American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Nat Bell Supply Inc (Applicant)	AAA Case No.	17-23-1302-5094
	Applicant's File No.	BT23-236971
- and -	Insurer's Claim File No.	8731434610000001
	NAIC No.	22055
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

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

Injured Person(s) hereinafter referred to as: EIP or "Assignor"

1. Hearing(s) held on 08/06/2024
   Declared closed by the arbitrator on 08/06/2024

   Heather Landeros, Esq., from The Tadchiev Law Firm, P.C. participated virtually for the Applicant

   Warren Sheinwald, Esq., from Geico Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$1,876.00**, 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

   This male EIP (first initial "B") was 50-years-old when he was injured as the driver in an automobile accident on 11/16/2022. The EIP was subsequently prescribed and provided with the 'Pain Away Home Care Laser Device' on 1/18/2023. The prescribed duration is not legible. The device was dispensed on 2/5/2023. Applicant seeks reimbursement of $1,876.00 for a 28-day rental of this device, from 2/5/2023 through 3/4/2023.

   There are two bills at issue for 14-days each ($938.00 x 2). Respondent timely denied each bill asserting the device lacked medical necessity based on the peer review report

by Kevin S. Portnoy, D.C. Applicant submitted a rebuttal by Dr. Aristide Burducea, D.O., dated 5/13/2024. Respondent also contends that the correct rental rate should be 10% of the paid wholesale invoice, per month.

The issues to be determined are (1) whether the disputed DME rental was medically necessary and, if so, (2) whether the amount sought is correct per fee schedule allowances.

4. Findings, Conclusions, and Basis Therefor

This case was decided based on prevailing law, the submissions of the parties as contained in the electronic file ["MODRIA"] maintained by the American Arbitration Association, and the oral arguments of the parties' representatives. There were no live witnesses.

Unless the parties' agreement provides otherwise, an arbitrator need not apply the rules of evidence, is not bound by principles of substantive law, may do justice as he sees it, and may apply his own sense of law and equity to the facts as he finds them to be. Matter of New Century Acupuncture, P.C. v. Country Wide Ins. Co., 48 Misc.3d 1201(A), 18 N.Y.S.3d 580 (Table), 2015 N.Y. Slip Op. 50919(U) at 2, 2015 WL 3821534 (Dist. Ct. Suffolk Co., C. Stephen Hackeling, J., June 18, 2015); *see also,* Rules for Arbitration of No-Fault Disputes in the State of New York; Effective August 16, 2013, [p](1), "The arbitrator shall be the judge of the relevance and materiality of the evidence offered, and strict conformity to legal rules of evidence shall not be necessary." https://nysinsurance.adr.org.

Medical Necessity

The burden is on the Respondent to prove, prima facie, that the services lacked medical necessity as Applicant's claim arrives to this arbitration carrying a presumption of medical necessity. Millennium Radiology, P.C. v. New York Central Mutual Fire Ins. Co., 23 Misc.3d 1121(A), 886 N.Y.S.2d 71 (Table), 2009 N.Y. Slip Op. 50877(U), 2009 WL 1261666 (Civ. Ct. Richmond Co., Katherine A. Levine, J., Apr. 30, 2009). The Respondent's denial for lack of medical necessity must be supported by a peer review or other competent medical evidence which sets forth a clear factual basis and medical rationale for denying the claim. Healing Hands Chiropractic, P.C. v. Nationwide Assurance Co., 5 Misc.3d 975, 787 N.Y.S.2d 645 (Civ. Ct. New York Co. 2004); CityWide Social Work & Psy. Serv., P.L.L.C. v. Travelers Indemnity Co., 3 Misc.3d 608, 609, 777 N.Y.S.2d 241, 242 (Civ. Ct. Kings Co. 2004).

