

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Affordable Medical Supply Inc.
(Applicant)

- and -

Geico Insurance Company
(Respondent)

AAA Case No.	17-22-1254-1459
Applicant's File No.	90346
Insurer's Claim File No.	567135210000002
NAIC No.	35882

ARBITRATION AWARD

I, Susan Mandiberg, 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: The EIP

1. Hearing(s) held on 07/17/2023
Declared closed by the arbitrator on 07/17/2023

Ilya Murafa, Esq. from Law Offices of Zara Javakov, Esq. P.C. participated virtually for the Applicant

Krista Varone, Claim Representative from Geico Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$3,035.94**, 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 35-year-old female EIP was a driver of a vehicle at the time of the instant motor vehicle accident on 2/25/22. Presently in dispute is billing for durable medical equipment dispensed to the EIP on 2/28/22 (consisting of a cervical collar, car seat, water circulating unit, LSO, mattress, bed board, massager, and cervical pillow), which Respondent timely denied reimbursement for premised upon a 4/14/22 peer review issued by Shruti Patel, M.D. Billing for a TLSO, dispensed to the EIP on date of service 4/14/22 is also in dispute, which Respondent contends is presently unripe for arbitration. Therefore, the issues presented are whether the durable medical equipment dispensed on 2/28/22 was medically necessary vis-à-vis the peer review upon which Respondent's

denial relies and whether the claim for date of service 4/14/22 is presently ripe for arbitration, respectfully. No Fee Schedule issues were interposed regarding this billing, nor were any issues of policy exhaustion raised. Additionally, at the time of the Hearing, Respondent's representative withdrew any lack of coverage defense initially interposed.

4. Findings, Conclusions, and Basis Therefor

The case was decided after due consideration of the arguments of the parties via Zoom and after a thorough review of the submissions and the documents contained in the electronic case folder maintained by the American Arbitration Association, which are incorporated by reference herein. This case involves billing for durable medical equipment dispensed to the EIP on 2/28/22 and on 4/14/22, following a motor vehicle accident that took place on 2/25/22. Respondent timely denied reimbursement for the 2/28/22 billing pursuant to a peer review issued by Shruti Patel, M.D. on 4/14/22. Respondent contends that the billing for date of service 4/14/22 is presently unripe for arbitration, which Applicant contests.

Pursuant to 11 NYCRR 65-4 (Regulation 68-D), §65-4.5, an Arbitrator shall be the judge of the relevance and materiality of the evidence offered...The Arbitrator may question any witness or party and independently raise any issue that the Arbitrator deems relevant to making an award that is consistent with the Insurance Law and Department Regulations. In addition, Master Arbitrator Peter J. Merani, in the case of Sports Medicine & Orthopedic Rehabilitation a/a/o "I.B." v. Country-Wide Ins. Co., AAA Case No. 17-R-991-14272-3, stated, in relevant part, that "the Arbitrator below is the trier of facts and must evaluate and weigh the evidence presented at the hearing in arrive at his decision. The Arbitrator, in weighing the evidence, has broad powers and discretion in determining what evidence is relevant and material. The Arbitrator is in the best position to evaluate the evidence and decide on the credibility of the submitted documents.

Notice is taken that the First Amendment to Regulation 68-D (11 NYCRR § 65-4), commonly referred to as "the Rocket Docket", provides, in pertinent part, that within thirty (30) calendar days after the American Arbitration Association advises respondent of its receipt of a request for arbitration, the respondent shall "provide all documents supporting its position on the disputed matter", or may request in writing for an additional 30 calendar days to respond". 11 NYCRR § 65-4.2 (3) (ii). "The written record shall be closed upon receipt of the respondent's submission or the expiration of the period for receipt of the respondent's submission". 11 NYCRR § 65-4.2 (3) (iii). After the written record is closed, any additional written submission can made "only at the request of or with the approval of the arbitrator". The submission of documents less than 30 days prior to a scheduled Hearing and without adequate notice to opposing counsel is unduly prejudicial. Moreover, an Arbitrator's choice not to allow late submissions has been upheld by the Courts. See: Matter of Mercury Cas. Co. v. Healthmakers Med. Group, P.C., 67 A.D.3d 1017, 888 N.Y.S.2d 762 (2nd Dept. 2009) and Matter of Global Liberty Ins. Co. v. Coastal Anesthesia Servs., LLC, 2016 NY Slip

