American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Prompt Medical Spine Care, PLLC (Applicant)	AAA Case No.	17-17-1075-0527
	Applicant's File No.	2031471
- and -	Insurer's Claim File No.	0428003289 2MT
Allstate Fire & Casualty Insurance Company (Respondent)	NAIC No.	29688

ARBITRATION AWARD

I, Anthony Kobets, 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 10/24/2018
   Declared closed by the arbitrator on 10/24/2018

   Justin Skaferowsky, Esq. from Israel, Israel & Purdy, LLP participated in person for the Applicant

   Hamilton Driggs, Esq. from Allstate Fire & Casualty Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 761.16**, was NOT AMENDED at the oral hearing.
   Stipulations WERE made by the parties regarding the issues to be determined.

   At the hearing, the parties' representatives stipulated to the timely service of the bills and denials, to the Applicant's prima facie burden and to the amount in dispute being in accordance with the applicable provisions of the New York State Workers' Compensation Fee Schedule.

3. Summary of Issues in Dispute

   In dispute are the Applicant's bills totaling $761.16 for a cervical epidural steroid injection with guidance performed on 7/12/17 and a medical evaluation performed on the patient (LR) on 7/26/17 as a result of injuries alleged to have been sustained in a motor vehicle accident on September 7, 2016.

The issue is whether the services were not medically necessary based upon the results of an Independent Medical Examination (IME) performed by Dr. Jimmy Lim, M.D. on 2/15/17 with an effective cutoff date of 5/23/17. Is the Applicant entitled to reimbursement for the services provided to the EIP?

4. Findings, Conclusions, and Basis Therefor

I have reviewed all documents as available in the ADR Center as of the date of this hearing pertaining to this case. This case was decided based on the submissions of the Parties as contained in the electronic case folder maintained by the American Arbitration Association and the oral arguments of the parties at the hearing. There was no testimony at the hearing. This case is linked with AAA case no. 171710638092 and AAA case no. 171710654453.

At the hearing, the parties' representatives stipulated to the timely service of the bills and denials, to the Applicant's prima facie burden and to the amount in dispute being in accordance with the applicable provisions of the New York State Workers' Compensation Fee Schedule.

The parties' representatives agreed that medical necessity was the sole issue in dispute herein.

The EIP (LR) was a 66-year old male driver who was allegedly involved in a motor vehicle accident on September 7, 2016. Thereafter on 7/12/17, the patient underwent a cervical spine steroid injection with guidance and on 7/26/17 the patient underwent a medical evaluation performed by the Applicant. Applicant is seeking no-fault reimbursement for these services.

A health care provider establishes its *prima facie* entitlement to payment as a matter of law by proof that it submitted a proper claim, setting forth the fact and the amount charged for the services rendered and that payment of no-fault benefits was overdue (see Insurance Law § 5106 a; Mary Immaculate Hosp. v. Allstate Ins. Co., 5 AD 3d 742, 774N.Y.S. 2d 564 [2004]; Amaze Med. Supply v. Eagle Ins. Co., 2 Misc. 3d 128A, 784 N.Y.S. 2d918, 2003 NY Slip Op 51701U [App Term, 2d & 11th Jud Dists]).

A treatment or service is medically necessary if it is "appropriate, suitable, proper and conducive to the end sought by the professional health service in consultation with the patient. It means more than merely convenient or useful treatment or services, but treatment or services that are reasonable in light of the patient's injury, subjective and objective evidence of the patient's complaints of pain, and the goals of evaluating and treating the patient." Fifth Avenue Pain Control Center v. Allstate, 196 Misc. 2d 801, 807-808 (Civ. Ct. Queens Cty. 2003). Medically necessary treatment or services must be "consistent with the patient's condition, circumstances and best interest of the patient with regard to the type of treatment or services rendered, the amount of treatment or services rendered, and the duration of the treatment or services rendered." Id. Medical

services are compensable where they serve a valid medical purpose. Sunrise Medical Imaging PC v. Lumbermans Mutual, 2001 N.Y. Slip Op. 4009.

