American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Metro Pain Specialists PC (Applicant)	AAA Case No.	17-20-1167-3211
	Applicant's File No.	00066341
- and -	Insurer's Claim File No.	32B0041Z4
	NAIC No.	25178
State Farm Mutual Automobile Insurance Company (Respondent)		

ARBITRATION AWARD

I, Kevin R. Glynn, 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 07/01/2021
   Declared closed by the arbitrator on 07/01/2021

   Justin Rosenbaum, Esq. from Drachman Katz, LLP participated in person for the Applicant

   Angelica Barcansky, Esq. from Rivkin & Radler LLP participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 1,133.83**, 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 Assignor, AL, is a 25yo male driver who was injured when involved in a motor vehicle accident on 8/10/19. AL suffered injuries which resulted in his seeking treatment. In dispute are the Applicant's claims for an office visit/prolonged evaluation (99214, 99358) performed on 11/4/19 in the amount of $297.39; an office visit (99204) performed on 11/5/19 in the amount of $92.98; and an office visit/prolonged evaluation (99214, 99358) performed on 12/18/19 in the amount of $297.39. These claims were denied pursuant to the EUO testimony of Leonid Shapiro, M.D., dated 10/25/18 and 11/5/18, and the report of James Dillard, M.D. Therefore, there is an issue if Respondent can sustain its defense.

Also, at issue are Applicant's claims for office visits (99204) performed on 8/19/19 in the amount of $148.69; (99214) performed on 9/30/19 in the amount of $92.98; and (99204) performed on 10/3/19 in the amount of $148.69. Respondent denied the claims based on the 120-day rule/outstanding verification requests. Therefore, the issue in dispute is whether Respondent's outstanding verification denials can be sustained.

4. Findings, Conclusions, and Basis Therefor

This case was decided based upon the submissions of the Parties as contained in the electronic file maintained by the American Arbitration Association, and the oral arguments of the parties' representatives. There were no witnesses. I reviewed the documents contained in MODRIA for both parties and make my decision in reliance thereon. Only the arguments presented at the hearing are preserved in this decision; all other arguments not presented at the hearing are considered waived. The documents submitted in the related hearing under AAA Case No.: 17-20-1171-1241, heard on the same day as this instant matter are being considered in this award.

Peer Review Report DOS: 11/4/19; 11/5/19; 12/18/19

I find that Applicant established a prima facie case of entitlement to reimbursement for its claims. Mary Immaculate Hospital v. Allstate Insurance Company, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004). Furthermore, I find that Respondent timely denied these claims upon final verification agreement between the parties.

To support a lack of medical necessity defense Respondent must "set forth a factual basis and medical rationale for the peer reviewer's determination that there was a lack of medical necessity for the services rendered." See Provvedere, Inc. v. Republic Western Ins. Co., 2014 NY Slip Op 50219(U) (App. Term 2, 11 and 13 Jud. Dists. 2014). Respondent bears the burden of production in support of its lack of medical necessity defense, which if established shifts the burden of persuasion to Applicant. See generally, Bronx Expert Radiology, P.C. v. Travelers Ins. Co. 2006 NY Slip Op 52116 (App Term 1st Dept. 2006). The Appellate Courts have not clearly defined what satisfies this standard except to the extent that "bald assertions" are insufficient. Amherst Medical Supply, LLC v. A Central Ins. Co., 2013 NY Slip Op 51800(U) (App. Term 1st Dept. 2013). To meet the burden of persuasion regarding medical necessity - in the absence of factually contradictory records - the applicant must submit a rebuttal which meaningfully refers to and rebuts the assertions set forth in the peer review report. See generally, Pan Chiropractic, P.C. v Mercury Ins. Co., 24 Misc 3d 136[A], 2009 NY Slip Op 51495[U] [App Term, 2d, 11th & 13th Jud Dists 2009].

Respondent's evidence established that these claims were timely denied pursuant to a peer review report by Dr. James N. Dillard, M.D., dated 7/16/20. Dr. Dillard opines:

> Thank you for the opportunity to review the medical records of patients being seen by health care providers

working with Metro Pain Specialists, and to comment on the appropriateness and legitimacy of the care provided.

