

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Jungman Michael Suh MD
(Applicant)

- and -

Progressive Casualty Insurance Company
(Respondent)

AAA Case No. 17-20-1174-0734

Applicant's File No. 3099197

Insurer's Claim File No. 18-1118402

NAIC No. 24260

ARBITRATION AWARD

I, Debbie Thomas, 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 02/16/2022
Declared closed by the arbitrator on 02/16/2022

Elvira Messina from Law Offices of Andrew J. Costella Jr., Esq. participated in person
for the Applicant

Danielle Mazzola from Progressive Casualty Insurance Company participated in person
for the Respondent

2. The amount claimed in the Arbitration Request, **\$3,230.96**, 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
Applicant seeks reimbursement in the amount of \$3,230.96 for EMG/NCV studies of the upper and lower extremities and office visits performed between June 8, 2018 and August 13, 2018 on Assignor, K.A.Y., a 54-year-old female who was the driver of a motor vehicle involved in an accident on April 2, 2018. Respondent denied reimbursement for the electrodiagnostic studies based on the peer review report of Uriel Davis, D.O., which concluded that the testing was not medically necessary. Respondent denied reimbursement for the office visits based upon the May 31, 2018 Independent Medical Examination ("IME") of Andrew Miller, M.D., which determined that further treatment was not medically necessary as of June 15, 2018. The issues presented are

whether the electrodiagnostic testing performed by Applicant was medically necessary; and whether Respondent's denial of treatment past the date of IME cut-off was appropriate.

4. Findings, Conclusions, and Basis Therefor

The within award is based upon this arbitrator's review of the record as well as oral argument at the time of the hearing of this matter.

Under Sec. 5102 of the New York Insurance Law (McKinney 1985), No-Fault first party benefits are reimbursement for all medically necessary expenses on account of personal injuries arising out of the use or operation of a motor vehicle.

It is well settled that a healthcare provider establishes its prima facie entitlement to No-Fault benefits as a matter of law by submitting evidentiary proof that the prescribed statutory billing forms had been mailed and received and that payment of No-Fault benefits were overdue. *Westchester Medical Center v. Lincoln General Insurance Company*, 60 A.D.3d 1045, 877 N.Y.S.2d 340 (2 Dept. 2009); *Mary Immaculate Hospital v. Allstate Insurance Company*, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004). Respondent's denial(s) indicating receipt of the proof of claim shows that Applicant mailed the proof of claim form(s) to the Respondent (see, *Ultra Diagnostic Imaging v. Liberty Mutual Insurance Co.*, 9 Misc.3d 97). The evidence is sufficient to make out a prima facie case of entitlement to recovery of Applicant's bill.

The burden then shifted to the insurer to come forward with sufficient evidence to rebut the presumption of medical necessity which attached to the providers' claim forms. See, *West Tremont Med. Diagnostic, P.C. v. Geico Ins. Co.*, 13 Misc.3d 131(A) (N.Y. App. Term 2006).

EMG/NCV Studies- Peer Review Report

Respondent denied reimbursement for EMG/NCV studies of the upper and lower extremities based on the peer review report of Uriel Davis, D.O. Dr. Davis notes that Assignor is a 55-year-old female who was the restrained driver of a motor vehicle involved in an accident on April 2, 2018. There was no loss of consciousness at that time. Following the accident, she did not go to a hospital.

Assignor was seen in consultation by Jungman Michael Suh, M.D. on April 12, 2018. At that time, she complained of pain in the neck, back, and shoulders. On examination of the cervical spine, there was tenderness and spasms with decreased range of motion. On examination of the lumbar spine, there was tenderness with decreased range of motion. Motor strength was 4/5 and reflexes were 1+. Assignor was started on a therapy program at that time and advised to undergo MRIs.

Assignor underwent an MRI of the lumbar spine on May 30, 2018, which revealed disc bulges at L2-L3, L3-L4 and L4-L5 and disc herniation at L2-L3. She also underwent an MRI of the cervical spine on May 30, 2018, which revealed disc herniation at C5-C6 and multilevel foraminal stenosis. She underwent an Upper and Lower EMG/NCV, conducted by Applicant on June 8, 2018, which revealed right C5-C6 radiculopathy.