Op 08964 (1st Dept. 2016). All evidence not submitted by either party within thirty (30) days prior to the date of the scheduled Hearing, in the interests of fairness, is precluded and shall not be considered herein.

It is well-settled under New York State No-Fault Law that a health care provider establishes its prima facie entitlement to judgment as a matter of law by proof that it submitted a claim, setting forth the fact and the amount of the loss sustained, and that payment of No-Fault benefits was overdue. *Damadian MRI in Canarsie, PC a/a/o Tyrone Harley v General Assurance Co.*, 1006 NY Slip Op. 51048U; Supreme Court of NY, App. Term, 2nd Dept., June 2, 2006; See: Insurance Law §5106 (a); 11 NYCRR §65-1.1; *Mary Immaculate Hosp. v. Allstate Ins. Co.*, 5 AD3d 742, 774 N.Y.S.2d 564 (2004); *Amaze Med. Supply v. Eagle Ins. Co.*, 2 Misc. 3d 128A, 784 N.Y.S.2d 918 [2003 NY Slip Op 51701U (App. Term, 2nd & 11th Jud Dists.)]. See also: 11 NYCRR §65-1.1; *Vista Surgical Supplies, Inc. v. Metropolitan Prop. and Cas. Ins. Co.*, 2005-1328 K C., 2006 NY Slip Op. 51047U, June 2, 2006. Based upon the evidence submitted herein, I find Applicant has established its prima facie case.

Lack of Medical Necessity Defense = Date of Service 2/28/22:

The evidence demonstrates that the 35-year-old female EIP was a driver of a vehicle involved in the instant motor vehicle accident on 2/25/22. Following the accident, the EIP did not seek/receive emergent treatment. Three days after the accident, on 2/28/22, the EIP presented for an initial evaluation with John Greco, M.D. At the time of this initial exam, the EIP complained of mid-back pain, lower back pain, and right hip pain, respectfully. The EIP's cervical spine exam revealed normal findings. There was no examination performed to the EIP's lumbar spine. The examination of the EIP's thoracic spine revealed diminished/painful ranges of motion. Both muscle strength and sensation were normal/within normal limits, the EIP's gait was intact, and there were no positive objective/provocative findings noted upon examination. Dr. Greco diagnosed the EIP with thoracolumbar radiculopathy and hip pain unspecified. The treatment plan called for physical therapy, consultations, MRI testing of the EIP's thoracic spine, lumbar spine, and right hip, range of motion testing, prescription medication (Flexeril) and follow-up. Additionally, Dr. Greco prescribed medical supplies, as denoted in his report, consisting of an orthopedic car seat, water circulating cold pad with pump, LSO, egg crate mattress, and massager, respectfully. The bed board, cervical pillow and cervical collar were not referenced in Dr. Greco's report as necessary (or recommended) for this EIP, although there were spaces in the pre-printed report that delineated such items. Nevertheless, that same day, Dr. Greco issued a prescription for all of the aforementioned items. All of the relevant medical reports, treatment notes, test results and documents were carefully reviewed and considered, in addition to a peer review rebuttal generated by a non-treating provider, Drora Hirsch, M.D.

Respondent timely denied reimbursement for the billing for date of service 2/28/22 based upon a peer review report generated by Shruti Patel, M.D. on 4/14/22, which concluded that the instant items of durable medical equipment dispensed on 2/28/22 was not medically necessary. Applicant contests this peer review pursuant to its peer review rebuttal generated by Dr. Hirsch.

