

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Citimed Services, PA , Dynamic Surgery
Center, LLC , Premier Anesthesia Associates
PA
(Applicant)

- and -

AAA Case No.	17-18-1109-3841
Applicant's File No.	none
Insurer's Claim File No.	322398C67
NAIC No.	25178

State Farm Mutual Automobile Insurance
Company
(Respondent)

ARBITRATION AWARD

I, Paul Weidenbaum, 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: IP

1. Hearing(s) held on 09/24/2020
Declared closed by the arbitrator on 09/24/2020

Dino Di Rienzo from Dino R. DiRienzo Esq. participated in person for the Applicant

Jonathan De Pasquale from James F. Butler & Associates participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 3,887.23**, 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 arbitration arises out of medical and anesthesia services provided to the injured person, a 33 year old female, who was involved in a motor vehicle accident which occurred on 12/16/17.

Whether the Respondent's reduction/denial of the Applicant's claim for reimbursement of No-Fault benefits based on fee schedule can be sustained?

4. Findings, Conclusions, and Basis Therefor

This arbitration arises out of surgical services provided to the injured person, a 33 year old female, who was involved in a motor vehicle accident which occurred on 12/16/17. Applicant seeks reimbursement in the sum of \$3,887.23. Respondent denied any further reimbursement based on fee schedule, and has submitted the fee analysis of Mercy Acuna, C.P.C. dated 3/18/19 in support of its fee schedule defense.

Ms. Acuna concluded that no additional reimbursement is due as the Respondent previously reimbursed Applicant the appropriate amount for the services at issue based upon the applicable provisions of the fee schedule, as follows:

"This review is to determine the allowable amount per fee schedule. NJ Fee Schedule Calculation: Per PART 68 - CHARGES FOR PROFESSIONAL HEALTH SERVICES (Regulation 83) 68.6 Health services performed outside New York State If a professional health service reimbursable under section 5102(a)(1) of the Insurance Law is performed outside New York State, the permissible charge for such service shall be the prevailing fee in the geographic location of the provider. The NJ medical fee schedule is the prevailing fee in the geographic location of the provider. Per the NJ Medical Fee Schedules: Automobile Insurance Personal Injury Protection and Motor Bus Medical Expense Insurance Coverage 11:3-29.5 Outpatient surgical facility fees (a) ASC facility fees are listed in Appendix, Exhibit 1, by CPT code. Codes that do not have an amount in the ASC facility fee column are not reimbursable if performed in an ASC. (d) When multiple procedures are performed in an in an ASC or in an HOSF in the same operative session, the ASC facility fee or the HOSF fee, as applicable, for the procedure with the highest payment amount is reimbursed at 100 percent and reimbursement of any additional procedures furnished in the same session is 50 percent of the applicable facility fee. 1. A procedure performed bilaterally in one operative session is reported as two procedures and is subject to the multiple procedure reduction formula. 2. Subchapter, Appendices, Exhibit 1, the Physicians' and ASC Facility Fee Schedule and Exhibit 7, the HOSF fee schedule, indicate those CPT codes that, according to Medicare (see: www.cms.gov/ASCPayment/ASCRN/list.asp and <http://www.cms.gov/HospitalOutpatientPPS/>), are exempt from the multiple procedure reduction formula.

Charges from Dynamic Surgery Center: Date of service 7/13/2018 (EOR dated 9/4/2018) amount billed = \$1,012.32: Provider billed CPT code 62321, new code as of 1/1/2017. Per the NJ fee schedule FAQ: 9. The CPT code for the service to be performed has been changed since the fee schedule rule was last amended. The provider should always bill the actual and correct CPT code that he or she is providing. The amount that the insurer pays for the service is determined by the provisions of N.J.A.C. 11:3-29.4(e). NOTE: The description for CPT code 62321 is

"Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)" NOTE: The description for CPT code 62310 is "Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic" · CPT code 62321 is a new code as of 1/1/2017. The similar code that is in the fee schedule is 62310 therefore the fee applicable to CPT code 62310 is appropriate [see 11:3-29.4 (e)] · CPT code 62310 (for CPT code 62321) fee = \$1,012.32 The allowable amount per the NJ fee schedule = \$1,012.32 Date of service 9/15/2018 (EOR dated 9/4/2018) amount billed = \$2,586.34: Provider billed CPT codes 64490-50, 64491-50 and 64492-50. The allowable amount per the above rule [11:3-29.5(d) 1 and 2]: · CPT code 64490 = \$1,012.32 paid at 100% SCS#: 174139-26CR1 · CPT code 64490 = \$506.16 (50% of \$1,012.32) · CPT code 64491 = \$355.95 @ 50% = \$177.98 · CPT code 64491 = \$355.95 @ 50% = \$177.98 · CPT code 64492 = \$355.95 @ 50% = \$177.98 · CPT code 64492 = \$355.95 @ 50% = \$177.98 CPT code 64491 and 64492 does not have an indication in the fee schedule that it is exempt from the multiple reduction formula (does not have an X= ASC codes Not Subject to Multiple Procedure Reductions) The total allowable amount per the NJ fee schedule = \$2,230.40 Charge from Citimed Services PA: Date of service 7/13/2018 (EOR dated 8/27/2018) amount billed = \$1,575.00: · Provider billed CPT code 01992 x 2 units Per the NJ Medical Fee Schedules: Automobile Insurance Personal Injury Protection and Motor Bus Medical Expense Insurance Coverage 11:3-29.4 Application of medical fee schedules (p) The ANES code on the Physicians' Fee Schedule is the conversion factor for anesthesia units. Payors shall follow the Medicare Claims Processing Manual and other guidelines for calculating the number of units for the various CPT codes for the administration of anesthesia and other billing situations, such as directing or supervising Certified Nurse Anesthetists and other non-physician anesthesia providers. These can be found at: www.cms.hhs.gov/center/anesth.asp. · Per the Medicare guidelines: Actual anesthesia time in minutes is reported on the claim. For anesthesia services furnished on or after January 1, 1994, the A/B MAC computes time units by dividing reported anesthesia time by 15 minutes. Round the time unit to one decimal place. Total time = 19 minutes (13:06 to 13:25) = 1.26 = 1.3 time unit (Round the time unit to one decimal place.) Base unit = 5 Total units = 6.3 (5+1.3) · Per the NJ Medical Fee Schedule, the conversion factor for anesthesia for the North Region = \$86.47 x 6.3 units = \$544.76 The allowable amount per the NJ fee schedule = \$544.76

Charge from Premier Anesthesia Associates, PA: Date of service 7/27/2018 (EOR dated 9/4/2018) amount billed = \$1,350.00: · Provider billed CPT code 01992 x 2 units Per the NJ Medical Fee Schedules: Automobile Insurance Personal Injury Protection and Motor Bus Medical Expense Insurance Coverage 11:3-29.4 Application of medical fee schedules (p) The ANES code on the Physicians' Fee

Schedule is the conversion factor for anesthesia units. Payors shall follow the Medicare Claims Processing Manual and other guidelines for calculating the number of units for the various CPT codes for the administration of anesthesia and other billing situations, such as directing or supervising Certified Nurse Anesthetists and other non-physician anesthesia providers. These can be found at: www.cms.hhs.gov/center/anesth.asp. · Per the Medicare guidelines: Actual anesthesia time in minutes is reported on the claim. For anesthesia services furnished on or after January 1, 1994, the A/B MAC computes time units by dividing reported anesthesia time by 15 minutes. Round the time unit to one decimal place. Total time = 16 minutes (12:09 to 12:25) = 1.06 = 1.1 time unit (Round the time unit to one decimal place.) Base unit = 5 Total units = 6.1 (5+1.1) · Per the NJ Medical Fee Schedule, the conversion factor for anesthesia for the North Region = \$86.47 x 6.1 units = \$527.47 The allowable amount per the NJ fee schedule = \$527.47 NY Fee Schedule Calculation: Charges from Dynamic Surgery Center: NOTE: As of October 1, 2015, the NY WCB implemented the Enhanced Ambulatory Patient Group (EAPG) for the Ambulatory Fee Schedule.

Below is the rule related to out-of-state facilities:

