

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Fifth Avenue Surgery Center LLC
(Applicant)

- and -

Progressive Casualty Insurance Company
(Respondent)

AAA Case No. 17-20-1186-9972

Applicant's File No. NA

Insurer's Claim File No. 20-2703379

NAIC No. 11851

ARBITRATION AWARD

I, Alison Berdnik, 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: Claimant

1. Hearing(s) held on 12/01/2021
Declared closed by the arbitrator on 12/01/2021

Robin Grumet, Esq., of counsel from Jakubowitz Law Firm PC participated for the Applicant

Jean Schabhuttl from Progressive Casualty Insurance Company participated for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 5,939.80**, was AMENDED and permitted by the arbitrator at the oral hearing.

At the commencement of the hearing, Applicant amended the amount in dispute \$5,839.85 to bring the charges into compliance with what Applicant deems is the appropriate fee schedule. Specifically, Applicant has reduced the original amount of the bill from \$11,617.57 to \$11,567.57 to bring the charges into compliance with the 3M Grouper Software printout contained in evidence in the record below and has subsequently withdrawn the claim in the amount of \$50.00 for the PPE Covid supply cost. Taking into account the original payment made by Respondent, Applicant amended the amount in dispute to \$5,839.85.

Stipulations WERE NOT made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute

The Claimant, TS, a 30-year-old male, was a passenger in a motor vehicle involved in an accident on February 26, 2020. At issue in this case is \$5,839.85, as amended, which represents the balance of Applicant's claim for a facility fee associated with right shoulder arthroscopic surgery performed June 25, 2020. Applicant originally submitted a claim to Respondent in the amount of \$11,617.57. Respondent reimbursed Applicant \$5,677.72, and timely denied the balance asserting that the charges exceed those permitted under the New York Workers' Compensation Fee Schedule (the "Fee Schedule").

The sole issue presented for determination is whether Applicant's charges exceed those permitted under the appropriate Fee Schedule.

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 present to testify during the hearing. I reviewed the documents contained in MODRIA for both parties and make my decision in reliance thereon.

An Applicant establishes its *prima facie* showing of an entitlement to judgment as a matter of law by submitting evidentiary proof that the prescribed statutory billing forms had been mailed, received by the Respondent and that payment of no-fault benefits is overdue. *Mary Immaculate Hospital v. Allstate Insurance Company*, 5 A.D.2d 742, 774 N.Y.S.2d 564 (2nd Dept. 2005). A facially valid claim has been defined as one that sets forth the name of the patient, date of accident, date of service, description of services rendered and the charges for those services. *See, Vinings Spinal Diagnostic P.C. v. Liberty Mutual Insurance Company*, 186 Misc. 2d 128(A), 784 N.Y.S.2d 918 (2003).

At issue in this case is \$5,839.85, as amended, which represents the balance of Applicant's claim for a facility fee associated with right shoulder arthroscopic surgery performed June 25, 2020. Applicant originally submitted a claim to Respondent in the amount of \$11,617.57. Respondent reimbursed Applicant \$5,677.72, and timely denied the balance asserting that the charges exceed those permitted under the New York Workers' Compensation Fee Schedule (the "Fee Schedule"). As noted above, Applicant has amended the claim to \$5,839.85.

The submission of Respondent's Denial of Claim Form ("NF-10") establishes that Respondent received Applicant's claim and that Respondent has not paid the claim. *Lopes v. Liberty Mutual Ins. Co.*, 24 Misc.3d 127(A), 2009 N.Y. Slip Op. 51279(U),

2009 WL 1799812 (App. Term 2nd, 11th & 13th Dists. Jan. 26, 2009). Thus, the submission of Respondent's NF-10 in this proceeding is sufficient to satisfy Applicant's burden in this instance.

As such, the burden now shifts to Respondent to establish that Applicant's charges exceed those permitted under the governing fee schedule, and that it appropriately reimbursed Applicant for the services at issue and, as such, no further reimbursement is due.

The rates charged by Applicant must be in accordance with Insurance Law §5108. The services in dispute were performed subsequent to the effective date of the Fourth Amendment to Regulation 68-C (April 1, 2013). 11 NYCRR 65-3.8(g)(1) now states that proof of fact that the amount of loss sustained pursuant to Insurance Law 5106(a) shall not be deemed supplied by an applicant to an insurer and no payment shall be due for claimed medical services under any circumstances: (i) when the claimed medical services were not provided to an injured party; or (ii) for those claimed medical services that exceed the charges permissible pursuant to Insurance Law 5108(a) and (b) and the regulations promulgated thereunder for services rendered by medical providers.