With regard to the cervical collar and cervical pillow, as discussed above, it is noted that the EIP had no complaints regarding her cervical spine, nor were there any positive findings, whatsoever, at the time of the 2/28/22 EIP's physical examination performed by Dr. Greco, after which these items of DME were prescribed. In fact, neither a cervical collar nor cervical pillow were recommended in the examination report, which contained spaces in the preprinted sections for such items that were left blank. Moreover, there were no diagnoses rendered vis-à-vis the EIP's cervical spine. Nevertheless, Dr. Greco issued a prescription for these items nonetheless. According to Dr. Patel, there is no utility for these items. Authoritative sources are cited in support of Dr. Patel's opinion. Although the peer review rebuttal presumably recites a standard of care "for neck pain" this is inapplicable to the EIP herein, which is, in fact, noted in the rebuttal, which states that the EIP's complaints were limited to mid and lower back pain and right hip pain, respectfully. Moreover, while the peer review rebuttal acknowledges that the EIP was diagnosed with thoracolumbar radiculopathy and unspecified hip pain (with no diagnoses rendered vis-à-vis the EIP's cervical spine), these facts are omitted in Dr. Hirsch's recommendation for such items. Although Dr. Hirsch posits that "the cervical collar was prescribed to provide palliative care to this patient due to its stabilization effect," and that a cervical pillow was necessary "to reduce muscle tension and spasm and to diminish pain in the cervical spine and head" such statements are unsupported by the actual evidence, which she purportedly reviewed.

With regard to the car seat, Dr. Patel cites to authoritative sources enunciates a standard of care, that includes "physical therapy and anti-inflammatory" as the "first line management and soft tissue injury, neck and back pain. Orthopedic car seats as prescribed in this case, would not be standard of care and have not shown efficacy. Such devices are often recommended in individuals who were unable to correct their posture on their own. This management deviates from standard of care and therefore the orthopedic car seat was not medically necessary." The rebuttal states that "The patient was recommended a car seat as to maintaining a right posture without making adjustment was mandatory for the patient as back pain is aggravated by movement and prolonged sitting." This is further unsupported by the evidence, given that there was no stated reason for the prescription of this device. Moreover, Dr. Hirsch failed to provide any authoritative source(s) in support of the utility of a car seat or, with reference to the EIP's findings upon exam, why this item would be medically necessary for the EIP herein.

For the water circulating unit with hot/cold pads, Dr. Patel acknowledges that heating and cooling therapy is widely used for treatment of musculoskeletal pain in clinical practice, Dr. Patel takes issue with the necessity of this device, given that there is no difference or added benefits, in her opinion, from treatment with physical therapy and local application of hot and cold packs, thus providing this device is a deviation from the standard of care. In contrast, Dr. Hirsch describes the benefits of such treatment, but fails to contest the opinion as rendered by the peer reviewer. Instead, Dr. Hirsch refers to the treating physician, rather than rebuts the peer review's contentions.

For the LSO, Dr. Patel cites to authority, and opines that the EIP had a sprain/strain injury with no fracture, instability, or surgical intervention planned, thereby rendering any treatment with a lumbar support not medically necessary. She notes that standard of

care for back pain "remains to be conservative therapy with physical therapy and NSAID use for anti-inflammatory." Additionally, she posits that "lumbar support is only shown some evidence and management of compression fractures, and instability. In contrast, Dr. Hirsch states: "The patient was prescribed an LSO as it provides only partial and not complete immobilization of the lumbar spine. Ranges of motion are slowly initiated over the course of the entire treatment plan until a full range of motion is achieved. The use of an LSO was to limit the painful ranges of motion during the healing process. An LSO is custom fitted by a professional to accommodate the patient's unique shape. Based on the severity of the patient's condition and her body conformation, the Lumbar Sacral Support is needed with Anterior-Posterior-Lateral Control for actual motion control (restriction), limiting improper mobility and muscular activity in the lumbar region." While such conditions might well warrant the prescription for an LSO, there were no findings of any diminished ranges of motion in the EIP's lumbar spine, pursuant to the 2/28/22 report of Dr. Greco, who prescribed this device. Additionally, there were no positive provocative test findings regarding the EIP's lumbar spine or any diagnosis specifically pertaining to the EIP's lumbar spine, aside from "thoracolumbar radiculopathy." Thus, the rebuttal is not grounded in the EIP's actual medical records and physical conditions at/about the time this item was prescribed.