Peer Review

On 3/20/2023, Dr. Portnoy reviewed the relevant records, including the referral/prescription for the Pain Away Laser device and delivery record, the bill for the initial 2-week rental, chiropractic records, physical therapy records, MRI reports for the chest, cervical spine, and lumbar spine, ultrasound reports for the left shoulder, lumbar

spine, and cervical spine, outcome assessement summary report, DXD radiographic analyses for the cervical spine and lumbar spine, and evaluation reports and other records. After reviewing the records, Dr. Portnoy stated, in part:

> [] It is my professional opinion that the claimant is not in need of the pain away laser home. In order to substantiate the chiropractic necessity of the pain away laser home, it is necessary to have contemporaneous chiropractic documentation that relates to the specific need for the pain away laser home. This would include, at least, documentation of evaluation for the pain away laser home, instruction in safe and effective use of the pain away laser home and follow up in relation to response to treatment with the pain away laser home, including any complications as well as compliance with instructions. Dr. Kim fails to provide any chiropractic necessity for the pain away laser home. Specifically, a pain away laser home could be ineffective without appropriate evaluation prior to prescription, along with detailed instruction in self application. Dr. Kim does not provide any chiropractic documentation that relates to the specific need for the pain away laser home. Dr. Kim does not indicate how the pain away laser home, will aide in devising, altering, reducing the number of visits to his office or enhancing the clinical prognosis of the claimant.
>
> [citation omitted]
>
> In this clinical case, the claimant was involved in a motor vehicle accident on 11/16/2022 and sustained an injury to the neck and low back. As per the cited guideline, *LLLT should only be used as an adjuvant therapy for pain relief in patients with neuropathic pain and neurologic deficits."* However, as per the cited guideline there was no documented evidence of [] neuropathic pain and neurologic deficits. Hence as per the cited guideline and available records, the pain away laser was not necessary.

In the reference cited, *NCBI, The Use of Low Level Laser Therapy (LLLD For Musculoskeletal Pain, 2015 Jun 9*, the study concluded, this device "should only be used as an adjuvant therapy for pain relief in patients with neuropathic pain and neurologic deficits."

Rebuttal Case

To rebut Dr. Portnoy's conclusions, Applicant relies on contemporaneous records and a rebuttal report by Dr. Aristide Burducea, D.O., dated 5/13/2024. Dr. Burducea disagrees with Dr. Portnoy and provides a contrary rationale with contrary medical support. Dr. Burducea summarized the EIP's history, clinical findings, and diagnostic test results. Dr. Burducea also noted that Dr. Portnoy only addressed the initial rental period, from 2/5/2023 through 2/18/2023.

Dr. Burducea pointed out that the "delivery receipt certifies that the patient received instructions on how to use the device." It is noted that the evaluation report for 1/18/2023 also states the EIP was educated on the safe and effective use of medical equipment.

Dr. Burducea stated, "There is a robust amount of peer-reviewed literature that indicates that LLLT is a safe and overwhelmingly efficacious treatment method for musculoskeletal pain relief and accelerated healing for any location in the body." Dr. Burducea provided articles that support LLLT for radiculopathy. The report of 1/18/2023 notes diagnoses of cervical and lumbar radiculopathy. Cervical foraminal compression test was positive and straight leg raise test was positive. The EIP described pain as "burning, radiating, exacerbated with movement." The ultrasound performed on 12/26/2022 revealed findings "consistent with nerve irritation" in the cervical and lumbar regions.

Dr. Burducea also stated, "Please also note that LLLT devices, such as the Erchonia FX-635, have been approved by the FDA as "indicated for the adjunctive use in providing temporary relief of nociceptive musculoskeletal pain."

(https://www.accessdata.fda.gov/cdrh_docs/pdf19/K190572.pdf)

The Pain Away Laser uses the same technology, and has been classified as the same type of device (https://www.accessdata.fda.gov/cdrh_docs/pdf17/K171354.pdf)."

Discussion

I am now tasked with weighing these competing reports to determine which is more persuasive on the issue of medical necessity. I find myself persuaded by Applicant. Based on the above, I am persuaded by the contrary rationale and the authoritative support relied upon by Dr. Burducea. IT appears this device was medically necessary for this EIP's specific injuries. Applicant has met its shifted burden and proven medical necessity by a preponderance of credible evidence.