The language of 11 NYCRR §65-3.8(g)(1) does not place any additional requirement on a medical provider to substantiate the calculation of its fees as part of its *prima facie* case; the burden of asserting a defense that a provider billed in excess of the fee schedule remains on the insurer, who need not pay the bill if it determines that the bill contravenes the fee schedule. *East Coast Acupuncture, PC v. Hereford Insurance Company*, 51 Misc.3d 441, 26 N.Y.S.3d 441 (Civil Ct. Kings Co. 2016). If respondent needed further documentation or additional information for services billed when there is no specific code in the Workers' Compensation fee schedule the insurer needs to request additional verification in accordance with 11 NYCRR 65-3.5(b). *Bronx Acupuncture Therapy v. Hereford Insurance Company*, 2017 NY Slip Op. 50101(U) (App. Term 2nd Dept. 2017), *aff'd* ___ A.D.3d ___, 2019 N.Y. Slip Op. 06059 (2nd Dept. Aug. 7, 2019).

In *Saddle Brook Surgicenter, LLC v. All State Ins. Co.*, 48 Misc.3d 336, 8 N.Y.S.3d 875 (Civ. Ct. Bronx Co. 2015), the Court found, "The purpose of the [no-fault] statute and the fee schedules promulgated thereunder is to 'significantly reduce the amount paid by insurers for medical services, and thereby help contain the no-fault premium'" (*48 Misc.3d at 340) (*Goldberg v Corcoran*, 153 A.D.2d 113, 118 [2nd Dept. 1989], *quoting Governor's Program Bill*, 1977 McKinney's Session Laws of NY at 2449, and *citing Governor's Mem in Support of Assembly Bill A7781-A.*)

Respondent, however, continues to have 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 26240, 13 Misc.3d 172, 822 N.Y.S.2d 378, 2006 N.Y. Misc. LEXIS 1519 (Civil Ct, Kings Co. 2006). *See also, Power Acupuncture PC v. State Farm Mutual Automobile Ins. Co.*, 11 Misc.3d 1065(A), 816 N.Y.S.2d 700, 2006 NY Slip Op 50393(U), 2006 N.Y. Misc. LEXIS 514 (Civil Ct, Kings Co. 2006). An insurer who raises a fee schedule defense, "will prevail if it

demonstrates that it was correct in its reading of the fee schedules." *Jesa Medical Supply, Inc. v. Geico Ins. Co.*, 2009 N.Y. Slip Op. 29386, 25 Misc.3d 1098, 887 N.Y.S.2d 482 (Civ. Ct. Kings Co. 2009). If Respondent fails to demonstrate by competent evidentiary proof that a plaintiff's claims were more than the appropriate fee schedules, defendant's defense of noncompliance with the appropriate fee schedules cannot be sustained. *See, Continental Medical PC v. Travelers Indemnity Co.*, 11 Misc.3d 145(A), 819 N.Y.S.2d 847, 2006 NY Slip Op. 50841(U), 2006 N.Y. Misc. LEXIS 1109 (App. Term 1st Dept. *per curiam*, 2006).

An insurer's unilateral decision to either change an Applicant's CPT codes, pay reduced fees for disputed medical services, or deny the claim in its entirety, is ineffectual when unsupported by a peer review report or by other proof setting forth a sufficiently detailed factual basis and medical rationale for the code changes, denials, or reductions. *Amaze Medical Supply v. Eagle Insurance Company*, 2 Misc.3d 128(A) (App. Term 2nd and 11th Jud. Dists. 2003).

I am, however, also permitted to take judicial notice of the Workers' Compensation Fee Schedule. *Kingsbrook Jewish Medical Center the Allstate Insurance Company*, 61 A.D.3d 13 (2nd Dept. 2009); *LVOV Acupuncture PC v. Geico Insurance Company*, 32 Misc.3d 144(A) (App. Term 2nd, 11th & 13th Jud. Dists. 2011); *see also, Natural Acupuncture Health PC v. Praetorian Insurance Company*, 30 Misc.3d 132(A), 2011 N.Y. Slip Op. 50040(U) (App. Term 1st Dept. 2011).

According to 12 NYCRR 39-2.1, effective October 1, 2015, the Workers' Compensation Board adopted EAPG (Enhanced Ambulatory Patient Group) payment methodology implemented by the Department of Health in 2009 for determining fees for ambulatory surgery performed in the State of New York. According to the Regulation, "Payment for ambulatory surgery services shall be made according to the ambulatory patient groups (APG) methodology, governing reimbursement for licensed freestanding ambulatory surgical centers and hospital-based ambulatory surgery services as set forth herein and subject to WCB specific adjustments. The effective date of this Subpart shall be October 1, 2015."