Dr. Patel also opined that mattress and bed board prescribed for the EIP were both not medically necessary. As noted above, Dr. Greco, who prescribed both items, failed to reference the need nor recommendation for a bed board in his actual examination report on 2/28/22. Yet, this item was included in the array of durable medical equipment prescribed that same day. With regard to the bed board, the peer reviewer notes that such an item (which is also known as a "transfer board or sliding board) is "useful when patients are unable to use upper body strength to transfer. Standard of care is to use a transfer board when a patient is unable to mobilize themselves." Additionally, bed board is "generally recommended for claimants with below hip or knee amputation, and who are currently on a non-weightbearing status." None of these conditions were applicable to the EIP herein. The rebuttal fails to reference the lack of actual recommendation for the bed board, but states that it is a "standard item that can be prescribed for patients with acute soft-tissue injuries." There is no authoritative source in support of Dr. Hirsch's opinions regarding the bed board. Similarly, with regard to the mattress prescribed, the peer review of Dr. Patel, citing to studies in literature, posits that this item "is recommended for patients with high risk to develop pressure ulcers and other injuries. They are often patients who are unable to move themselves and at risk for pressure points. Standard of care otherwise remains to use physical therapy." Although the rebuttal espouses the general effectiveness of bedding systems, there is no link to the EIP's conditions herein, nor any authoritative sources cited in support of the contention that this EIP had conditions that warranted the prescription of this device. Additionally, there is nothing in the medical records to demonstrate that the EIP was having any sleeping difficulties due to any injuries related to this accident.

The massager was determined to be outside the standard of care by Dr. Patel, since "the standard of care and management of soft tissue injuries remains conservative therapy with physical therapy and pharmacologic therapy with NSAIDs. The use of a massager has not been supported by peer-reviewed studies as being more effective than other

forms of conservative treatment." Thus, since the EIP was already pursuing a course of conservative treatment, the use of an at-home massager was determined not to be medically necessary. In contrast, the peer review rebuttal defers to the EIP's treating providers decision to prescribe this and references equivocal literature that "massage might be beneficial for patients with subacute and chronic nonspecific low-back pain, especially when combined with exercises and education." The fact that the EIP was pursuing a course of conservative treatment, including physical therapy, was that referenced in the rebuttal.