Out-of-state facilities

Bills submitted by out-of-state facilities should be reimbursed using the EAPG-based ambulatory surgery fee schedule. The Board will follow the Department of Health's guidance regarding out-of-state billing in the Policy and Billing Guidance Ambulatory Patient Groups Provider Manual Rates of payment for out-of-state providers in counties contiguous to New York City and New York's Dutchess, Putnam, Westchester, Rockland and Orange Counties will reflect the average APG payment for the same services applicable to New York State providers in those downstate areas. Out-of-state counties contiguous to the downstate rate region include: Sussex, Passaic, Bergen, Hudson, Essex, Middlesex, Union and Monmouth Counties in New Jersey; Pike County in Pennsylvania; and Litchfield and Fairfield Counties in Connecticut. Rates of payment for all other out-of-state providers will reflect the average APG payment for the same services applicable to providers in upstate New York. NOTE: The calculation of the appropriate fee was made manually. The 3M Core Grouping Software is endorsed by the NY Workers' Compensation Board but is not required. Per the New York Workers' Compensation Enhanced Ambulatory Patient Group (EAPG) Ambulatory Fee Schedule FAQ: 3. Will a new fee schedule be posted or must we calculate payments? An Ambulatory Surgery Fee Schedule will not be posted. Stakeholders may calculate payments either through the use of the 3M Grouper software, or manually. 8. Does the 3M Core Grouper software calculate inpatient and outpatient bills? The 3M Core Grouper software can be used to calculate APR DRGs for inpatient bills and EAPGs for outpatient bills. It should be noted that the 3M product is not required to make the necessary calculations. Alternate products may be available and the calculations can be done manually as well. 9. Is there a grace period for stakeholders who haven't purchased the software yet? There is no

grace period for stakeholders who have not purchased the software. The software is not required; facility bills can be manually calculated. Facility payment is due within 45 days. • The 3M Core Grouper Software do not review medical documentation and as such will make the recommendation/calculation based on what is entered in the system. Date of service 7/13/2018 (EOR dated 9/4/2018) amount billed = \$1,012.32: Provider billed CPT code 62321. • The EAPG group for CPT code 62321 is 214 and the EAPG weight assigned = $2.5273 \times \$295.94$ (base rate for downstate) = \$747.93 SCS#: 174139-26CR1 C1 • The capital add - on payment for ambulatory facility = \$81.37 The allowable amount per the NY fee schedule = \$829.30 Date of service 9/15/2018 (EOR dated 9/4/2018) amount billed = \$2,586.34: The provider submitted the charges using the revenue codes and CPT codes. A "crosswalk" was made to determine the appropriate EAPG group. Provider billed CPT codes 64490-50, 64491-50 and 64492-50. • The EAPG code for CPT code 64490, 64491 and 64492 is 220 and the EAPG weight assigned = $3.0358 \times \$295.94$ (base rate for downstate) = \$898.41 at 150% for the bilateral procedure = \$1,347.62 • All procedures in the same EAPG group are paid as one (multiple procedures consolidation). Per the APG Manual: Significant Procedure Consolidation: Significant procedure consolidation refers to the collapsing of multiple related significant procedure APGs into a single APG for the purpose of determining payment. The APG system relies on a significant procedure consolidation list developed on the basis of clinical judgment which identifies for each significant procedure APG, the other significant procedure APGs that are an integral part of the procedure and which can be performed with relatively little additional effort. The APG grouping logic consolidates related significant procedures. (Example: a Level I (primarily diagnostic) lower gastrointestinal endoscopy is consolidated into the Level II (primarily therapeutic) gastrointestinal endoscopy.) Unrelated significant procedures are not consolidated. Multiple unrelated significant procedures on the same date of service also are not consolidated in the APG classification system, but payment for additional unrelated significant procedures will be discounted • The capital add-on payment for an ambulatory facility = \$81.07 The allowable amount per the new EAPG system = \$1,428.99 Charge from Citimed Services PA: Date of service 7/13/2018 (EOR dated 8/27/2018) amount billed = \$1,575.00: • Provider billed CPT code 01992 x 2 units. SCS#: 174139-26CR1 • Per the NY Workers' Compensation Medical fee Schedule, Anesthesia Ground Rules # 6: Calculation of Total Anesthesia Values: The total anesthesia value is calculated by adding the listed basic value and time units. ***The time units are computed by allowing one unit for each 15 minutes or fraction thereof, of anesthesia time. A fraction of time is defined as one minute.*** Total time = 19 minutes (13:06 to 13:25) = 2 time units Base unit for 01999= 5 Total anesthesia units = 7.0 (5 + 2) • The conversion factor for anesthesia in region IV = \$27.01 The allowable amount per the NY fee schedule = \$189.07 ($\27.01×7) Charge from Premier Anesthesia Associates, PA: Date of service 7/27/2018 (EOR dated 9/4/2018) amount billed = \$1,350.00: • Provider billed CPT code 01992 x 2 units • Per the NY Workers' Compensation Medical fee Schedule, Anesthesia Ground Rules # 6: Calculation of Total Anesthesia Values: The total anesthesia value is calculated by adding the listed basic value and time units. ***The time units are computed by allowing one

unit for each 15 minutes or fraction thereof, of anesthesia time. A fraction of time is defined as one minute.*** Total time = 16 minutes (12:09 to 12:25) = 2 time units
Base unit for 01999= 5 Total anesthesia units = 7.0 (5 + 2) · The conversion factor for anesthesia in region IV = \$27.01 The allowable amount per the NY fee schedule = \$189.07 (\$27.01 x 7) Per the NY DFS: Frequently Asked Questions about Regulation 83 and the No-Fault Fee Schedule Q: What is the effective date of the 33rd Amendment to Regulation 83, and does it affect existing claims or only new claims?

