

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Island Ambulatory Surgery Center LLC  
(Applicant)

- and -

Geico Insurance Company  
(Respondent)

AAA Case No.	17-20-1168-1582
Applicant's File No.	00067152
Insurer's Claim File No.	0621430830101027
NAIC No.	22055

**ARBITRATION AWARD**

I, Kevin R. Glynn, 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

1. Hearing(s) held on 08/05/2021  
Declared closed by the arbitrator on 08/05/2021

Mikhail Guseynov, Esq. from Drachman Katz, LLP participated in person for the Applicant

David Muller, Esq. from Geico Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 1,548.90**, 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 Assignor, ND, is a 41yo female passenger who was injured in a motor vehicle accident on 11/28/19. ND suffered injuries which resulted in her seeking treatment. In dispute is Applicant's facility claim for a lumbar epidural steroid injection and epidurography (62326, 72275 59 TC) performed on 1/22/20, in the total amount of \$1,548.90. Respondent denied the claim based on a peer review report by Dr. Patel Kao, M.D., dated 2/14/20. Therefore, the medical necessity of the claim is the issue to be decided and if necessary, the proper amount of reimbursement.

#### 4. Findings, Conclusions, and Basis Therefor

This case was decided based upon the submissions of the Parties as contained in the electronic file maintained by the American Arbitration Association, and the oral arguments of the parties' representatives. There were no witnesses. I reviewed the documents contained in MODRIA for both parties and make my decision in reliance thereon. Only the arguments presented at the hearing are preserved in this decision; all other arguments not presented at the hearing are considered waived. Respondent's counsel objects to Applicant's fee coder affidavit as it was submitted on 8/3/21, two days before the hearing. Although pursuant to the undersigned's Rocket Docket rule any documents submitted within one week of the hearing would normally not be considered there is an exception for fee schedule proofs as this defense is not precludable and can be raised up to the date of the hearing the same exception is granted to Applicant to respond to fee schedule defenses. As such, Applicant fee schedule documents are being considered in this award.

I find that Applicant established a prima facie case of entitlement to reimbursement. Mary Immaculate Hospital v. Allstate Insurance Company, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2<sup>nd</sup> Dept. 2004). I also find that Respondent has established that it timely denied the claim.

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 2, 11 and 13 Jud. Dists. 2014). 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 1<sup>st</sup> Dept. 2006). The Appellate Courts have not clearly defined what satisfies this standard except to the extent that "bald assertions" are insufficient. Amherst Medical Supply, LLC v. A Central Ins. Co., 2013 NY Slip Op 51800(U) (App. Term 1<sup>st</sup> Dept. 2013). To meet the burden of persuasion regarding medical necessity - in the absence of factually contradictory records - the applicant must submit a rebuttal which meaningfully refers to and rebuts the assertions set forth in the peer review report. See generally, Pan Chiropractic, P.C. v Mercury Ins. Co., 24 Misc 3d 136[A], 2009 NY Slip Op 51495[U] [App Term, 2d, 11th & 13th Jud Dists 2009].

Respondent's evidence established that the bill was timely denied pursuant to a peer review report by Dr. Patel Kao, M.D., dated 2/14/20. After listing the medical records he reviewed, Dr. Kao opines:

According to the records, the claimant is a 41 -year-old female (DOB 06/22/1978) involved in a motor vehicle accident on 11/28/2019. The claimant was the backseat passenger and was wearing a restraint in a vehicle which was rear-ended. There was no report of loss of consciousness. The airbags did not deploy. There was an

emergency room visit on the same date. The claimant was seen by Dr. Jordan Fersel. The claimant reported neck pain, mid back, low back pain, right knee and left thumb pain. The claimant had chiropractic care, physical therapy, and acupuncture. The claimant did not have any imaging studies. The claimant was not prescribed any medications.

#### Discussion:

Based on the medical records provided, I come to the conclusion that surgical center facility fees associated with lumbar epidural steroid injection under fluoroscopic guidance performed on the date of 01/22/2020 by Island Ambulatory Surgery billed in the amount of \$ 1548.90 was not medically necessary.

Appropriate indications for lumbar epidural steroid injections include patients with symptoms of lumbar radicular pain syndromes, acute radicular pain syndromes, radicular pain symptoms suggestive of neural compressive etiology with signs of nerve root irritation. They are not recommended for non-specific low back pain such as non-acute axial back pain without radicular component, acute or non-acute back pain in the absence of significant radicular symptoms, or lumbar axial pain or non-radicular pain syndromes.

This is cited in Benjamin RM, et.al: "mechanical causes of low back pain, especially those accompanied by signs of nerve root irritation, may respond to epidural steroid injections."