Based on my review of claim files and the Examination Under Oath (EUO) testimony of Leonid Shapiro, M.D. dated October 25, 2018 and November 5, 2018, the patients treated by Metro Pain, alleged to be from motor vehicle accidents and made up of people who appear to have been in typical fender-bender car accidents without extensive trauma documented. These patients appear to be minimally injured, if injured at all.

Initial and follow-up examination reports in these charts are either done with a minimal check the box pre-printed form with a few fill-in blanks available or a conventional narrative report format. The check the box pre-printed forms convey strikingly little tangible information about each patient. The more conventional narrative reports are largely copied and pasted with much identical language from report to report.

For example, nearly all patients evaluated as documented with the narrative exam format have "Aggravating Factors: Pain is increased by extension and lateral rotation, exertion, prolonged sitting, bending, fatigue, lifting, pulling, prolonged standing and walking." It is not credible that so many patients would volunteer that exact same sequence of aggravating factors, patient to patient. Another example would be "Alleviating Factors: Pain is decreased occasionally by bed rest, sitting and sometimes by standing and walking and occasional nonsteroidal anti-inflammatory medication." Again, this being true for virtually all the patients with the exact same wording report to report is not credible.

Many Metro Pain examination notes have copy-and-paste statements that are internally self-contradictory within the same note. That is, that there are findings recorded in the reports that are objectively at odds with the diagnoses given. Multiple notes have supposed sensory and motor losses at multiple levels in the lower extremities yet with entirely normal deep tendon reflexes (DTRs) in the lowers (most DTRs in these reports are intact while multiple sensory and motor losses are documented - not credible). Despite these findings in the Metro Pain examination reports, bilateral multi-level sensory and motor losses are effectively never found in legitimate clinical practice. That alone is suspicious enough regarding these highly repetitive notes, but these same notes also uniformly state that "casual and tandem gait as well as heel and toe

walking are normal." This is not physiologically possible, is never seen in legitimate clinical practice, and further calls into serious question the veracity of all the other putative findings documented.

In the EUO of Dr. Shapiro on 11/5/18, page 299, Dr. Shapiro states that each patient receives an individually tailored treatment plan. That statement is not true based upon the examination of the chart records. Metro Pain treatment plans are highly repetitive and stereotypic, patient to patient. Indeed, Metro Pain patients receive essentially identical treatment plans over and over.

Some of the details documented in the EUO of Dr. Leonid Shapiro on 10/25/20 are relevant to this discussion. In page 46, line 21 of the EUO, Dr. Shapiro states, "If problems don't exist, they should be discharged somewhere in the vicinity of four months after conservative treatment." In reviewing hundreds of case charts of patients treated by Metro Pain Specialists, I was unable to find a single case in which any patient was just discharged without undergoing some invasive pain procedure.

On page 352, Dr. Shapiro admits that many patients receive the exact same treatment plan as many other patients, in contrast with his statements in page 299. Dr. Shapiro also admits on page 353 that the Metro Pain patients are given various pieces of durable medical equipment (DME) on a pre-determined protocol basis in his offices.

Most patients undergo multiple clinical assessment questionnaires ("Outcome Assessment Testing") at Metro Pain Specialists despite minimal findings in the exams. These questionnaires include the Neck Disability, Headache Disability, Oswestry, Roland-Morris, Shoulder Pain Score, and the Knee Score questionnaires, though many of these assessments are not actually scored, only single results points are recorded, which brings into question whether these tests were actually performed. There is no indication as to why all this testing was ordered or why it was necessary as the finding are not incorporated anywhere into the clinical notes.

Formal Outcomes Assessment Testing like this is not considered applicable or necessary in most legitimate medical care and are usually reserved to the research setting. Indeed, on page 310 of Dr. Shapiro's 11/5/18 EUO Dr. Shapiro states that he does not know the names of the

outcomes assessment questionnaires that his offices use, does not know when these assessments are done, and that "the answers don't matter that much."

As most of the patients seen by Metro Pain are at least 2-3 months out from their putative accidents, Metro pain is treating mostly chronic pain patients, by definition. Yet the practitioners at Metro Pain seem to be wholly unaware of or oblivious to current guidelines and practice standards for the treatment of chronic pain patients. Their patients, however, are directed exclusively into invasive, expensive, and therefore highly remunerative pain procedures.