While not always determinative, the treating physician's opinion is entitled to some deference. Oceanside Medical Healthcare, P.C. v. Progressive Ins., 2002 N.Y. Slip Op. 50188(U) at 5, 2002 WL 1013008 (Civ. Ct. Kings Co., Jack M. Battaglia, J., May 9, 2002).

Fee Schedule

Pursuant to *11 NYCRR, Section 65-3.16*, Measurement of no-fault benefits, (a) Medical expenses, (1), "Payment for medical expenses shall be in accordance with fee schedules promulgated under section 5108 of the Insurance Law and contained in Part 68 of this Title (Regulation 83).

The Workers' Compensation fee schedule, which is required by law and incorporated by reference into the Insurance Department Regulations, is of such sufficient authenticity

and reliability that it may be given judicial notice, and it need not be submitted to the court. Z.A. Acupuncture, P.C. v. Geico Ins. Co., 33 Misc.3d 127(A), 939 N.Y.S.2d 745 (Table), 2011 N.Y. Slip Op. 51842(U), 2011 WL 4949646 (App. Term 2d, 11th & 13th Dists. Oct. 11, 2011); Lvov Acupuncture, P.C. v. Geico Ins. Co., 32 Misc.3d 144(A), 939 N.Y.S.2d 741 (Table), 2011 N.Y. Slip Op. 51721(U), 2011 WL 4424472 (App. Term 2d, 11th & 13th Dists. Sept. 16, 2011).

As such, I take appropriate evidentiary notice of the NY WC Fee Schedule. If the fees can be determined from a straightforward reading of the fee schedule, no coder affidavit or fee audit is required. Absent a straight-forward calculation confirming the correct rate, 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 26240, 13 Misc.3d 172, 822 N.Y.S.2d 378, 2006 N.Y. Misc. LEXIS 1519 (Civil Ct, Kings Co. 2006).

Applicant billed $67.00 per day for the Pain Away device under CPT Code E1399, for a total of $938.00 for each 14-days. There is no specific rate of reimbursement in the DME Fee Schedule.

Respondent submitted a copy of the purchase invoice, which shows Applicant paid $2,995.00 for the device. On the disputed rental dates, the new 2022 DME Fee Schedule effective 4/4/2022 but was then delayed.

Applicant submitted a written position to support a delay of implantation of the DME Fee Schedule and stated in relevant part:

> Since code E1399 does not have a listed maximum reimbursable amount or rental fee in the WCB DME fee schedule, and since code E1399 was dispensed after April 4, 2022 and before June 1, 2023, the NoFault regulations limit the total rental charge to the lesser of the acquisition cost plus 50% and the usual and customary rate charged to the general public. Please see the relevant regulation attached. Per the attached invoice, the acquisition cost was $2,995.00. As such, determining the maximum permissible rental charge is limited to $4,492.50 ($2,995.00 * 150%) and the usual and customary price charged to the general public.

Applicant contends that since the subject rental dates were before 6/1/2023, Applicant is entitled to the rate set by the general public.

As for some background, on 12/23/2022, Adrienne Harris, Superintendent of Financial Services, provided a Statement of the Reasons for the Emergency Measure, Thirty-Sixth Amendment to 11 NYCRR 68 (Insurance Regulation 83). Adrienne Harris stated:

> In June 2021, the Chair of the Workers' Compensation Board ("Chair") adopted, via regulation, amendments to its Official New York Workers' Compensation Durable Medical Equipment Fee Schedule ("DME fee schedule"), which took effect on April 4, 2022. The Chair's amendments update the list of DME that is available; **increases the reimbursement amount for DME** listed in the fee schedule; and creates a prior