A presumption of medical necessity attaches to a Respondent's admission of the Applicant's timely submission of proper claim forms such as in the within case, the burden then switches to the respondent to demonstrate the lack of medical necessity. A.B. Medical Services, PLLC v. Lumbermens Mutual Casualty Company, 4 Misc.3d 86, 2004 N.Y. Slip Op. 24194 (App.Term 2nd and 11th Jud. Dists. 2004); Kings Medical Supply, Inc. v. Country-Wide Insurance Company, 5 Misc.3d 767, 2004 N.Y. Slip Op. 24394 (N.Y. Civ. Ct. Kings Co. 2004); Amaze Medical Supply, Inc. v. Eagle Insurance Company, 2 Misc.3d 128(A), 2003 N.Y. Slip Op. 51701(U) (App Term 2nd and 11th Jud. Dists. 2003). Respondent thus bears the burden of production and persuasion with respect to medical necessity of the treatment for which payment is sought. (See Bajaj v. Progressive, 14 Misc 3d 1202(A) (N.Y.C. Civ Ct 2006).

If an insurer asserts that the medical test, treatment, supply or other service was medically unnecessary the burden is on the insurer to prove that assertion with competent evidence such as an independent medical examination, a peer review or other proof that sets forth a factual basis and a medical rationale for denying the claim. (See A.B. Medical Services, PLLC v. Geico Insurance Co., 2 Misc. 3d 26 [App Term, 2nd & 11th Jud Dists 2003]; Kings Medical Supply Inc. v. Country Wide Insurance Company, 783 N.Y.S. 2d at 448 & 452; Amaze Medical Supply, Inc. v. Eagle Insurance Company, 2 Misc. 3d 128 [App Term, 2nd and 11thJud Dists 2003]).

An IME report asserting that no further treatment is medically necessary must be supported by a sufficiently detailed factual basis and medical rationale, which includes mention of the applicable generally accepted medical/professional standards. Carle Place Chiropractic v. New York Central Mut. Fire Ins Co., 19 Misc.3d 1139(A), 866 N.Y.S.2d 90 (Table), 2008 N.Y. Slip Op. 51065(U), 2008 WL 2228633 (Dist. Ct., Nassau Co., May 29, 2008, Andrew M. Engle, J.). An IME doctor must establish a factual basis and medical rationale for his asserted lack of medical necessity for future health care services. E.g., Ying Eastern Acupuncture, P.C. v. Global Liberty Insurance, 20 Misc.3d 144(A), (App. Term 2d & 11th Dists. Sept. 3, 2008).

Respondent timely denied payment of the bills in dispute herein based on the independent medical examination (IME) conducted by Dr. Jimmy Lim, M.D. on 2/15/17. The patient presented to the IME with complaints of headaches, neck pain, left shoulder pain and lower back pain. Examinations of the cervical spine, left shoulder and lumbar spine revealed full range of motion with no tenderness or spasms noted. Orthopedic tests, reflexes, sensation and motor strength were unremarkable and Dr. Lim diagnosed the patient with resolved: cervical sprain, left shoulder sprain and lumbar sprain. He concluded that there was no need for further orthopedic care including pain management injections. Respondent's counsel argued that the Respondent met its burden regarding the lack of medical necessity for the services in dispute herein.

If the insurer presents sufficient evidence establishing a lack of medical necessity, then the burden shifts back to the Applicant to present its own evidence of medical necessity. See: *West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co.*, 13 Misc3d 131A (2006). Once the insurer [Respondent] makes a sufficient showing to carry its burden of coming forward with evidence of lack of medical necessity,

"[Applicant] must rebut it or succumb." See, Bedford Park Med. Practice P.C. v American Transit Tr. Ins. Co., 8 Misc. 3d 1025 (A), 2005, 2005 NY Slip Op 51282 citing Bauman v Long Island Railroad, 110AD2d 739, 741, [2d Dept 1985]). Applicant's counsel argued that Dr. Lim's IME report was insufficient to sustain the Respondent's burden of proof that the post-IME cutoff services were not medically necessary.