Again, supported by Schneider MJ, et.al: "the only nonsurgical intervention favorably recommended by the North American Spine Society has been contradicted by recent reviews that conclude that the evidence for the effectiveness of epidural injections is of low quality."

This is a claimant with non-specific low back pain, and without clear-cut lumbar radiculopathy clinical picture supported by clinical examination, diagnostic imaging, and diagnostic EMG/NCS, indicating clear-cut nerve root irritation, and as such the lumbar epidural steroid injection is not medically necessary. Any associated epidurography, supplies, or anesthesia would also not be medically necessary.

#### References:

Benjamin RM, Manchikanti L, Parr AT, Diwan S, Singh V, Falco FJ, Datta S, Abdi S, Hirsch JA. The effectiveness

of lumbar interlaminar epidural injections in managing chronic low back and lower extremity pain. Pain Physician. 2012 Jul-Aug; Review. PubMed PMID: 22828691.

Schneider W, Ammendolia C, Murphy DR, Glick RM, Hile E, Tudorascu DL, Morton SC, Smith C, Patterson CG, Piva SR. Comparative Clinical Effectiveness of Nonsurgical Treatment Methods in Patients With Lumbar Spinal Stenosis: A Randomized Clinical Trial. JAMA Netw Open. 2019 Jan 4; 2(1):e186828. doi:

10.1001 /jamanetworkopen.2018.6828. PubMed PMID: 30646197; PubMed Central PMCID: PMC6324321...

Respondent has presented a medical rationale and factual basis to support its defense of lack of medical necessity. Accordingly, the burden now shifts to Applicant, who bears the ultimate burden of persuasion. See, Bronx Expert, supra.

Applicant relies upon the rebuttal report dated by Dr. Vitaliy Zhivotenko, D.O., dated 6/24/21. Dr. Zhivotenko responds to Dr. Kao, stating:

I respectfully disagree with the determination that the 1/22/20 Lumbar Epidural Steroid Injection (LESI), Epidurography and all associated services were not medically necessary. Dr. Kao denies the medical necessity of the 1/16/20 LESI in dispute based on his opinion that, "This is a claimant with non-specific neck/low back pain and without clear-cut lumbar radiculopathy clinical picture supported by clinical examination, diagnostic imaging... indicating clear-cut nerve root irritation." However, my patient's radicular lower back pain was clearly documented by multiple physicians. Please refer to my patient's 12/2/19 chiropractic examination where my patient complained of intermittent, sharp, stabbing, throbbing, stiff, aching lower back pain, corroborated by the physical examination findings of limited and painful range of motion and tenderness in the lumbar regions, as well as positive Kemp's and Straight Leg Raise tests. Please also refer to the 1/13/20 and 1/16/20 medical records at my office which clearly noted the patient's complaints of severe (8/10), constant, dull, aching, sharp, shooting, burning lower back pain radiating to the buttocks and bilateral legs with numbness/tingling in the feet/toes, corroborated by physical examination findings of tenderness, spasms, restricted and painful range of motion and decreased motor strength in the lower extremities as well as a positive Straight Leg Raise test. Additionally, please refer to the patient's positive 12/30/19

lumbar MRI which revealed multilevel disc bulges, findings which are clear lateralizing disc findings (protrusions), which indicated the medical necessity of the injections. These MRI findings, along with the patient's complaints, symptomatology, and positive physical examinations, indicated that Ms. [ND] did indeed have a component of acute lumbar radiculopathy to her pain, contrary to Dr. Kao's assessment. Please note the 2018-19 NIA Guidelines' criteria for epidural injections: "Neck or back pain: after 2 weeks or more of acute radicular pain that has failed to respond or poorly responded to conservative management; AND Average pain levels of 6 on a scale of 0 to 10 or Intermittent or continuous pain causing functional disability." <https://www1.radmd.com/media/201412/2015-nia-clinicalguidelines-v2.pdf>