In this case, Assignor sustained soft tissue injury. The standard of care for these types of injuries would be evaluation by a physician, ordering of plain radiographs (only if there is suspicion of fracture or a severe mechanism of injury), prescribing of medications such as anti-inflammatory medications, rest and/or conservative physiotherapy for a period of 6-8 weeks. If after this conservative treatment, there is deterioration in the condition or progressive, worsening neurological deficits, MRI may be indicated at that

point in time. At that point, interventional pain management or surgery may be indicated depending upon the results of the advanced imaging or the progression of the condition. However, the standard of care in medicine does not involve the routine use of Electrodiagnostic testing unless there is deterioration in the condition and there is a diagnostic dilemma present.

It appears that Assignor sustained a soft tissue injury that did not result in a neuropathic condition that needed to be ruled out. Essentially, there was no genuine diagnostic dilemma that would have medically justified an EMG/NCV study. In addition, the records do not indicate any progressive, worsening neurological deficits when she was seen by Jungman Michael Suh, M.D. on April 12, 2018. On examination at that time, motor strength was 4/5 and reflexes were 1+.

The diagnosis of radiculopathy is generally clinical in nature. Cervical radiculopathy is a clinical diagnosis made on the basis of the history and clinical findings. In this case, since there was no diagnostic dilemma and no other condition needed to be ruled out related to the accident, the Electrodiagnostic testing was not medically necessary or indicated in this case.

Additionally, electrodiagnostic studies are indicated when the exact localization is necessary for surgical nerve or nerve root decompression, or for the purpose of neurointerventional pain management techniques. This means that the NCV studies are performed when there is a differential diagnosis of radiculopathy, plexopathy, entrapment neuropathy, polyneuropathy, or myopathy, and the differential diagnosis cannot be clarified without these test results. The tests are used to provide information necessary to determine an appropriate course of therapeutic management that would not otherwise be possible.

In the case of radiculopathy, electrodiagnostic testing is of value when it is necessary to confirm the diagnosis because surgical management is being considered or because there is a differential diagnosis, which needs to be clarified, and these tests will then guide the treatment course accordingly. Elective surgery is considered in patients with persistent radicular pain and neurological deficit. Differential diagnosis that might be considered with radiculopathy and in which electrodiagnostic studies can provide information relevant to therapeutic management, would include entrapment neuropathy, or peripheral neuropathy. EMG/NCV studies are utilized to provide evidence of peripheral nervous system damage; as for prognosis of radiculopathy, this testing is not necessary. In this case, no such diagnostic dilemma existed.

According to the Guidelines For Ethical Behavior Relating to Clinical Practice Issues in Neuromuscular & Electrodiagnostic Medicine - Muscle Nerve, 42: 480-486, 2010), "The physician should perform a sufficiently comprehensive neuromuscular evaluation and/or EDX study that can address the issues necessary to determine or evaluate a reasonable differential diagnosis." Based upon clinical findings in this case, there was no differential diagnosis that would necessitate the performance of this study when the EMG/NCV had been performed. Also, in this case, there was no significant alteration in Assignor's treatment program following the EMG/NCV study that was dependent upon this testing. According to the Referral Guidelines for Electrodiagnostic Medicine Consultations, Electrodiagnostic studies "should not be obtained if the information will not potentially enhance the patient's care." (American Association of Neuromuscular & Electrodiagnostic Medicine, 1995-2009). Therefore, the upper and lower EMG/NCV study was not medically necessary.

Applicant submits a rebuttal to the peer review report by Jungman Michael Suh, M.D. Dr. Suh argues that in his peer review report, Dr. Davis appears to argue against every case in which patients utilize medically necessary needle EMG/NCV studies as opposed to refuting issues raised within the neurological records which specifically documented Assignor's positive objective clinical exam and test findings. Basically, the peer review report is simply just another insurance company funded polemic against Assignor's needle EMG/NCV studies without specifically addressing her neurological findings and medical facts.

The peer review doctor suggests a "6 week" arbitrary timetable prior to conducting the testing herein. Assignor's EMG studies were performed 9 weeks post-MVA. Moreover, the peer reviewer also seems to suggest that there is in fact no time criteria if there is a deterioration of the patient's condition and the presence of a diagnostic dilemma, both of which existed with respect to Assignor.