Applicant, an Ambulatory Surgical Center ("ASC"), has submitted one bill containing the following codes/descriptions [\[1\]](#):

CPT code 29821 RT - \$3,026.24 (shoulder arthroscopy/surgery)

CPT code 29822 RT 59 - \$1,472.45 (shoulder arthroscopy/surgery)

CPT code 29825 RT 59 - \$1,472.45 (shoulder arthroscopy/surgery)

CPT code 29826 RT 59 - \$1,472.45 (shoulder arthroscopy/surgery)

CPT code 29999 RT 59 - \$1,472.45 (arthroscopy of joint)

The parties do not dispute that the EAPG methodology is appropriate in this instance to calculate the rate of reimbursement for the services at issue. However, the crux of the dispute arises over the applicability of NCCI edits as well as Applicant's application of modifier 59 to the subsequent codes billed in addition to the primary procedure, namely 29822, 29825, 29826 and 29999.

Essentially, Applicant asserts that because the procedure involved multiple incisions and, according to Applicant, different procedures, Applicant is, therefore, entitled to reimbursement while utilizing modifier 59 to reflect these additional procedures.

Modifier 59 is defined in the Fee Schedule, in pertinent part, as follows:

Under certain circumstances it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support 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....

In support of its defense, Respondent offers a fee audit authored by Lori Curtin, a Certified Professional Coder. Ms. Curtin discusses, in detail, the implementation of EAPG methodology. She explains that the calculation for the maximum amount allowed under EAPG is the "APG Code Weight" multiplied by the "New York Workers' Compensation Base Rate" which equals the subtotal. The Capital Add-On then gets added where appropriate in order to arrive at the total payment for the primary APG group. APG groups other than the primary APG group do not receive a Capital Add-On. Ms. Curtin further explains that the APG Code Weight is based on the APG code and the CPT code/procedure performed as followed by Medicaid and the New York State Department of Health. The New York Workers' Compensation Base Rate is derived from 150% of Medicaid's hospital base rate. The New York Workers Compensation Base Rate, as well as the Capital Add-On has two regions: upstate and downstate. For the upstate region, the NY Workers Compensation rate is \$228.62 and for downstate the rate is \$295.94. For the upstate region, the Capital Add-On is \$109.90 for ASCs and \$108.48 for hospitals. For the downstate region, the Capital Add-On is \$81.37 for ASCs and \$115.70 for hospitals.

Ms. Curtin further explains that the National Correct Coding Initiative Edits ("NCCI Edits") adopted by Medicare and Medicaid limit the use of modifier 59 when applied in the context of arthroscopy. She states that the NCCI edits outline the exceptions when multiple arthroscopic procedures are performed on the same (ipsilateral) shoulder. Respondent offers copies of the relevant sections of the NCCI General Rules and Guidelines in support of Ms. Curtin's affidavit.

Ms. Curtin maintains that CPT codes 29821, 29822-59, 29825-59, 29826-59, and 29999-59, when billed together, do not meet the criteria for qualified payable exceptions, and, therefore, application of modifier 59 is inappropriate.

Ms. Curtin maintains that Applicant was properly reimbursed \$5,677.72 for the services at issue as CPT code 29881 is the most extensive procedure per the National Correct Coding Initiative is correctly billed under APG group 38. She asserts that the multiple incisions utilized by the surgeon in this case does not qualify for the use of Modifier 59. She explains that, according to the implementation guide, "...Significant procedure consolidation refers to the collapsing of multiple related significant procedure APGs into a single APG for the purpose of determining payment...", and that, according to the EAPG Schedules in the 3M APG Crosswalk database, CPT code 29821 is assigned to APG group 38, and 29822, 29825, 29826 and 29999 are all assigned to APG Group 37. She states that APG 37 consolidates into APG 38 for payment purposes. The application of the predetermined weight, discounts, rate, and capital add-on result in CPT code 29821 being compensated at 100% in the amount of \$5,677.72. Respondent offers copies of the relevant APG Groups from the 3M APG Crosswalk database and Manual Calculation Sheet in support of Ms. Curtin's affidavit.