The treatment plan for nearly every patient at Metro Pain offices is essentially the same. Many patients are directed toward costly and potentially dangerous invasive pain medicine procedures based upon shoddy evaluations with fabricated, non-credible findings. These patients are uniformly directed into these procedures without consideration of other potential options for the patients, in violation of accepted consensus guidelines for pain patients. Other reasonable options for these patients are not even mentioned or discussed in these notes, as typically occurs in legitimate medical practice.

Most patients seen at Metro Pain have had an initial course of treatment with chiropractic, acupuncture, and physical therapy. These notes are meagre, highly repetitive, and apparently not individualized visit to visit, virtually always leading to the same repeated treatments with little to no variation. These daily notes and the periodic re-examinations rarely show much if any improvement or recovery in these patients, leading to more treatment.

There was no indication in the records that these various providers' care was coordinated in any way, or why all this simultaneous care was necessary. I not aware of any research literature that supports the necessity of chiropractic, acupuncture and physical therapy services being delivered simultaneously for such patients.

In pages 365 through 370, Dr. Shapiro admits that there is virtually no coordination of care between the medical physicians, chiropractors, physical therapists, and acupuncturists working with the same patients together in the Metro Pain offices. Having reviewed many of these charts, I can confirm that I was unable to find any evidence of coordination of care between these various practitioners in the records, raising concerns as to whether

the care plans rendered were at all centered around the specific and individual needs of each patient by the various Metro Pain practitioners seeing the patients.

Apparently, the vast majority of patients seen at Meto Pain offices require costly and potentially dangerous invasive pain medicine procedures. All patients are uniformly directed into these procedures without consideration of other potential options for the patients, in violation of accepted consensus guidelines for pain patients. Other reasonable options for these patients are not even mentioned or discussed in these notes, as typically occurs in medical practice.

After a few months of such care, many patients are directed into invasive pain procedures for no apparent reason. For example, patient Benjamin Ferreria was ostensibly injured in an automobile accident on 8/29/16. On 11/20/2016, this patient was seen by practitioners at Mefro Pain Specialists. The exam documented entirely normal neurological exams of the upper and lower extremities (neck and low back), but he was given the diagnoses of multilevel radiculopathies of the cervical and lumbar spine. This is physiologically impossible. Even more disturbingly, Mr. Ferreria was then subjected to Cervical Epidural Steroid Injection and Epidurography by Dr. Abbatematteo of Meto Pain on that date based upon spurious diagnoses that were specifically contradicted by the exam done on that date.

David Naranjo was ostensibly injured in a car accident on 11/27/17. The police report on that date indicates "no injury". After 2 months of conservative treatment with physical therapy, acupuncture, and chiropractic, he is seen on 1/31/18 by Metro Pain. He is supposedly reporting a "moderate 8/10" pain scale even though the report states that "casual and tandem gait as well as heel and toe walking are normal". Tenderness is reported in both sides of his neck and low back with some non-focal 4/5 weakness in both arms and legs, but the sensory exam and deep tendon reflexes are intact. Meto Pain goes on in the note to recommend Cervical and Lumbar facet injections as well as multiple Lumbar Epidural Steroid Injections. No other options are considered. This sequence of evaluation and treatment direction is entirely inappropriate and unjustifiable.

The electrodiagnostic studies performed on these patients are very poorly done. According to the American Academy of Neuromuscular and Electrodiagnostic

Medicine (AANEM) white papers, these tests should only be done when specific focal findings are shown on a careful neurological exam, and the electrodiagnostic studies should flow from and be tailored to these specific neurological findings, essentially to confirm the clinical suspicions. This is certainly not the practice standard at the Metro pain offices. Usually, no specific reason is given for doing the studies, occasionally only stating that they feel the patient is not getting better. ms is not an acceptable reason to do these painful studies. In addition, the testing is technically very poorly done. Often, the findings do not match the diagnoses and peripheral muscles are routinely under sampled to be able to make the putative radiculopathy diagnoses.

In 2011, the Institute of Medicine of the National Academies entered into a multi-year consensus forming project aimed at improving the understanding of pain and improving pain care nationally. The latest ongoing iteration of that work resides in the IOM Report on Relieving Pain in America (Date last modified: December 23, 2019) https://www.painconsortium.nih.gov/Resource Library./IOM Relieving Pain. Based upon the highest quality research literature available, these multidisciplinary guidelines de-emphasize the use of potentially dangerous medications and procedures, rather recommending that the core of chronic pain treatment should rely on patient self-care, mobilization, and mind/body therapies.