Applicant also presented a rebuttal by Dr. Sebastian Lattuga, M.D. dated 8/22/18, wherein he reviewed the patient's medical records including the IME report by Dr. Jimmy Lim, M.D. and stated, inter alia, that "[a]s documented in the medical reports attached hereto, the examination findings of the treating physicians before and after the IME clearly indicate that the patient had yet to reach pre-injury status. Also, according to the findings upon diagnostic testing, the IME doctor's diagnosis of resolved cervical, left shoulder and lumbar sprain injury was inaccurate."

The evidence herein demonstrated that the patient was initially examined by Dr. Timur Hanan, M.D. on 9/12/16 and presented with complaints of headaches, as well as neck pain, left shoulder pain, lower back pain, and left hip pain. Examination of the cervical spine revealed decreased range of motion with spasms. Examination of the lumbar spine revealed decreased range of motion with tenderness. Examination of the left shoulder revealed decreased range of motion with tenderness and a positive Neer test and Hawkins's test. Manual muscle testing was 4/5 in the left shoulder and the gait was antalgic. Examination of the left hip revealed decreased range of motion with tenderness and a +4/5 muscle test. Sensory examination was decreased in the left upper and lower extremity and Straight Leg Raising (SLR) test was positive on left side at 45 degrees. The patient was diagnosed with Other cervical disc displacement, unsp cervical re; Other intervertebral disc displacement, lumbar reg.; Post-traumatic headache, unspecified, intractable; Strain of muscle, fascia and tendon at neck level; Strain of must/tend the rotator cuff of left shoulder; Strain of muscle, fascia and tendon of lower back; Strain of muscle, fascia and tendon of left hips. The treatment plan included physical therapy treatments and medications.

On 09/19/16, the patient was reexamined by Dr. Hanan and presented with complaints of headaches, as well as neck pain with numbness and tingling, left shoulder pain, radiating lower back pain, and left hip pain. Examination of the cervical spine revealed decreased range of motion with tenderness and spasms. Examination of the lumbar spine revealed decreased range of motion with tenderness. Examination of the left shoulder revealed decreased range of motion with tenderness and a positive Neer test and Hawkin's test. Manual muscle testing was 4/5 in the left shoulder and the gait was antalgic. Examination of the left hip revealed decreased range of motion with tenderness and a +4/5 muscle test. Sensory examination was decreased in left upper and lower extremity and SLR was positive on left side at 45 degrees. The patient was diagnosed with Other cervical disc displacement, unsp cervical re; Other intervertebral disc displacement, lumbar reg.; Post-traumatic headache, unspecified, intractable; Strain of muscle, fascia and tendon at neck level; Strain of must/tend the rotator cuff of left shoulder; Strain of muscle, fascia and tendon of lower back; Strain of muscle, fascia and tendon of left hips. The treatment plan included an MRI of the left shoulder to rule out a rotator cuff tear.

An MRI of the left shoulder performed on 9/29/16 revealed a tear of the anterior labrum, a partial rotator cuff tear and joint effusion.

Physical therapy treatment notes from September 2016 - January 2017 documented the patient's complaints of pain and the treatments rendered. The assessments indicated that the patient showed good tolerance to all physical therapy treatments given and the plan recommended continuing with the treatments as planned to "[a]chieve normal functional capabilities for ADL's."

An MRI of the cervical spine performed on 10/27/2016 revealed disc herniations at C3-C4, C4-C5, C5-C6 and C6-C7 with central and foraminal narrowing.