In support of its claim, Applicant offers an affidavit by Roza Vinogradov, a Certified Professional Coder. Similar to Ms. Curtin, Ms. Vinogradov also provides a comprehensive discussion surrounding the implementation of EAPG methodology, its definitions, and application. Similar to Ms. Curtin, Ms. Vinogradov also utilizes the 3M Core Grouper software in performing her calculations. Essentially, Ms. Vinogradov contends that under the rules promulgated by the Department of Health, modifier 59 was appropriately appended to the CPT codes billed by Applicant. She argues that the operative report notes three incisions (posterior, anterior, and lateral), thus permitting 29821, 29822-59, 29825-59, 29826-59, and 29999-59 to be correctly coded together pursuant to their matching AMA descriptions. She contends that the codes are not integral to one another and can be performed independently of each other and, as such, meet the requirements for the use of modifier 59.

Respondent also offers a subsequent affidavit authored by Ms. Curtin in rebuttal to the arguments raised by Ms. Vinogradov wherein she reiterates her explanations surrounding Applicant's inappropriate application of modifier 59 to the services at issue. Applicant offers another affidavit by Ms. Vinogradov in response to Ms. Curtin's rebuttal, and Respondent offers yet a third affidavit authored by Ms. Curtin.

In *Fifth Avenue Surgery Center, LLC and Progressive Casualty Ins. Co.*, AAA case no. 17-21-1204-0647, Arbitrator Lester Hill was asked to consider the merits of Respondent's fee schedule defense supported by expert analysis in response to Applicant's claim for a facility fee associated with right shoulder surgery, together with the administration of a nerve block with ultrasonic guidance. In that case, Arbitrator Hill was asked to specifically address that Applicant's application of modifier 59 to the surgical services at issue:

The applicant asserts that the Centers for Medicare and Medicaid, MLN Matters, and the National Correct Coding Initiative (NCCI) are not applicable to ambulatory surgical centers facility fees under the New York State Workers Compensation Fee Schedule. Therefore, there is no prohibition in including other CPT codes with Modifier 59 since there are multiple incisions during the surgery.

12 NYCRR 329 - 2.1 provides that payment for ambulatory surgical centers services shall be made according to the ambulatory patient group methodology. I find the respondent's argument persuasive that Modifier 59 is not applicable and should not be reported for the surgery. The language utilized under the APG system states that the purposes of the EAPG is to "bundle related services into logical groups for classification, payment and reporting". The word "bundle" is prominently in the definition. The stated goal is that the EAPG system is "designed to reflect the resources used in an ambulatory visit. These include nursing and technician time, drugs, supplies, ancillary tests, equipment and treatment time". That is why there are groups noted such as APG group 37 and 38, designed, as stated above to reflect the resources used in an ambulatory visit by the facility. More complicated surgeries that require more time provide for greater compensation as reflected in the group designation. In this instance, the surgical time was significantly less than 30 minutes, as reflected in the medical records. Following the logic of the applicant, the fact that the applicant billed for two codes with Modifier 59, all completed in significantly less than 30 minutes, entitles the applicant for additional reimbursement of approximately \$1945.84 (in addition to the \$5677.77 billed under CPT code 29821). It must be remembered that this is the facility fee, not the surgical fee, where the surgeon's skill and training are reflected in the reimbursement for each of the additional CPT codes billed. I fail to see how the applicant is entitled to significantly more reimbursement if the surgeon performs one CPT code or five CPT codes within the significantly less than 30-minute surgical session. Looking at the definition of Modifier 59, the logic of the EAPG system is demonstrated. "Documentation must support 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". The EAPG system attempts to group services that are ordinarily encountered or performed on the same day by the same individual. As an arbitrator, I have handled well in excess of 1000 arthroscopic surgery cases. I have reviewed approximately 50 randomly selected arthroscopic surgery cases and not one involved a single

portal incision, not one. A review of arthroscopic surgery described for the layman on the Internet states that typically multiple portals or incisions are utilized during a typical arthroscopic procedure. Obviously, utilizing multiple incisions or portals is not the factor that determines whether the procedure is "not ordinarily encountered or performed on the same day". To utilize the multiple incision concept as the basis to justify the use of Modifier 59 for the facility is avoiding the purpose of the EAPG system to group or bundle services to reflect the resources used in the ambulatory visit by the facility.

Furthermore, I accept and find persuasive the logic and factual analysis submitted by the respondent with respect to CPT codes 76942 and 64415. The applicant submitted a second claim for these codes and per the Policy and Billing Guidance Ambulatory Patient Groups Provider Manual, the respondent is not entitled to reimbursement for these codes as they must be contained in the one bill submitted by the facility.