All the aforementioned, directly applies to my patient. Therefore, the ESI in discussion was entirely warranted at this juncture, in exact accordance with the NIA 2018-19 Guidelines. In fact, I would like to note that while MRI testing was conducted on my patient's lumbar spine on 12/30/19, Dr. Kao failed to review it. It is understood that physicians should make every effort to obtain all available diagnostic testing that would aid in the proper evaluation and treatment of patients and that it is the standard of care to review an MRI in patients after traumatic injuries. Had Dr. Kao reviewed this patient's lumbar MRI testing, he would have been able to form a nexus between the findings in which the MRI reports revealed and the patient's symptomatology, and likely would have drawn a different conclusion regarding pain management treatment, as the clear positive results contained therein further support the medical necessity for further treatment. Please note the significant MRI findings of multiple disc bulges. The positive MRI findings are clearly indicative of radiculopathy, thereby indicating the medical necessity for further medical intervention for this patient. Dr. Kao's failure to review the available MRI, calls into question the validity of his clinical assessment of the patient's condition. Dr. Kao further quoted literature which questions the efficacy of ESI treatment. Foremost, that a procedure may not have an established rate of effectiveness does not render the procedure medically unnecessary. The absence of substantial literature further does not equate to a lack of medical necessity. More notably, Dr. Kao states that the evidence of the effectiveness of ESI treatment is of very low quality, but simultaneously, provides literature as to when ESI treatment is effective, thus confirming that this procedure

falls under an acceptable standard of care, is generally performed, and that the efficacy of this treatment has already been established. Further, please note, as an alternative to surgery, or as an adjunct to physical therapy, ESI offers the potential for significant improvement of pain. A patient who has failed basic non-invasive conservative treatment, exhibits continued pain and radicular symptoms, and has positive MRI findings, is an ideal candidate for ESI treatment. Studies vary in the effectiveness of this technique, with reports varying between 50-90% of patients showing significant improvement. Patients with radicular pain are excellent candidates for injections. The potential for improved outcomes in this subset of patients is described in White AH, Derby R, Wynne G., Epidural Injections For The Diagnosis and Treatment of Lower Back Pain. *Spine* (1990; 5:78-72); "Substantial relief is...likely to arise from epidural injection in those patients presenting with acute radicular pain." It is well documented that epidural steroid injections can be beneficial in treatment of patients with spinal injury and radicular symptoms. See, Epidural Steroids in the Management of Chronic Spinal Pain: A Systematic Review, Salahadin, et al, *Pain Physician*, 2007, 10:185-212. In an article presented at the 31st Annual Meeting of the American Society of Regional Anesthesia and Pain Medicine, in April 6-9, 2006, in Palm Desert, CA; it was noted that the role of epidural steroid injections in the conservative management of radicular pain is simply to facilitate earlier pain relief and return to full function.

(<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3048441/>) Furthermore, epidural steroid injections (ESIs) have been endorsed by the North American Spine Society and the Agency for Healthcare Research and Quality (formerly, the Agency for Healthcare Policy and Research) of the Department of Health and Human Services as an integral part of nonsurgical management of radicular pain from cervical and lumbar spine disorders. The efficacy of epidural steroid injections for radicular low back pain is well known and documented, Nicolas Rathmell writes in his textbook, *Atlas of Image-Guided intervention*, that the 3 quality of evidence and grading of recommendations of interlaminar epidural steroid injections for patients with radicular pain is "1B strong recommendation, moderate quality evidence, Benefits clearly outweigh risks and burden. Strong recommendation, can apply to most patients in most circumstances without reservation." In another example, a systematic review, published by

Benyamin, R.M., et. al., looked at 26 trials and determined, "The evidence based on this systematic review is good for lumbar epidural injections under fluoroscopy for radiculitis secondary to disc herniation with local anesthetic and steroids." (The effectiveness of lumbar interlaminar epidural injections in managing chronic low back and lower extremity pain, Benyamin RM, *Palin Physician*, 2012 Jul-Aug 15(4):E363- 404). 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 procedures. 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 never examined the patient and was retained by the insurance carrier, has no responsibility for the patient's best interests. Therefore, for the aforementioned reasons, it would be inappropriate for this doctor to deny the medical necessity of the 1/22/20 LESI procedure. [ND] is a 41-year-old female who presented to the office of my associate, Dr. Leonid Reyfman, on 1/13/20 for an evaluation of her neck, lower back, right knee and left thumb pain due to a motor vehicle accident which occurred on 11/28/19. At the time of the accident, the patient was the restrained backseat passenger of a vehicle which was struck on the rear by a secondary vehicle. She was transported by ambulance to the hospital emergency room where she was evaluated, treated and released for outpatient care. She then began a course of conservative treatments including physical therapy, acupuncture, chiropractic care and pain medication, all of which failed to properly address Ms. [ND]'s accident-related injuries and pain. At the time of the 1/13/19 office visit, the patient complained of constant, dull, aching, sharp, shooting, burning lower back pain radiating to the buttocks and bilateral legs with numbness/tingling in the feet/toes. The pain was rated a severe 8/10 and was exacerbated by mechanical-type activities including standing, sitting, bending forward, lifting and twisting, whereas standing and walking worsened the leg pain. The patient also reported impaired work tolerance, difficulty sleeping, concentrating and performing activities of daily living. At the time, the patient was advised to avoid repetitive forceful, strenuous, twisting, jerky activities which may aggravate the underlying condition. ESI treatment was considered, should the pain persist. Ms. [ND] next presented to my office on 1/22/20 complaining of unrelenting radicular