An MRI of the lumbar spine performed on 10/27/2016 revealed disc herniations at L3-L4 and L4-L5 with central and foraminal narrowing; a broad disc bulge at L5-Sl narrowing the right sided neural foramen and abutting the exiting right L5 nerve root; a disc bulge at L2-L3 ; and Grade I anterolisthesis of L4 upon L5.

On 11/6/16, the patient was examined by Dr. Dov Berkowitz, M.D. and presented with complaints including left shoulder pain. Past surgical history is notable for both knees and left ankle arthroscopy and surgery related to colon cancer as well as herniorrhaphy. Examination of the left shoulder documented decreased range of motion with pain and weakness as well as positive O'Brien's, Neer and Hawkins tests. MRI of the left shoulder was noted to reveal positive tearing of the labrum and partial rotator cuff tear with a joint effusion. Left shoulder surgery was recommended following the examination.

EMG/NCV testing performed on 11/17/2016 revealed evidence of left C5-C6 radiculopathy, right L5 radiculopathy and evidence of a moderate bilateral carpal tunnel syndrome (median nerve compression neuropathy at wrist) affecting sensory and motor components.

On 11/30/16, the patient underwent a left shoulder arthroscopic surgery with related services. The preoperative diagnosis was traumatic anterior labral tearing and traumatic rotator cuff tearing. The postoperative diagnosis was traumatic anterior labral tearing; traumatic rotator cuff tearing; extensive hypertrophic synovitis; significant hyperemic bursitis; multiple adhesions; and thickened coracoacromial ligament.

On 1/5/17, the patient was examined by Dr. Demetrios Mikelis, M.D. and diagnosed with herniated cervical intervertebral disc; cervical radiculopathy; and lumbar disc herniation with radiculopathy.

On 01/25/2017 the patient was examined by Dr. Billy Ford, M.D. and presented with complaints of neck pain rated as 9/ 10 on a scale, with radiation to the bilateral upper extremity. The pain was described as constant, dull and sharp and shooting in character. Examination of cervical spine revealed tenderness on palpation, spasms and restricted range of motion. Reflexes were decreased and Sensations were altered in the bilateral

C5, C6 and C7. The diagnoses were cervical nerve root impingement and cervical disc herniations and the patient was recommended a cervical epidural steroid injection and to continue physical therapy.

On 02/08/2017 the patient underwent cervical epidural steroid injection with epidurography under fluoroscopic guidance at C6-C7 level with general anesthesia. The diagnoses were cervical sprain, radiculopathy and cervical herniated nucleus pulposus.

On 2/16/17, the patient was reexamined by Dr. Demetrios Mikelis, M.D. and presented with complaints of neck pain and back pain. Examinations of the cervical spine and lumbar spine revealed tenderness on palpation, spasms and restricted range of motion. Spurling test was negative bilaterally, tenderness to palpation was negative, Faber's test was negative, left facet loading was negative and right facet loading was positive. Reflexes were decreased and some sensation was altered. The diagnoses included herniated cervical disc, cervical radiculopathy; and lumbar disc herniation with radiculopathy. The patient elected continuing with conservative care and undergoing epidural injections.

On 02/22/2017 the patient was reexamined by Dr. Billy Ford, M.D. and presented with complaints of neck pain and back pain. Examinations of the cervical spine and lumbar spine revealed tenderness on palpation, spasms and restricted range of motion. Spurling test was negative bilaterally, tenderness to palpation was negative, Faber's test was negative, left facet loading was negative and right facet loading was positive. Reflexes were decreased and some sensation was altered. The diagnoses included cervical nerve root impingement, herniated lumbar disc, bilateral lumbosacral nerve root lesions and cervical disc herniations. The patient was recommended conservative care and pain medications.

On 3/6/17, the patient was examined by Dr. Sebastian Lattuga M.D. and presented with complaints of neck pain and back pain. Examinations of the cervical spine and lumbar spine revealed tenderness on palpation, spasms and restricted range of motion. The diagnoses included herniated cervical disc, cervical radiculopathy; and lumbar disc herniation with radiculopathy. The patient elected continuing with conservative care and undergoing epidural injections.