Another egregious error made by the insurance company's peer reviewer is his failure to recognize how the EMG testing would be helpful in guiding Assignor's further care. As Dr. Suh specifically pointed out in his June 4, 2019 narrative report, Assignor would benefit from EMG/NCV testing as Dr. Suh would be able to both better and further evaluate her condition being medically cognizant that if her radiculopathy was severe, then the future treatment plan may be modified and she would benefit from a pain management consultation specifically for treatment concerning her cervical and lumbar spine.

Dr. Davis erroneously claims that there was allegedly no "diagnostic dilemma". Dr. Suh specifically noted in his June 4, 2018 follow-up neurology exam, which is the re-exam that recommended the EMG testing herein, that in addition to radiculopathy, there indeed was a diagnostic dilemma and/or differential diagnosis including plexopathy or other peripheral nerve entrapments involving the upper and lower extremities such as piriformis syndrome be either be ruled out or assessed.

Dr. Davis, who never examined Assignor, also erroneously claims that she supposedly had no deteriorating condition and/or neurological deficits. Dr. Suh notes that prior to performing the EMG/NCV studies, he conducted detailed comprehensive neurological evaluations of Assignor on April 12, 2018, May 10, 2018 and June 4, 2018. Moreover, Assignor suffered for over two months of persistent and progressively worsening neck and low back pain radiating into her extremities associated with paresthesia coupled with positive objective clinical exam findings including but not limited to neurological deficits such as diminished motor, reflex and sensory exams without substantive improvement in her neuromuscular complaints after receiving conservative care which included both physical therapy, acupuncture and chiropractic care.

Dr. Davis's report fails to cogently address that in the clinical setting described in this case, the EMG/NCV testing was clinically appropriate and medically necessary. The testing was performed in accordance with generally accepted medical care including the standards of care established by the New York State Workers Compensation Board, the American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM), WCB and Agency for Health Care Policy and Research, (AHCPR). Indeed, if physicians were to forego testing and continue treating patients on the basis of uncorroborated radicular diagnoses it could lead to significantly lengthier overall treatment plans

characterized by false starts and stops as debilitating alternative neuropathic conditions escape notice and are left unchecked. On the basis of positive neurological findings and the lack of Assignor's considerable improvement from conservative treatment, the electrodiagnostic testing was necessary to properly diagnose her condition and to objectively verify or rule out the presence or absence and severity of radiculopathy or peripheral neuropathy in qualitative and quantitative terms. Dr. Suh's detailed neurological exams revealed multiple neurological deficits and positive orthopedic tests indicative of radiculopathy and nerve root involvement and MRIs of the cervical and lumbar spine revealed significant disc pathology. The examination findings and the MRI evidence support an indication for a differential diagnosis and appropriate investigation by way of electrodiagnostic testing.

According to the New York State Workers Compensation Board Injury Medical Treatment Guidelines, EMG is appropriate for any of the following: To substantiate the diagnosis of radiculopathy, to determine if radiculopathy is acute or chronic, to rule out other potential causes for the symptoms and to confirm radiculopathy if significant radiating symptoms are present for greater than 4 weeks after the onset of injury and no obvious level of nerve root dysfunction is evident on examination, or to determine the extent of injury in patients with an established level of injury. Again, the performance of electrodiagnostic testing on Assignor was consistent with the above stated guidelines. This testing was also performed to substantiate the diagnosis of radiculopathy, to rule out other potential causes for the symptoms, and to determine the extent of injury once the level of injury was clearly established. The test was necessary to confirm the suspected clinical impression. Confirmatory tests are necessary, regardless of whether they will be used to assess the appropriateness of more aggressive treatment options or not. The aim is to prove and document. The primary use of EMG is to document the problem and guide care. It confirms clinical suspicion and incidentally rules out a patient's potential lack of truthfulness or abnormal low pain threshold where either may adversely affect establishing the proper treatment plan. The ultimate judgment regarding the propriety of any specific procedure or course of action must be made by the physician or medical physicist in light of all the circumstances present. Thus, an approach that differs from the guidelines, standing alone, does not necessarily imply that the approach was below the standard of care. To the contrary, a conscientious practitioner may responsibly adopt a course of action different from that set forth in the guidelines when, in the reasonable judgment of the practitioner, such course of action is indicated by the condition of the patient, limitations on available resources, or advances in knowledge or technology subsequent to publication of guidelines. Moreover, the practice of medicine involves not only the science, but also the art of dealing with prevention, diagnosis, alleviation, and treatment of disease. The variety and complexity of human conditions make it impossible to always reach the most appropriate diagnosis or to predict with certainty a particular response to treatment. Simply stated, Dr. Davis' misguided and biased report not provide meaningful medical reason to override the decision to perform EMG/NCV for this patient.