In addition, Dr. Shapiro and the other Metro Pain Specialists working in his offices routinely violate multiple core tenets of the guidelines and practice standards of his own American Society of Anesthesiologists (ASA) consensus guideline standards from April 2010 https://anesthesiology.pubs.asahq.org/article.aspx?articleid=1932775

Authors at Harvard, Stanford and the University of Washington argued against this increasing overuse of spinal injection procedures in 2013 (Kennedy DJ, Baker RM, Rathrnell JP. Use of Spinal Injections for Low Back Pain. JAMA. 2013;310(16):1736). Dr. Shapiro and his associates are apparently unaware of these authoritative recommendations.

Authors at the Johns Hopkins School of Medicine argued in 2015 against the overuse of medical procedures in American medicine, arguing that this adverse tendency leads to significantly increased costs with poorer patient

outcomes, (Romano MJ et al. The Association Between Continuity of Care and the Overuse of Medical Procedures. JAM4 Intern Med. 2015; 175(7): 11481154). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5577558/

Aside from Metro Pain ignoring all these important practice standards as well as community best practice standards, there is little to no attention paid in these records to the unique and individual status and history of these patients, but rather the patients are pushed forward into procedures without discussion of any appropriate alternatives.

In summary, virtually all patients received the same succession of nearly identical pre-determined boilerplate testing and treatments by Metro Pain practitioners, in violation of accepted practice standards for the specialties involved. Any possible responses or lack or response to the treatments were not ever incorporated into the plan of care going forward. There was clearly no coordination of care documented between the chiropractic, physical therapy, acupuncture, medical, anesthesiology, or other treatment interventions.

I am a licensed physician who is Board Certified for 30 years in Physical Medicine & Rehabilitation, specializing in Pain Medicine and Integrative Care, a fully trained and licensed chiropractor, and a fully trained and licensed acupuncturist. As a former Assistant Clinical Professor of Rehabilitation Medicine at Columbia University College of Physicians and Surgeons, and a Pain Medicine Attending Physician at Beth Israel Medical Center, it is my professional opinion that these records demonstrate clear and intentional patterns of abusive professional misconduct, representing flagrant deviations from acceptable standards of pain medicine practice. There is an overwhelmingly clear pattern of unnecessary, pre-determined, excessive, abusive and potentially dangerous testing and treatment of patients, as well as excessive orders for DME. This clear pattern represents consistent gross violations of accepted standards of practice.

It appears that the above summarized practice patterns were put in place to maximize financial reimbursement rather than appropriate patient care.

Attached to this report are the claims I specifically reviewed in preparation of this report. I have also attached a list of claims I am aware that Metro Pain has submitted

> and believe that these claims, based on the above findings, will contain the same issues and concerns as noted in my report. Based on the above findings, I believe that other bills and documentation from Metro Pain Specialists for the above identified medical services will contain the same issues and concerns as noted in my report.

However, I agree with Applicant's counsel that this report fails to address the specific claims at issue herein. Dr. Dillard discusses "the vast majority of patients" and "most patients" but fails to specify if this patient is included in those descriptions. I find that Respondent fails to demonstrate a medical rationale and factual basis to support its defense that the claims were not medically necessary. Accordingly, Applicant is awarded reimbursement of these claims.

120 Day Rule/Additional Verification Requests DOS: 8/19/19; 9/30/19; 10/3/19

Pursuant to Insurance Law §5106(a) and 11 NYCRR §65-3.8, No-Fault benefits are overdue if not paid or denied within 30 calendar days after the insurer receives proof of claim, which shall include verification of all the relevant information requested.

An Applicant establishes prima facie showing of entitlement to No-Fault benefits under Article 51 of the Insurance Law by "submitting evidence that payment of no-fault benefits are overdue, and proof of its claim, using the statutory billing form, was mailed to and received by the defendant insurer." Viviane Etienne Med. Care, P.C. v. Country-Wide Ins. Co., 25 N.Y.3d 498, 14 N.Y.S. 3d 283 (Court of Appeals, 2015).