On 5/17/2017 the patient was reexamined by Dr. Billy Ford, M.D. and presented with complaints of neck pain and back pain. Examinations of the cervical spine and lumbar spine revealed tenderness on palpation, spasms and restricted range of motion. Spurling test was negative bilaterally, Straight Leg Raise test was negative bilaterally, tenderness to palpation was negative, Faber's test was negative, left facet loading was negative and right facet loading was positive. Reflexes were decreased and some sensation was altered. The diagnoses included cervical nerve root impingement, herniated lumbar disc, bilateral lumbosacral nerve root lesions and cervical disc herniations. The patient was recommended a lumbar epidural steroid injection.

On 5/24/17, the patient underwent a lumbar epidural steroid injection with epidurography under fluoroscopic guidance at L4-L5 level. The diagnoses were lumbar sprain, radiculopathy and lumbar herniated nucleus pulposus.

On 6/7/17, the patient underwent a lumbar epidural steroid injection with epidurography under fluoroscopic guidance at L4-L5 level. The diagnoses were lumbar sprain, radiculopathy and lumbar herniated nucleus pulposus.

On 6/21/17 the patient underwent a lumbar epidural steroid injection with epidurography under fluoroscopic guidance at L5-S1 level. The diagnoses were lumbar sprain, radiculopathy and lumbar herniated nucleus pulposus.

On 7/12/17 the patient underwent cervical epidural steroid injection with epidurography under fluoroscopic guidance at C6-C7 level with general anesthesia. The diagnoses were cervical sprain, radiculopathy and cervical herniated nucleus pulposus.

On 7/26/2017 the patient was reexamined by Dr. Billy Ford, M.D. and presented with complaints of neck pain and back pain. Examinations of the cervical spine and lumbar spine revealed tenderness on palpation, spasms and restricted range of motion. Spurling test was negative bilaterally, Straight Leg Raise test was negative bilaterally, tenderness to palpation was negative, Faber's test was negative, left facet loading was negative and right facet loading was positive. Reflexes were decreased and some sensation was altered. The diagnoses included cervical nerve root impingement, herniated lumbar disc, bilateral lumbosacral nerve root lesions and cervical disc herniations. The patient was recommended continuing with physical therapy.

On 8/3/17, the patient underwent bilateral lumbar medial branch blocks at L2, L3, L4, and L5 dorsal ramus for bilateral facet joints L3-4, L4-5, L5-S1. The preoperative diagnosis and post-operative diagnosis were lumbago/low back pain; panniculitis affecting regions of neck and back, sacral and sacrococcygeal region; and possible facetogenic pain. The indications stated that the patient "has failed to respond to conservative therapy including physical therapy, NSAIDS, Home Exercises and Medications."

On 8/17/17, the patient underwent a bilateral lumbar medial branch blocks at L2, L3, L4, and L5 dorsal ramus for bilateral facet joints L3-4, L4-5, L5-S1. The preoperative diagnosis and post-operative diagnosis were lumbago/low back pain; panniculitis affecting regions of neck and back, sacral and sacrococcygeal region; and possible facetogenic pain. The indications stated that the patient "has failed to respond to conservative therapy including physical therapy, NSAIDS, Home Exercises and Medications."

On 9/12/17, the patient underwent a bilateral cervical medial branch blocks at C4-C7; and fluoroscopic localization of needle placement. The preoperative and postoperative diagnoses were cervicalgia, panniculitis and possible cervical facetogenic pain.

On 10/20/17, the patient underwent a bilateral lumbar medial branch Rhizotomy at L2, L3, L4, and L5 dorsal ramus for bilateral facet joints L3-4, L4-5, L5-S1. The preoperative diagnosis and post-operative diagnosis were lumbago/low back pain; panniculitis affecting regions of neck and back, sacral and sacrococcygeal region; and possible facetogenic pain.