Unequivocally, Assignor's EDX evaluation would provide other differential diagnosis which may have required a different treatment plan and may also have led to the prognosis of her current condition. Dr. Suh's detailed, contemporaneous and positive neurological exam findings were practically a textbook example of a diagnostic dilemma and differential diagnosis being presented in order to perform the reasonable and

medically-necessary electro-diagnostic studies. In addition to the proper standard of neurological care, even the NYS medical guidelines recognize that Needle EMG's (Electromyogram), peripheral nerve conduction studies (NCS) and motor and sensory evoked potentials substantiate the diagnosis of radiculopathy or spinal stenosis in patients with neck and low back pain ... NCS are done in addition to needle EMG to rule out other potential causes for the symptoms (co-morbidity or alternate diagnosis involving peripheral nerves) and to confirm radiculopathy. It is recommended and preferred that EDS in the out-patient setting be performed and interpreted by physicians board-certified in Neurology (which Dr. Suh is) or Physical Medicine and Rehabilitation. Recommendations: C.2.a.ii, EDS (must include needle EMG and NCS) are recommended where a CT or MRI is equivocal and there are ongoing complaints of pain, weakness, and/or numbness/parasthesias that raise questions about whether there may be a neurological compromise that may be identifiable. Dr. Suh also met the criteria of the 2016 AAEM practice guidelines as well as the AANEM Position Statement guidelines, both of which have traditionally held the medical position that the only person who can responsibly determine the appropriate tests to investigate a particular patient's clinical symptoms is the patient's treating-referring physician concerning the EDX evaluation.

Contrary to the peer reviewer's assertion, a genuine diagnostic dilemma was in fact presented to justify the needle EMG/NCV studies, and Assignor's treatment regimen would be altered depending on the results of the EMG testing including a pain management consultation referral as previously discussed and clearly noted within the exam reports. A clinical differential diagnosis and diagnostic dilemma would also include a peripheral neuropathic and myopathic lesion versus a root lesion that would not be resolved with a mere history, neurological exam and MR imaging studies. Unbeknownst to Dr. Davis, the EMG/NCV studies were extremely helpful in assessing Assignor's cervical and lumbar spine nerve root dysfunction revealing evidence of right C5/6 radiculopathy. The EMG testing would have also ruled out motor and sensory spinal nerve root and peripheral nerve abnormalities and further evaluated Assignor's persistent and radiating spinal pain.

After careful consideration of the documents submitted and the parties' oral arguments at the hearing, I find in favor of Applicant. I am persuaded by the rebuttal of Dr. Suh and find that Applicant has refuted the peer review report of Dr. Davis and established that the EMG/NCV studies of the upper and lower extremities were medically necessary. Dr. Suh notes that the testing was performed nine weeks after the motor vehicle accident. During this time, Assignor's had persistent and progressively worsening neck and low back pain radiating into her extremities associated with paresthesia, and coupled with positive objective clinical exam findings including neurological deficits such as diminished motor, reflex and sensory exams without substantive improvement in her neuromuscular complaints after receiving conservative care. In this case, in addition to radiculopathy, there was a diagnostic dilemma and/or differential diagnosis including plexopathy or other peripheral nerve entrapments involving the upper and lower extremities such as piriformis syndrome. The testing was medically necessary in light of Assignor's ongoing symptoms that were not responding to conservative treatment, neurological deficits, and a diagnostic dilemma. Applicant has met its burden of persuasion in rebuttal. Accordingly, this portion of Applicant's claim for reimbursement is awarded.