> authorization process for certain DME listed in the DME fee schedule for which no reimbursement amount is assigned and for DME that is not listed in the DME fee schedule. As a result of these amendments, the Chair eliminated the lesser of acquisition cost plus 50% or usual and customary fee calculation for DME, the permissible charge for which no fee has been established. The Chair also required that all DME be provided by Medicaid-enrolled DME providers **and capped the total accumulated rental charge for DME listed in the DME fee schedule to the purchase price of the DME**.
>
> The adoption of a prior authorization process in the DME fee schedule for certain DME would not apply to reimbursement for DME in the no-fault insurance system; therefore, no set prices for DME would be established for use in no-fault. **The absence of a cost control measure in place for DME used in the no-fault system would result in the unwarranted depletion of patients' $50,000 no-fault insurance benefits as a result of exorbitant prices for the purchase of DME for which no price is set in the workers' compensation DME fee schedule, and unlimited rental charges that could far exceed the purchase price of the DME**.
>
> In order to mitigate the problems to the no-fault system stemming from the Chair's recent amendments to the workers' compensation DME fee schedule, the Superintendent deems it **necessary to adopt an emergency amendment to 11 NYCRR 68 (Insurance Regulation 83) to cap the purchase and total accumulated rental of DME for which either no price has been established in the DME fee schedule or for DME not listed in the DME fee schedule. Such a cap will only provide a consistent reimbursement methodology for both listed and unlisted DME and safeguard against the unwarranted depletion of patients' $50,000 no-fault insurance benefits because of unlimited rental charges. (emphasis added).**

Evidentiary notice is taken of 12 NYCRR 442.2(a)(2)(b), which provides, "The maximum permissible monthly rental charge for such equipment, supplies and services provided on a rental basis shall not exceed the lower of the monthly rental charge to the general public or the price determined by the New York State Department of Health area office. The total accumulated monthly rental charges shall not exceed the fee amount allowed under the Medicaid fee schedule."

The NYSDOH has not established a rental price for the device at issue.

I agree with Arbitrator Ellen Weisman's analysis. In **AAA Case No. 17-15-1020-9528**, Arbitrator Weisman found that "the Medicare rate most accurately reflects the intended monthly rental charges to the general public as there is no other authoritative source which has promulgated a fixed rate. Moreover, assigning a specific rate is a legislative mandate which cannot be altered in the arbitration forum. Arbitrator Weisman also addressed the argument by providers that the Medicare rates do not reflect charges to the general public, I agree with Arbitrator Ellen Weisman's analysis. In **AAA Case No. 17-15-1020-9528**, Arbitrator Weisman stated:

> Applicant's counsel's argument that Medicare charges for treatment of disabled and elderly patients do not reflect charges to the general public is found to be misguided. Since the statute specifically states that the accumulated monthly rental charge shall not exceed the Medicaid fee schedule, which also caters to a specific population of patients, there is no reason to suggest that the Medicare rate is improper despite the fact that it also covers a specific population of patients. Thus, I find that it would be patently improper[] to require an insurer to pay a rate in excess of the rate set by Medicare. A healthcare provider cannot set arbitrary and excessive fees, and then argue that they reflect the usual and customary rates charged to the general public. Rather, I am convinced that the rate charged by Applicant is unsupported, arbitrary and excessive, and as such it runs counter to the intent of the No-Fault Regulation of cost containment. As a result, no further payment is owed. This finding is supported by the Master Arbitrator Awards of Anne L. Powers (**AAA Case No.: 99-15-1009-2471**) and Master Arbitrator Richard B. Ancowitz (**AAA Case No.: 99-15-1006-8739**) which upheld the imposition of the Medicare rate. Since Respondent paid slightly in excess of the Medicare rate, no further payment is owed.

On this issue, Arbitrator Allison Schimel provided further persuasive guidance. In **AAA Case No. 17-22-1265-2291**, Arbitrator Schimel determined:

> The Medicare DMEPOS Fee Schedule can be found on the www.cms.gov website. CMS stands for Centers for Medicare and Medicaid. This is clearly the applicable amount and the most reasonable indicator of the prevailing rate charged to the general public, since it is specifically referenced in the New York State Medical Fee Schedule which applies to No-fault, which states "The total accumulated monthly rental charges shall not exceed the fee amount allowed under the Medicaid fee schedule." (emphasis added). The application of these rates has been affirmed in prior arbitration matters by Master Arbitrator Robyn D. Weisman in **AAA Case No. 99-17-1071-9428,** Master Arbitrator Marilyn Felenstein in **AAA Case No. 99-18-1102-7880**, and Master Arbitrator Richard B. Ancowitz in **AAA Case No. 99-19-1122-2031**.
>
> Pursuant to the DMEPOS Fee Schedule, Applicant billed for a 56 day CPM rental in this case. $21.52/day x 56 days = a total of $1,205.12. Applicant billed for a 28 day rental for the CTU. Pursuant to the DMEPOS Fee Schedule, the calculations for the CTU are as follows: $42.89 / 30 = $1.43 per day for 28 days = $40.04 for the CTU rental. Accordingly, $1,205.12 + $40.04 + $19.50 for the sheepskin pad = a total award of $1,264.66.