A: January 23, 2018. The changes effected by the 33rd Amendment to Regulation 83 would be applicable to claims with a date of service occurring on or after January 23, 2018. If a claim contains dates of service which are both prior to and after January 23, 2018, the portion of the claim incurred prior to that date would not be subject to the 33rd Amendment to Regulation 83, irrespective of the date of accident, or the date the bill was received by the insurer. The amended fee schedule for professional services [11 NYCRR 68.6 (b)] apply in this case since the DOS is 9/15/2018. Section 68.6. Health services performed outside New York State. (a)(1) If a professional health service reimbursable under [section 5102(a)(1) of the] Insurance Law section 5102(a)(1) is performed outside [New York] this State, the [permissible charge] amount that the insurer shall reimburse for [such] the service shall be the lower of the amount charged by the provider and the prevailing fee in the geographic location of the provider with respect to services: (i) that constitute emergency care; (ii) provided to an eligible injured person that is not a resident of this State; or (iii) provided to an eligible injured person that is a resident of this State who, at the time of treatment, is residing in the jurisdiction where the treatment is being rendered for reasons unrelated to the treatment. (2) For purposes of this subdivision, emergency care means all medically necessary treatment initiated within 48 hours of a motor vehicle accident for a traumatic injury or a medical condition resulting from the accident, which injury or condition manifests itself by acute symptoms of sufficient severity such that absence of immediate attention could reasonably be expected to result in: death; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part. Medically necessary treatment shall include immediate prehospitalization care, transportation to a hospital or trauma center, emergency room care, surgery, critical and acute care. Emergency care extends during the period of initial hospitalization until the patient is discharged from the hospital. (b) Except as provided in subdivision (a) of this section, if a professional health service reimbursable under Insurance Law section 5102(a)(1) is performed outside this State with respect to an eligible injured person that is a resident of this State, the amount that the insurer shall reimburse for the service shall be the lowest of: (1) the amount of the fee set forth in the region of this State that has the highest applicable amount in the fee schedule for that service; (2) the amount charged by the provider; and (3) the prevailing fee in the geographic location of the provider.

Overall: Charges from Dynamic Surgery Center: Per the NJ fee schedule (prevailing fee in the geographic location of the provider) the total allowable

amount = \$3,242.72 (\$1,012.32 + \$2,230.40) The total amount charged by the provider = \$3,598.66 The allowable amount per the NY fee schedule = \$2,258.29 (\$829.30 + \$1,428.99) As per the 33rd Amendment, if payment is allowed, the allowable amount = \$2,258.29 (lowest amount). The provider was paid per the fee schedule. Charge from Citimed Services PA: Per the NJ fee schedule (prevailing fee in the geographic location of the provider) the total allowable amount = \$544.76 The total amount charged by the provider = \$1,575.00 The allowable amount per the NY fee schedule = \$189.07 As per the 33rd Amendment, if payment is allowed, the allowable amount = \$189.07 (lowest amount). The provider was paid per the fee schedule. Charge from Premier Anesthesia Associates, PA: Per the NJ fee schedule (prevailing fee in the geographic location of the provider) the total allowable amount = \$527.47. The total amount charged by the provider = \$1,350.00. The allowable amount per the NY fee schedule = \$189.07 As per the 33rd Amendment, if payment is allowed, the allowable amount = \$189.07 (lowest amount). The provider was paid per the fee schedule."

This Award is rendered after thorough review and consideration of the evidence submitted by the parties to the Electronic Case File [ECF] maintained by the American Arbitration Association [AAA], as well as the oral arguments presented by the representatives of the respective parties during the hearing.

At issue herein is the proper rate of payment for the surgical services provided to the injured person on date of service 7/13/18 through 7/27/18, and billed by the Applicant.