Office Visits- IME

Respondent denied reimbursement for office visits based upon the May 31, 2018 orthopedic IME of Andrew Miller, M.D., which determined that further treatment was not medically necessary as of June 15, 2018.

Assignor reported to Dr. Miller that she was the seat-belted driver of a motor vehicle involved in an accident on April 2, 2018. She was not rendered unconscious and did not sustain any lacerations. She did not seek immediate medical attention at the time of the accident. She reported initial complaints of headaches, pain in the low back, right shoulder, left shoulder, right knee and left knee.

On April 10, 2018, Assignor started a course of physical therapy, acupuncture and chiropractic treatment that included massage at a frequency of 2-3 times a week. Additional MRIs were performed of the neck and back. She reported that treatments have been beneficial, and was continuing the recommended treatments 2-3 times a week at the time of the IME. Dr. Miller also noted Assignor's current complaints of pain in the neck, mid back, low back, right shoulder, left shoulder, right knee and left knee. She stated that the pain from her low back radiates to the left side of her leg. She denied any other complaints of pain and reported that she did not sustain any other injuries. Therefore, Dr. Miller's examination was limited to the neck, back, shoulders and knees.

Examination of the Cervical Spine revealed no tenderness to palpation of the cervical paraspinal musculature. There was no tenderness to palpation of the trapezii. No muscle spasm was noted. Range of motion of the cervical spine revealed flexion 50 degrees (50 degrees being normal), extension 60 degrees (60 degrees being normal), right rotation 80 degrees (80 degrees being normal), left rotation 80 degrees (80 degrees being normal), right lateral flexion 45 degrees (45 degrees being normal), and left lateral flexion 45 degrees (45 degrees being normal).

On neurological examination, there were no sensory deficits in the upper extremities. Deep tendon reflexes of the biceps and triceps were present and equal bilaterally. Muscle strength in each range was 5/5. No atrophy of intrinsic muscles was noted.

Examination of the Thoracic Spine revealed no spasm. There was no tenderness to palpation over the paraspinal musculature. Range of motion of the thoracic spine revealed right lateral bending 45 degrees (45 degrees being normal), left lateral bending 45 degrees (45 degrees being normal), right rotation 30 degrees (30 degrees being normal) and left rotation 30 degrees (30 degrees being normal).

Examination of the Lumbar Spine revealed no spasm. There was no tenderness noted over the paraspinal musculature on palpation. Range of motion of the lumbar spine revealed flexion 60 degrees (60 degrees being normal), extension 25 degrees (25 degrees being normal), and right and left lateral bending 25 degrees (25 degrees being normal).

Neurological examination revealed patellar and Achilles reflexes to be 2+. Muscle strength of the lower extremities was graded at 5/5 bilaterally. Sensory examination of the lower extremities including the medial and lateral thighs, calves and feet were normal. There was no atrophy noted in the intrinsic muscles of the lower extremities. Straight leg raising was negative. Assignor was able to tiptoe and heel walk.

Examination of the Right Shoulder revealed no tenderness on palpation of the shoulder. There was no effusion noted. There was no crepitus at the joints. Range of motion of the

right shoulder revealed abduction 180 degrees (180 degrees being normal), forward flexion 180 degrees (180 degrees being normal), internal rotation 80 degrees (80 degrees being normal) and external rotation 90 degrees (90 degrees being normal). There was no impingement sign. Neer's sign was negative. Apprehension signs (anterior/posterior) were negative. O'Brien's, Yergason, Speed's, Hawkins's and Drop Arm tests were all negative.

Examination of the Left Shoulder revealed no tenderness on palpation of the shoulder. There was no effusion noted. There was no crepitus at the joints. Range of motion of the left shoulder revealed abduction 180 degrees (180 degrees being normal), forward flexion 180 degrees (180 degrees being normal), internal rotation 80 degrees (80 degrees being normal) and external rotation 90 degrees (90 degrees being normal). There was no impingement sign. Neer's sign was negative. Apprehension signs (anterior/posterior) were negative. O'Brien's, Yergason, Speed's, Hawkins's and Drop Arm tests were all negative.