lower back pain. 4 MRI of the Lumbar Spine (12/30/19):  
 • L4/L5: Concentric annular bulge encroaching bilateral extra foraminal space and intraforaminal fat  
 • L5/S1: Concentric annular bulge encroaching bilateral extra foraminal space and intraforaminal fat  
 Physical Examination Lower Back (1/22/20):  
 • Tenderness in lower back and sacroiliac region, as well as spinous processes L3-S1  
 • Muscle spasm along lumbar paravertebral, multifidus, sacrospinalis, gluteus and piriformis bilaterally  
 • Limited range of motion of lumbar spine and pelvis, especially with flexion (pain)  
 • Patient's ability to get on/off examination table was moderately impaired  
 • Mobility on the examination table was moderately impaired  
 • Positive Facet Loading test bilaterally  
 • Positive Straight Leg Raise test for lower back pain  
 • Decreased motor strength: knee extension and hip flexors;  
 • Based on the history, examination and imaging, the patient was diagnosed with lumbar disc displacement. My indications were as follows: Radicular pain syndromes lasting at least 3 weeks (in this case, nearly 2 months) having been treated with conservative care treatments or NSAIDs and without evidence of trending toward spontaneous resolution. Due to the above evaluation and given the lack of improvement with conservative therapies and pain medication, the patient was given the option to proceed with a lumbar epidural steroid injection to elucidate the pain generator and to provide therapeutic benefits in terms of analgesia and functional activity. The patient failed basic non-invasive conservative treatment, exhibited continued pain and radicular symptoms, and had a positive MRI. Typically, after a minimum of 4-6 weeks of failed conservative treatment, ESI treatment is acceptable. Here, the patient underwent extensive (failed) conservative treatment. We discussed the risks and benefits of a lumbar epidural steroid injection for symptomatic pain relief. The patient elected to proceed. Therefore, the LESI in discussion was administered on 1/22/20. In conclusion, as my above evaluation provides, Ms. [ND] experienced continued radicular lower back pain, her MRI was positive, and the pain had impacted her ability to conduct daily living activities. Non-invasive conservative treatments had failed and the patient's lower back pain had not sufficiently been addressed. Therefore, the 1/22/20 LESI procedure was entirely justified and medically necessary. For all of the above reasons and based on my personal examination of the patient, I disagree with Dr. Kao's peer review conclusion that the 1/22/20 injection was not medically necessary. Kindly



reconsider this matter for payment. I certify and affirm that the information contained in this document is true and accurate to the best of my knowledge based on a reasonable degree of medical certainty....

I find that Dr. Khivotenko has meaningfully addressed and contradicted Dr. Kao's opinion. I find the rebuttal report more persuasive than the peer report; I find that it meaningfully rebuts the opinion by Dr. Kao and by a preponderance of the evidence has established the medical necessity of the claim. Accordingly, Applicant is awarded reimbursement of the claim.

### **Fee Schedule**

Respondent has the burden of coming forward with competent evidentiary proof to support its fee schedule defenses. See Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co., 2006 NY Slip Op 26240, 12 Misc.3d 172, 822 N.Y.S.2d 378, 2006 N.Y. Misc. LEXIS 1519 (Civil Ct, Kings Co. 2006). If Respondent fails to demonstrate by competent evidentiary proof that an Applicant's claims were in excess of the appropriate fee schedule, Respondent's defense of noncompliance with the appropriate fee schedule cannot be sustained. See, Continental Medical PC v. Travelers Indemnity Co., 11 Misc.3d 145A, 819 N.Y.S.2d 847, 2006 NY Slip Op 50841U, 2006 N.Y. Misc. LEXIS 1109 (App. Term, 1<sup>st</sup> Dep't, per curiam, 2006).