Once Applicant makes a prima facie case of medical necessary, as I find Applicant has done herein, the burden then shifts to Respondent who may refute Applicant's prima facie showing with medical evidence that the services provided were not medically necessary. A denial claiming lack of medical necessity must be supported by a peer review, IME report or other competent medical evidence which sets forth a clear factual basis and medical rationale for denying the claim. See: *Healing Hands Chiropractic, P.C. v. National Assurance Co.*, 5 Misc3d 975; *Citywide Social Work, et al. v. Travelers Indem. Co.*, 3 Misc3d 608; *Amaze Medical Supply, Inc. v. Eagle Ins. Co.*, 2 Misc3d 128(A); *Rockaway Boulevard Medical P.C. v. Travelers Property Cas. Corp.*, 2003 N.Y. Slip Op. 50842(U), 2003 WL 21049583 (App. Term 2nd & 11th Dists. Apr. 1, 2003). Indeed, the burden is on the insurer to prove that the medical services were not medically necessary. See: *Behavioral Diagnostics v. Allstate Ins. Co.*, 3 Misc. 3d 246, 776 N.Y.S.2d 178, 2004 Slip Op. 24041 (Civ. Ct. Kings County 2004); *A.B. Medical Services v. Geico Ins.*, 2 Misc. 3d 26, 773 N.Y.S.2d 773, 2003 Slip Op 23949 (App Term, 2nd Dept. 2003). See also: *Elm Medical P.C. v. American Home Assurance Co.*, 2003 Slip Op. 51357U 2003 N.Y. Misc. LEXIS 1337 (Civ. Ct., Kings Co., 2003); *Fifth Ave. Pain Control Ctr. v. Allstate Ins. Co.*, 196 Misc. 2d 801, 766 NYS2d 748 (Civ. Ct., Queens Co., 2003). An insurance carrier must, at a minimum, establish a detailed factual basis and a sufficient medical rationale for its asserted lack of medical necessity. *Vladimir Zlatnick, M.D., P.C., v. Travelers Indem. Co.*, 12 Misc3d 128(A), 2006 N.Y. Slip Op. 50963(U) (App. Term 1st Dept. 2006); *Delta Diagnostic Radiology, P.C. v. Progressive Cas. Ins. Co.*, 21 Misc.3d 142(A), 2008 N.Y. Slip Op. 52450(U) (App. Term 2nd, 11th, and 13th Jud. Dists. 2008). A peer review report's factual basis may be insufficient if it fails to provide specifics of the claim, is conclusory, or otherwise lacks a basis in the facts of the claim. *Devonshire Surgical Facility, Carnegie Hill Orthopedic Services, P.C. v. American Transit Ins. Co.*, 31 Misc.3d 129(A), 2011 N.Y. Slip Op. 50513(U) (App. Term 1st Dept. 2011); *East Coast Acupuncture Services, P.C. v. American Transit Ins. Co.*, 14 Misc.3d 135(A), 2007 N.Y. Slip Op. 50213(U) (App. Term 1st Dept. 2007).

In this case, after a thorough review of the credible evidence, and for the reasons set forth above, I find that the peer review is, on balance, more persuasive than the peer review rebuttal in evidence. I therefore find that the peer review set forth a clear standard of care and deviation of such standard vis-à-vis the prescription for these items for the EIP herein. Although Applicant has submitted a peer review rebuttal generated by Dr. Hirsch, as discussed above, I do not find it persuasive vis-à-vis these items and find that the citations proffered in support of the rebuttal are rather general in nature rather than specifically geared to the EIP herein. Additionally, in the rebuttal, there is no meaningful discussion of the EIP's complaints, findings upon exam, and the actual

medical report generated by Dr. Greco, who prescribed this array of items merely three days after the date of this motor vehicle accident. I therefore find that the rebuttal did not credibly refute the opinions noted in the peer review, as described above. Therefore, I find that Respondent's denial for the billing covering date of service 2/20/22 is supported by the credible evidence and, as a result, should be sustained. Accordingly, this portion of the claim is denied.

Defense Claim is Unripe - Date of Service 4/14/22:

