate-not consolidated with CPT 63075- EAPG Base Weight 17.6103 x Base rate $295.94 x 50%- Maximum Fee $2,605.78.

CPT Code 22526-59- Primary Procedure - Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level- Modifier 59 appropriate- not consolidated with CPT 63075- EAPG Base Weight 17.6103 x Base rate $295.94 x 50%- Maximum Fee $2,605.78.

CPT Code 22527-59- Intra-service work associated with primary procedure- Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; 1 or more additional levels- Modifier 59 is appropriate- not consolidated with CPT 22526- EAPG Base Weight 17.6103 x Base rate $295.94 x 50%- Maximum Fee $2,605.78.

CPT Code 62291- EAPG Base Weight 2.5300 x Base rate $295.94 x 100%- Maximum Fee $748.73.

CPT Code 72285- EAPG Base Weight 3.252 x Base rate $295.94 x 100%- Maximum Fee $962.54.

Total correct fee is 14,821.54.

"3M Core Grouper Software (note the 3M software is used and recommended by the NYWCB to calculate EAPG payments) explaining that "multiple significant procedures result in discounting instead of consolidation." As explained in the 3M documents, the term "discounting" means 50% reimbursement. Similarly here, the multiple surgical procedures are discounted (reimbursed at 50%) rather than consolidated (zero reimbursement). See the chart above as well as the attached 3M software audit both showing a 50% weight multiplier was applied for the multiple significant procedure codes, in accordance with EAPG guidelines… Modifier 59 was used properly to signify different procedures and separate incisions. The CPT Manual states Modifier 59 is appropriately used for a "different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual separate incisions are made." In this case modifier 59 was justified due to both different procedures and different sites. Specifically, the operative report lists different procedures performed: discectomies (63075 and 63076) and annuloplasties (22526 and 22527). In addition, these procedures were performed at different anatomic sites: the C4-C5 and C5-C6… The correct EAPG group for CPT 62291 is 278; and the correct group EAPG for CPT 72285 is 284.

I take judicial notice of the Workers' Compensation Fee Schedule. See Kingsbrook Jewish Medical Center v. Allstate Insurance Company, 61 A.D.3d 13, 20 (2nd Dept.

2009); 32 Misc.3d 144(A), 2011, LVOV Acupuncture, P.C. v. Geico Ins. Co., N.Y. Slip Op. 51721(U) (App. Term 2nd , 11th and 13th Jud. Dists. 2011); Natural Acupuncture Health, P.C. v. Praetorian Ins. Co., 30 Misc.3d 132(A), 2011 N.Y. Slip Op. 50040(U) (App. Term 1 Dept. 2011). In reviewing the fee schedule evidence, I find the submitted fee affidavit of Alpa Prajapati contradicts and fully explains the inaccuracies of the fee affidavit of Jeffrey Futoran. The procedure that EIP underwent was involved definitely encompassed 2 distinct anatomic sites and procedures, allowing for modifier 59 classification of CPT 62291 and 72285 into group 999 is incorrect.

Applicant's award is $14,821.54.

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
	All City Family Healthcare Center	**11/25/19 - 11/25/19**	**$14,821.55**	**Awarded: $14,821.55**
Total			**$14,821.55**	**Awarded: $14,821.55**

B. The insurer shall also compute and pay the applicant interest set forth below. 03/28/2020 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Based on the submission of a timely denial, interest shall be paid from the above date, until the date that payment is made at a rate of 2% per month.

C. Attorney's Fees

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

As this matter was filed after February 4, 2015, this case is subject to the provisions promulgated by the Department of Financial Services in the Sixth Amendment to 11 NYCRR 65-4 (Insurance Regulation 68-D). Accordingly, the insurer shall pay the applicant an attorney fee, in accordance with newly promulgated 11 NYCRR 65-4(d). After calculating the sum total of the first party benefits awarded in this arbitration plus interest thereon, Respondent shall pay Applicant an attorney's fee equal to 20% of the sum total, subject to no minimum and a maximum of $1,360.00.

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

05/01/2021
(Dated)

Hersh Jakubowitz

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:
90e846342465a941726363305cc6aed8

Electronically Signed

Your name: Hersh Jakubowitz
Signed on: 05/01/2021