Respondent submits the fee coder affidavit by Carolyn Mallory, CPC, dated 12/29/20. Ms. Mallory opines that the charge for the injection should be reimbursed as billed in the amount of \$976.38, but that Applicant improperly used modifier 59 when billing the charge for the epidurography and argues that the epidurography charge is included in CPT 62323 and therefore not separately reimbursable. Ms. Mallory states:

The AMA "CPT Manual" and the NCCI program define modifiers that may be appended to HCPCS/CPT codes to provide additional information about the services rendered. Modifiers consist of two alphanumeric characters. Modifiers may be appended to HCPCS/CPT codes only if the clinical circumstances justify the use of the modifier. A modifier shall not be appended to a HCPCS/CPT code solely to bypass an NCCI PTP edit if the clinical circumstances do not justify its use. If a state Medicaid program imposes restrictions on the use of a modifier, the modifier may only be used to bypass an NCCI PTP edit if the Medicaid restrictions are fulfilled. c) Modifier 59: Modifier 59 is an important NCCI PTP associated modifier that is often used incorrectly. With regard to NCCI PTP edits, its primary purpose is to indicate that two or more procedures are performed at different anatomic sites or different patient encounters. It shall only be used if no other modifier more appropriately describes the relationships of the two or more procedure

codes. Modifier 59 is used appropriately for different anatomic sites during the same encounter only when procedures which are not ordinarily performed or encountered on the same day are performed on different organs, or different anatomic regions, or in limited situations on different, non-contiguous lesions in different anatomic regions of the same organ. Modifier 59 and other NCCI-Associated modifiers should NOT be used to bypass a PTP edit unless the proper criteria for use of a modifier are met. Documentation in the medical record must satisfy the criteria required by an NCCI- associated modifier that is used. The NCCI PTP edits define when two procedure HCPCS/CPT codes may not be reported together, except under special circumstances. If an edit allows use of NCCI PTP-associated modifiers, the two procedure codes may be reported together if the two procedures are performed at different anatomic sites or different patient encounters...

Applicant responds with a fee coder affidavit by Esther Tchatchanachvili, CPC, dated 8/3/21, in which the affiant opines:

I had the opportunity to review the fee coder affidavit from Ms. Mallory CPC. She improperly asserts that code 72275, the epidurography, is not reimbursable.

Code 72275 is a column 2 code, which means that it is bundled into Code 64483 unless it's proven that both services are distinct and separately identifiable from one another.

With that being said, CPT' further elaborates on 72275 use in the parenthetical notes beneath the code.

Specifically, CPT@ states the following:

"(For injection procedure, see 62280, 62281, 62282, 62320, 62321, 62322, 62323, 62324, 62325, 62326, 62327, 64479, 64480, 64483, 64484).

"(Use 72275 only when an epidurogram is performed, images documented, and a formal radiologic report is issued)."

As the parenthetical note states, before considering reporting an epidurogram, make sure the physician performs a true, separate diagnostic study. Fluoroscopic imaging and dye injection do not warrant consideration of code 72275. However, as the parenthetical notes also state, you may report 72275 separately with an NCCI edit

overriding modifier, such as modifier 59 (Distinct Procedural Service), as long as you have documentation to support that the provider performed a true separate epidurogram alongside the injection.

Ms. Mallory is incorrect in stating that the procedure in question would not qualify for separate reimbursement for Code 72275, the epidurography. The operative procedure clearly shows that a diagnostic intraoperative epidurogram was performed.

Based on the fee schedule calculations and the attached documents prepared by myself, the outstanding fee schedule amount for date of service 1/16/2020 is \$1,548.90.

I find the affidavit by Ms. Tchatchanachvili more persuasive and find that Applicant was entitled to use the modifier 59 to bill the epidurography separately. Applicant is awarded the claim in the billed amount of \$1,548.90.

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
	Island Ambulatory Surgery Center	01/22/20 - 01/22/20	\$1,548.90	Awarded: \$1,548.90
Total			\$1,548.90	Awarded: \$1,548.90

- B. The insurer shall also compute and pay the applicant interest set forth below. 06/11/2020 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

In the instant matter Applicant is awarded interest pursuant to the no-fault regulations. 11 NYCRR 65-3.9 (a) provides that Interest shall be calculated "at a rate of two percent per month, calculated on a pro rata basis using a 30 day month." Pursuant to 11 NYCRR 65-3.9 (c), "if 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 Department of Financial Services regulations, interest shall not accumulate on the disputed claim or element of claim until such action is taken." Applicant electronically submitted its claim for arbitration on 6/11/20, more than thirty days after receipt of the denial of claim. Therefore, interest shall run effective 6/11/20.

C. Attorney's Fees

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

An attorney's fee of 20% shall be paid on the sum of the awarded claim plus interest, subject to 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, Kevin R. Glynn, do hereby affirm upon my oath as arbitrator that I am the individual described in and who executed this instrument, which is my award.

08/09/2021  
(Dated)

Kevin R. Glynn

### **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:**  
3b47477f675463281037e7679170a6d9

### **Electronically Signed**

Your name: Kevin R. Glynn  
Signed on: 08/09/2021