The general rule is that a No-Fault carrier is generally precluded from raising any defenses to a claim where a denial is not made within thirty (30) days of receipt of the claim, unless the thirty-day period is extended by a proper and timely demand for further verification of the claim. See: 11 NYCRR §65-3.8(c); Insurance Law §5106(a); *Presbyterian Hosp. in the City of New York v. Maryland Cas. Co.*, 90 N.Y.2d 274; *New York Hosp. Med. Ctr. Of Queens v. Country-Wide Ins. Co.*, 295 A.D.2d 583, 744 N.Y.S.2d 201; 11 NYCRR 65.15 [d] & [e]. This rule is consistent with the policy underlying the No-Fault Law, which is to ensure "swift reimbursement of accident victims who had serious injuries" (*Pavone v. Aetna Cas. & Sur. Co.*, 91 Misc.2d 658, 663, A.D.2d 580, rev'd on other grounds 49 N.Y.2d 757); 11 NYCRR §65.15(g)(3). Additionally, per *Presbyterian Hospital v. Maryland Cas. Co.*, 90 N.Y.2d, 274 (NY Court of Appeals 1997), preclusion is the appropriate remedy where the insurer fails to issue a timely denial of claim. This 30-day period may be extended by, inter alia, a timely demand by the insurance company for further verification of a claim [See: 11 NYCRR §65-3.5(b) and §65-3.6(b)]. Such a demand must be made within 15 business days of receipt of the completed application [See: 11 NYCRR §65- 3.5(b)]. If the demanded verification is not received within 30 days, the insurance company must issue a follow-up request within 10 days of the insured's failure to respond [See: 11 NYCRR §65-3.6(b)]. A claim need not be paid or denied until all demanded verification is provided. See: 11 NYCRR §65-3.8(b)(3); *Westchester County Med. Ctr. v. New York Cent. Mut. Fire Ins. Co.*, 262 A.D.2d 553, 554, 692 N.Y.S.2d 665). No-Fault benefits are overdue, however if not paid within 30 calendar days after the insurer receives verification of all of the relevant information requested pursuant to 11 NYCRR §65.15(d). See: 11 NYCRR §65-3.8(a)(1); *New York Hosp. Med. Ctr. of Queens v. Country Wide Ins. Co.*, 295 A.D.2d 583, 584, 744 N.Y.S.2d 201).

The billing for date of service 4/14/22 was discussed in detail with the parties at the time of the Hearing. It is noted that Respondent's evidentiary submission contains no affidavit regarding any purported outstanding verification regarding this billing. However, as stipulated by the parties at the time of the Hearing, after Respondent's receipt of this bill on 6/7/22, Respondent issued one and only one (1) request for an Examination Under Oath of the provider, which was dated 6/23/22. This EUO scheduling letter of 6/23/22 scheduled the EUO for 7/7/22 and further sought additional information with regard to the acquisition cost of the item of durable medical equipment, among other things. It is uncontested that there is no follow-up request for an EUO or for any additional verification regarding the cost of the TLSO, nor was there any denial issued for this particular bill. Given that Respondent failed to issue any follow-up requests for this particular bill, I find that it was improperly delayed for payment. I therefore find that Applicant is entitled to reimbursement for this billing in the amount billed, \$778.11.

Conclusion:

Based on the foregoing, after careful review of the totality of the credible evidence, and for the reasons set forth herein, I find that Respondent has credibly refuted Applicant's prima facie case for the durable medical equipment dispensed on date of service 2/28/22. I therefore find, on balance, that Respondent's peer review is more credible and persuasive than the peer review rebuttal in evidence. This portion of the claim is denied. However, for the billing generated for date of service 4/14/22, I find that Respondent failed to properly toll the time to pay, delay, or deny this claim. As such, payment is overdue and is awarded herein.

Accordingly, Applicant is awarded the total sum of \$778.11 and the remainder of this claim is denied.

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
	Affordable Medical Supply Inc.	02/28/22 - 02/28/22	\$2,257.83	Denied
	Affordable Medical Supply Inc.	04/14/22 - 04/14/22	\$778.11	Awarded: \$778.11
Total			\$3,035.94	Awarded: \$778.11

- B. The insurer shall also compute and pay the applicant interest set forth below. 06/13/2022 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Respondent shall pay the Applicant interest computed from the above-noted date, at a rate of 2% per month, simple, and ending with the date of payment of the award subject to the provisions of 11 NYCRR §65-3.9(e).

C. Attorney's Fees

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

The insurer shall also pay the Applicant an attorney's fee based upon the amount awarded herein and the interest, as calculated in section "B" above, and in accordance with the relevant Regulations.

- 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 NY

SS :

County of Nassau

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

07/19/2023
(Dated)

Susan Mandiberg

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:
a55a9de281390e0d6662fac3359f9895

Electronically Signed

Your name: Susan Mandiberg
Signed on: 07/19/2023