Arbitrator Hill's analysis, coupled with Ms. Curtin's expert analysis, is instructive and persuasive. The services rendered in this instance did not involve different surgeries, were not performed in different sessions, and did not involve different anatomical sites or organ system. Rather, the overall procedure at issue, namely, arthroscopic shoulder surgery, involved multiple incisions. Parenthetically, while I have in previous cases found fee coder affidavits insufficient to determine whether one or more incisions were made, thus entitling Applicant to additional reimbursement, in this instance, I am persuaded by Ms. Curtin's analysis that, regardless of whether one or more than one incision was made, appending modifier 59 to the codes billed in this instance is an attempt to circumvent the underlying purpose of APG. (See AAA case no. 17-20-1189-0169, Arb. Felix Papadakis, 11/1/21.)

Therefore, after careful deliberation of the competing coder affidavits, I find, as a matter of fact, Respondent's affidavit more persuasive. Applicant has not sufficiently explained how these separate incisions and procedures would not ordinarily be encountered or performed on the same day by the same individual to warrant the application of modifier 59 for these codes, and, as such, I am not convinced by Ms. Vinogradov that Applicant appropriately appended modifier 59 to CPT codes 29822, 29825, 29825, and 29999. Contrary to the argument presented by Applicant, under the October 1, 2015 EAPG implementation memo prepared by the New York State Workers' Compensation Board, the NCCI edits are, in fact, applicable to the instant claim.

While the 3M worksheet may appear to comport with the Applicant's proffered fee amount, the 3M worksheet does not conclusively demonstrate the proper fee schedule rate since the software's accuracy is dependent upon the accuracy of the information entered into the 3M program in the first instance. (See *New Horizon Surgical Center LLC v. Maya Insurance Company*, AAA Case No.: 17-19-1131-1478, Arbitrator Jan Chow, 8/21/20). The 3M worksheet itself warns the user to "review documentation to

determine if modifier should be reported" when a modifier is inputted in the software to suppress an NCCI edit. Therefore, the accuracy of a 3M worksheet is entirely dependent upon the accuracy of the input and, as such, the appropriate use of the modifier is still determined by the individual inputting the information, thus adding a subjective component to the calculation.

In weighing the evidence presented, I find that the NYS APG Manual, "Grouping Elements of the APG Payment System" directs multiple related significant procedures to be consolidated into one single APG for the purpose of determining payment. Ms. Curtin's affidavit, coupled with the supporting documentation submitted by Respondent, establishes that it would be inappropriate to append modifier 59 to the CPT codes reported in addition to the primary procedure, in this instance, right shoulder arthroscopy. Modifier 59 is appropriate for "different procedures/surgeries" when they are performed at separate anatomic sites, or at separate patient encounters on the same date of service. However, it is not appropriate if the different procedures were performed on the same anatomic site and during the same patient encounter. In this case, the alleged different procedures were all performed on the same shoulder during the same patient encounter, thus rendering modifier 59 inappropriate, and I am, therefore, persuaded by Ms. Curtin that modifier 59 should not have been inputted to the 3M Core Grouper software nor included on the subject bill. I agree with Respondent's assertions that the use of modifier 59 is conditioned upon separate incisions and different procedures "not ordinarily encountered or performed on the same day by the same individual" and I further agree that Applicant has not sufficiently explained how the incisions and procedures at issue here would not "ordinarily be encountered or performed on the same day" by the same individual sufficient to warrant application of modifier 59 to the codes at issue in this proceeding.

Parenthetically, this analysis is congruent with the analyses by IHCs regarding the same issue found in the following awards: Arbitrator Ann Lorraine Russo, *Surgicore Surgical Center LLC v. State Farm*, AAA case no. 17-19-1116-2108 (4/22/2020), Arbitrator Victor Moritz, *Fifth Avenue Surgery Center LLC v. Allstate*, AAA case no. 17-18-1113-9435 (3/23/2020), and Arbitrator Ann Lorraine Russo, *Fifth Avenue Surgery Center LLC v. National General Insurance Online, Inc.*, AAA case no. 17-18-1091-0535 (8/30/2019). In weighing all of the evidence, and the arguments presented by the parties' representatives, I am persuaded by Respondent that it was inappropriate to append modifier 59 to CPT codes 29822, 29825, 29826, and 29999, as they are subsumed into the main procedure, namely 29821.

For the reasons noted above, I find that Respondent has appropriately reimbursed Applicant for the services at issue in this proceeding. Accordingly, Applicant's claim for additional reimbursement is denied.

[\[1\]](#) Applicant's bill also includes CPT code A4649. However, Applicant's claim for reimbursement for services rendered under this code was withdrawn at the commencement of the hearing.

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 Suffolk

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

12/09/2021
(Dated)

Alison Berdnik

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:
1d815ee968deba00bdded5217699ff3e

Electronically Signed

Your name: Alison Berdnik
Signed on: 12/09/2021