The law is clear that the Respondent must "conclusively demonstrate" the proper fee schedule rate of payment for the services rendered in a "coherent manner". *Viviane Etienne Med. Care, P.C. v. Country-Wide Ins. Co.*, 2013 N.Y. slip Op 50199(U)(App. Term, 2d Dept. 2013) ["Defendant was not entitled to the dismissal...because defendant failed to conclusively establish its stated defense, that the fees charged exceeded the amounts set forth in the workers' compensation fee schedule"]; *Tyorkin v. Garrison Prop. & Cas. Ins. Co.*, 2016 N.Y. Slip Op 50846(U)(Civ. Ct., Kings co., 2016) ["Upon review of the defendant's affidavit from a certified professional coder, the Court finds that Ms. Moreno did not explain the exact amounts allowable in a coherent manner"].

A proper denial must include the information called for in the prescribed denial of claim form and must promptly apprise the claimant "with a high degree of specificity" of the ground or grounds on which the disclaimer is predicated. *Apple Tree Acupuncture, P.C. v Interboro Ins. Co.*, 2011 NY Slip Op 52364(U) [34 Misc 3d 132(A)] (App. Term, 2d Dept, 2011), *St. Vincent's Hosp. & Med. Ctr. v New Jersey Mfrs. Ins. Co.*, 82 AD3d 871, 872 [2011], quoting *Nyack Hosp. v State Farm Mut. Auto. Ins. Co.*, 11 AD3d 664 [2004]). Arbitrator Horowitz aptly noted, in *Mobility Experts Medical, PC v American Transit Ins. Co.*, AAA 412011028175, "timely denial of a no-fault claim alone does not avoid preclusion where said denial is factually insufficient, conclusory, vague or otherwise involves a defense that has no merit as a matter of law. See, *New York University Hospital Rusk Institute v. Hartford Accident and Indem. Co.*, 32 A.D. 2d 458, 820 N.Y.S.2d 309 (2d Dept. 2006). See also, *Apple Tree Acupuncture, P.C. v Interboro Ins. Co.*, 2011 NY Slip Op 52364(U) [34 Misc 3d 132(A)] (App. Term, 2d Dept, 2011).

Respondent argues that the fees charged by Applicant for the services in issue were in excess of those permitted under the Workers' Compensation Fee Schedule. 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). See also, *Power Acupuncture PC v. State Farm Mutual Automobile Ins. Co.*, 11 Misc.3d 1065A, 816 N.Y.S.2d 700, 2006 NY Slip Op 50393U, 2006 N.Y. Misc. LEXIS 514 (Civil Ct, Kings Co. 2006). If Respondent fails to demonstrate by competent evidentiary proof that a plaintiff's claims were in excess of the appropriate fee schedules, defendant's defense of noncompliance with the appropriate fee schedules cannot be sustained. See, *Continental Medical PC v. Travelers Indemnity Co.*, 11 Misc.3d 145A, 819 N.Y.S.2d 847, 2006 NY Slip Op 50841U, 2006 N.Y. Misc. LEXIS 1109 (App. Term, 1st Dep't, per curiam, 2006).

Respondent may interpose a defense in a timely denial that the claim exceeds the fees permitted by the Workers' Compensation schedules, but Respondent must, at minimum, establish, by evidentiary proof, that the charges exceeded that permitted by law. *Abraham v. Country-Wide Ins. Co.*, 3 Misc.3d 130A, 787 N.Y.S.2d 678, 2004 NY Slip Op 50388U, 2004 N.Y. Misc. LEXIS 544 (App. Term, 2d Dept. 2004). A brief from Respondent's counsel is not the substantive equivalent of "competent evidentiary proof." Furthermore, if an insurer contests and reduces a medical provider's fees for medical services rendered, then such reduction must be based upon a medical doctor's peer review or medical analysis of the services rendered vis-à-vis the fees charged and a medical explanation regarding why the charges are best described by another CPT billing code.

In the instant matter, the Respondent's coding adjustment was made based upon the fee audit prepared by Mercy Acuna, C.P.C., a professional fee coder. I find the fee analysis presented by Respondent's fee coder, Ms. Acuna, to be credible and persuasive.

It is therefore my determination that the Respondent's decision to down code and reimburse the Applicant the fee schedule allowable per the opinions and conclusions of Ms. Acuna was appropriate. Accordingly, the Respondent's denial is sustained, and the Applicant's claim for reimbursement in the amount of \$3,887.23 is hereby denied in its entirety. This decision is in full disposition of all claims for No-Fault benefits presently before this Arbitrator.

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

09/24/2020
(Dated)

Paul Weidenbaum

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:
53b0250ee772956e6801f441d08291f8

Electronically Signed

Your name: Paul Weidenbaum
Signed on: 09/24/2020