I find the above analyses persuasive.

A daily charge of $67.00 per day would produce $24,455.00 annually. **The acquisition cost of $2,995.00 would be reached in about 45-days**. I have reviewed the DME Fee Schedule. This would be extremely inconsistent with any other charge in the fee schedule. For example, Applicant's proposed $67.00 would exceed the documented

rental per week for a hospital bed rental, an external defibrillator, and home ventilator with tracheotomy tube. The only item that would cost more to rent is the Air fluidized bed, which has a purchase cost over $20,000.00.

Applicant's position is simply not plausible or realistic. "One of the primary purposes in limiting the maximum charges for DME and orthotic devices is to ensure that insureds' $50,000.00 in maximum No-Fault benefits are not artificially depleted by inflated DME and orthotic device charges." Government Employees Ins. Co. v. Li-Elle Service, Inc., 2103 WL 829302 at 5 (E.D.N.Y., Vera M. Scanlon, J., Feb. 11, 2013). It would be necessary to ignore this primary purpose if the rental rate for the disputed Pain Away device could exceed every other rental rate in the DME Fee Schedule except for one item priced over $20,000.00.

It should also be noted that the Medicare rates are generally, and noticeably, higher than the rates allowed by No-Fault for most all DME. This further supports that Applicant's rate of $67.00 per is arbitrary, excessive, and not supported by any reasonable methodology.

See, https://www.cms.gov/medicaremedicare-fee-service-paymentdmeposfeescheddmepos-fee-schedule/dme22

The 2018 New York Workers' Compensation Fee Schedule, General Ground Rule 4, states: "The Durable Medical Equipment Fee Schedule adopted is still the Medicaid Fee Schedule." The current New York State Medicaid Program Durable Medical Equipment, Prosthetic, Orthotic, And Supply Manual Policy Guidelines state: "For DME items that have been assigned a Maximum Reimbursement Amount (MRA), the rental fee is 10% of the listed MRA. For DME items that do not have a MRA, the rental fee is calculated at 10% of the equipment provider's acquisition cost."

See, https://www.emedny.org/ProviderManuals/DME/PDFS/DME_Policy_Section.pdf

The Appellate Division, First Department in Matter of Global Liberty Ins. Co. v. ISurply, LLC, 2018 NY Slip Op 04961 (1st. Dept. 2018), issued a decision on 7/3/2018, which confirms that the one sixth/one tenth fee limitation is applicable, the Court stating: "It is true that the Medicaid DME fee schedule, which listed certain codes for DMEs, some of which had a MRA and some of which did not, established that for those that did not have a MRA, the monthly rate of 1/6 of the equipment provider's acquisition cost would apply. Additionally, pursuant to 12 NYCRR § 442.2(b), "the total accumulated monthly charges shall not exceed the fee amount allowed under the Medicaid fee schedule." Therefore, the law supports the one-sixth/one-tenth fee limitation set forth in New York State Medicaid Program Durable Medical Equipment Manual Policy Guidelines applies to no-fault fee calculations of the rental of medical equipment. See, Matter of Glob. Liberty Ins. Co., *supra*; *see also,* Geico v. MissSupply, Inc., Supreme Court, Nassau County, Index No.: 66953/18.

I've reviewed the arbitration awards submitted by both parties and appreciate there are differences of opinion with some arbitrators following the '10 percent' rationale and some allowing the billed amounts, regardless of the daily rate.