On 11/20/17, the patient underwent a bilateral cervical medial branch blocks at C4, C5, C6 and C7 for bilateral facet joints C4-5, C5-6 C6-7; and fluoroscopic guidance of needle placement. The preoperative diagnosis and post-operative diagnosis were cervicalgia/neck pain; panniculitis affecting regions of neck and back, sacral and sacrococcygeal region; and possible cervical facetogenic pain.

On 1/3/18, the patient underwent a percutaneous lumbar discectomy at L3-4 and L4-5. The diagnosis was lumbar herniated disc at L3/4 and L4/5.

Based upon a review of the evidence herein and the arguments of counsel, I find that the Respondent has met its burden regarding a lack of medical necessity and that the Applicant's documents failed to sufficiently rebut the lack of medical necessity for the 7/12/17 and 7/26/17 services. Pan Chiropractic, P.C. v. Mercury Ins. Co., 24 Misc.3d 136(a) (App. Term 2d, 11 & 13 Dist. July 9, 2009). The Applicant herein failed to submit sufficient objective evidence of ongoing symptomology that would support the medical necessity for the services in dispute herein. I am persuaded by Dr. Lim's comprehensive examination using a goniometer and the patient's lack of any objective findings at the IME, including a negative compression test, a negative Spurling's test, a negative Hawkin's test, a negative Neer's test, a negative Speed's test, a negative Suclus test, a negative cross abduction test, a negative Apprehension test, a negative Laseague's test, a negative Fabere's test, full rotator cuff strength, full reflexes, full upper and lower muscle strength, intact upper and lower sensation and a normal gait. Dr. Lim's comprehensive assessment regarding the lack of necessity for additional orthopedic treatment was more convincing than the Applicant's proofs in this matter, including the operative reports, which unexplainably indicated that conservative treatment failed. Dr. Lim's IME report provided a sufficient medical rationale and factual basis to justify a lack of medical necessity for the additional services provided to the patient based on the patient's symptomology and clinical findings documented in the medical records. Where an IME report provides a factual basis and medical rationale for an opinion that services were not medically necessary and the provider fails to present any evidence to refute that showing, the claim should be denied. AJS Chiropractic, P.C. v. Mercury Ins. Co., 22 Misc.3d 133(A), 880 N.Y.S.2d 871 (Table), 2009 N.Y. Slip Op. 50208(U), 2009 WL 323421 (App. Term 2d & 11th Dist. Feb. 9, 2009).

Additionally, I find that the Applicant's proofs failed to meaningfully rebut the arguments made in the IME report or provide a sufficient reasonable medical rationale for the performance of the additional treatments considering the patient received various pain medications, had been undergoing conservative treatment with questionable improvement and there was no indication that that the course of conservative treatment was failing or that continuing with conservative treatment would not yield beneficial results. I do not find that the Applicant's proofs sufficiently delineated why this particular patient necessitated the disputed services following the IME cutoff. Thus, comparing the relevant evidence presented by both parties against each other and the above referenced medical necessity standard, I find in favor of the Respondent, and deny reimbursement for the 7/12/17 and 7/26/17 dates of service in the amount of $761.16. This decision is in full disposition of all claims for No-Fault benefits presently before

this Arbitrator. Any further issues raised in the hearing record are held to be moot and/or waived insofar as not raised at the time of the hearing.

This arbitrator has not made a determination that benefits provided for under Article 51 (the No-Fault statute) of the Insurance Law are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of Assignor. As such and in accordance with the provisions of the prescribed NYS Form NF-AOB (the assignment of benefits), Applicant health provider shall not pursue payment directly from Assignor for services which were the subject of this arbitration, notwithstanding any other agreement to the contrary.

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 Nassau

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

11/21/2018
(Dated)

Anthony Kobets

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:
04c4b5a4e02ce50c4e7e79836f5cb3c2

Electronically Signed

Your name: Anthony Kobets
Signed on: 11/21/2018