Examination of the Right Knee revealed no tenderness or effusion noted. There was no evidence of atrophy of the quadriceps noted on inspection. Range of motion was to 140 degrees flexion (150 degrees being normal). Extension was to 0 degrees (0 degrees being normal). McMurray Test, Lachman, anterior drawer, pivot shift and posterior drawer tests were all negative. There was no evidence of patello-femoral crepitus. The knee was stable on valgus and varus stressing.

Examination of the Left Knee revealed no tenderness or effusion noted. There was no evidence of atrophy of the quadriceps noted on inspection. Range of motion was to 140 degrees flexion (150 degrees being normal). Extension was to 0 degrees (0 degrees being normal). McMurray Test, Lachman, anterior drawer, pivot shift and posterior drawer tests were all negative. There was no evidence of patello-femoral crepitus. The knee was stable on valgus and varus stressing.

Dr. Miller diagnosed cervical, thoracic and lumbar spine sprains/strains, resolved; right and left shoulder sprains/strains, resolved; and right and left knee sprains/strains, resolved. Based on his examination of Assignor and clinical experience, Dr. Miller determined that orthopedic treatment was not medically necessary from an orthopedic viewpoint to any of the examined areas. Dr. Miller concluded there was no medical necessity for physical therapy, prescription medication, office visits, surgery or injections to any of the examined areas. Assignor's subjective complaints were not correlated by objective findings.

Respondent has factually demonstrated the services rendered were not medically necessary. Accordingly, the burden now shifts to Applicant, who bears the ultimate burden of persuasion. *See generally, Bronx Expert Radiology, P.C. v. Travelers Ins. Co.*, 2006 NY Slip Op 52116 (App. Term 1 Dept. 2006).

Applicant has not submitted a formal rebuttal to the IME report of Dr. Miller. Instead, Applicant relies on the medical records submitted, including evaluations performed by Dr. Suh on May 10, 2018 and June 4, 2018. Dr. Suh noted Assignor's continued complaints of neck and low back pain, paresthesia, focal weakness, and diminished deep reflexes. EMG/NCV studies of the upper and lower extremities was recommended to further evaluate Assignor's symptoms that were refractory to conservative treatment. EMG/NCV studies revealed evidence suggestive of right C5-C6 radiculopathy. An MRI

of the lumbar spine performed on May 30, 2018, revealed disc bulges at L2-L3, L3-L4 and L4-L5 and disc herniation at L2-L3. An MRI of the cervical spine performed on May 30, 2018, revealed disc herniation at C5-C6 and multilevel foraminal stenosis.

After careful consideration of the documents submitted and the parties' oral arguments at the hearing, I find in favor of Applicant. I find that Applicant has set forth a more credible and persuasive argument regarding the medical necessity for continuing treatment. Although the IME report of Dr. Miller sets forth a credible position that Assignor presented on May 31, 2018 without objective evidence of injury, the evidence submitted by Applicant demonstrates sufficient evidence of objective measures of injury to rebut the IME and establish medical necessity for continued treatment. The contemporaneous medical and objective testing reports detail findings that warranted continued treatment. In light of the findings noted in these reports, I am not persuaded that Assignor's injuries had resolved as of the time of the IME. Accordingly, this portion of Applicant's claim for reimbursement is also awarded.

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
	Jungman Michael Suh MD	06/08/18 - 08/13/18	\$3,230.96	Awarded: \$3,230.96
Total			\$3,230.96	Awarded: \$3,230.96

- B. The insurer shall also compute and pay the applicant interest set forth below. 08/04/2020 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

In accordance with 11 NYCRR 65-3.9(c) interest shall be paid on the claim awarded in the amount of \$3,230.96 from August 4, 2020, the date the arbitration was requested.

C. Attorney's Fees

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

In accordance with 11 NYCRR 65-4.6(d) the insurer shall pay Applicant an attorney's fee on the claim awarded in the amount of \$3,230.96.

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

02/28/2022

(Dated)

Debbie Thomas

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:
b01bd741000de492579831dc3961e29e

Electronically Signed

Your name: Debbie Thomas
Signed on: 02/28/2022