For the foregoing reasons, I find that the one-tenth fee limitation set forth in the New York State Medicaid Program Durable Medical Equipment Manual Policy Guidelines applies to the no-fault fee calculation for the device at issue.

Applicant paid $2,995.00. The monthly rental would be $299.50 or $9.983333 per day. The total for 14-days is $139.77.

Applicant's argument that application of the "1/10th rule" is unconstitutional is meritless. The above rationale is based on guidelines in effect prior to the implantation of the new DME fee schedule. *See*, Matter of Global Liberty Ins. Co., *supra* and the awards by Master Arbitrator Robyn D. Weisman in **AAA Case No. 99-17-1071-9428,** Master Arbitrator Marilyn Felenstein in **AAA Case No. 99-18-1102-7880**, and Master Arbitrator Richard B. Ancowitz in **AAA Case No. 99-19-1122-2031**.

Conclusion

Having carefully considered the submissions of the parties, the relevant case law, and the arguments of respective counsel, I conclude that the preponderance of the credible evidence supports a finding in favor of Applicant.

Applicant is awarded $9.983333 per day x 14-days = $139.77 x 2 = $279.54.

5. Optional imposition of administrative costs on Applicant.
   Applicable for arbitration requests filed on and after March 1, 2002.

   I do NOT impose the administrative costs of arbitration to the applicant, in the amount established for the current calendar year by the Designated Organization.

6. **I find as follows with regard to the policy issues before me:**
   - ☐ The policy was not in force on the date of the accident
   - ☐ The applicant was excluded under policy conditions or exclusions
   - ☐ The applicant violated policy conditions, resulting in exclusion from coverage
   - ☐ The applicant was not an "eligible injured person"
   - ☐ The conditions for MVAIC eligibility were not met
   - ☐ The injured person was not a "qualified person" (under the MVAIC)
   - ☐ The applicant's injuries didn't arise out of the "use or operation" of a motor vehicle
   - ☐ The respondent is not subject to the jurisdiction of the New York No-Fault arbitration forum

Accordingly, the applicant is AWARDED the following:

A.

Medical		From/To	Claim Amount	Status
	Nat Bell Supply Inc	**02/05/23 - 02/18/23**	**$938.00**	**Awarded: $139.77**
	Nat Bell Supply Inc	**02/19/23 - 03/04/23**	**$938.00**	**Awarded: $139.77**
Total			**$1,876.00**	**Awarded: $279.54**

B. The insurer shall also compute and pay the applicant interest set forth below. 06/06/2023 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Applicant is awarded interest pursuant to the no-fault regulations. *See generally*, 11 NYCRR §65-3.9. Interest shall be calculated "at a rate of two percent per month, calculated on a pro rata basis using a 30-day month." 11 NYCRR §65-3.9(a). A claim becomes overdue when it is not paid within 30 days after a proper demand is made for its payment. However, the regulations toll the accrual of interest when 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 Insurance Department regulations." *See*, 11 NYCRR 65-3.9(c); and OGC Op. No. 10-09-05 (interest accrues from date Applicant "*actually requests arbitration*" or commences a lawsuit). The Superintendent and the New York Court of Appeals have interpreted this provision to apply regardless of whether the particular denial at issue was timely. LMK Psychological Servs., P.C. v. State Farm Mut. Auto. Ins. Co., 12 N.Y.3d 217 (2009). Interest begins the first business day following a weekend arbitration request or due date.

C. Attorney's Fees

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

Applicant is awarded statutory attorney fees pursuant to the no-fault regulations. See, 11 NYCRR §65-4.5(s)(2). The award of attorney fees shall be paid by the insurer. 11 NYCRR §65-4.5(e). Accordingly, "the attorney's fee shall be limited as follows: 20 percent of the amount of first-party benefits, plus interest thereon, awarded by the arbitrator or the court, subject to a maximum fee of $1360." *Id*.

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 Onondaga

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

09/03/2024
(Dated)

Fred Lutzen

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:
a5f55a26f6767d4e915b2ae36d8035e0

Electronically Signed

Your name: Fred Lutzen
Signed on: 09/03/2024