Once Applicant establishes its prima facie case, the burden of proof shifts to Respondent to come forward with admissible evidence demonstrating the existence of a material issue of fact. Amaze Medical Supply Inc. v. Eagle Ins. Co., 2 Misc.3d 128(A), 2003 N.Y. Slip Op. 51701(U)(App. Term, 2nd Dept, 2nd & 11th Jud Dists., 2003). If an insurer asserts that the claim(s) are premature due to outstanding verification, the insurer must demonstrate that the verification request and follow-up verification request were timely issued, and that no response was received. Compas Med., P.C. v. Praetorian, 49 Misc 3d 129(A), 2015 NY Slip Op 51403(U)(App Term, 2nd , 11th and 13th Jud. Dists. 2015). As required by 11 NYCRR §65-3.5(b), the initial request for verification is to be made within 15 business days of receipt of the claim. A request that is sent beyond the 15 business days is still valid so long as it is issued within 30 days from receipt of the claim; such a deviation will simply reduce the insurer's time to pay or deny by the same number of days. 11 NYCRR §65-3.8(l). See Nyack Hosp. v. General Motors Acceptance Corp., 8 NY3d 294, 2007 NY Slip Op 02439 (Court of Appeals, 2007). On the other hand, if the initial request for verification is made beyond 30 days from receipt of the claim, the request will be deemed a nullity and the time to pay or deny will have expired. Compas Med., P.C. v. Farm Family Cas. Ins. Co., 2015 NY Slip Op 51631(U) (App. Term 2nd, 11th and 13th Jud. Dists. 2015). Additionally, after 30 calendar days from the original request, the insurer has a regulatory duty to issue a second verification request within the following 10 calendar days. 11 NYCRR §65-3.6(b). The obligation to pay or deny a claim is not triggered until the insurer has received all of the relevant information that was requested. Hospital for Joint Diseases v. State Farm Mut. Auto.

Ins. Co., 8 AD3d 533, 2004 NY Slip Op 05413 (App. Div., 2nd Dept., 2004). If the insurer can demonstrate that the initial verification request and follow-up verification request were timely issued, and that no response was received, the matter will be deemed premature and not ripe for adjudication. See Mount Sinai Hosp. v. Chubb Group of Ins. Co., 43 AD3d 889, 2007 NY Slip Op 06650 (App. Div., 2nd Dept., 2007).

Furthermore, pursuant to 11 NYCRR §65-3.8(b)(3), "an insurer may issue a denial if, more than 120 calendar days after the initial request for verification, the applicant has not submitted all such verification under the applicant's control or possession or written proof providing reasonable justification for the failure to comply…"

I find that Applicant has established its prima facie case, thereby shifting the burden to Respondent.

I find that Respondent timely and properly sought verification for each of these three claims and that Applicant failed to submit the requested verification or respond to the demands within 120 days of the initial requests on 9/27/19; 11/7/19 and 11/20/19. Furthermore, I find that Respondent timely and properly denied the claims based on the Assignor's failure to submit the requested verification. As such, these claims are denied.

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 Op 26240, 12 Misc.3d 172, 822 N.Y.S.2d 378, 2006 N.Y. Misc. LEXIS 1519 (Civil Ct, Kings Co. 2006). If Respondent fails to demonstrate by competent evidentiary proof that an Applicant's claims were in excess of the appropriate fee schedule, Respondent's defense of noncompliance with the appropriate fee schedule 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 fails to submit sufficient evidentiary proof to establish that the claim amounts are not in compliance with the appropriate Fee Schedule. Accordingly, Applicant is awarded reimbursement of its claims in the amounts of $297.39; $148.69; and $297.39. The remaining three claims are 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
	Metro Pain Specialists PC	**08/19/19 - 08/19/19**	**$148.69**	**Denied**
	Metro Pain Specialists PC	**09/30/19 - 09/30/19**	**$92.98**	**Denied**
	Metro Pain Specialists PC	**10/03/19 - 10/03/19**	**$148.69**	**Denied**
	Metro Pain Specialists PC	**11/04/19 - 11/04/19**	**$297.39**	**Awarded: $297.39**
	Metro Pain Specialists PC	**11/05/19 - 11/05/19**	**$148.69**	**Awarded: $148.69**
	Metro Pain Specialists PC	**12/18/19 - 12/18/19**	**$297.39**	**Awarded: $297.39**
Total			**$1,133.83**	**Awarded: $743.47**

B. The insurer shall also compute and pay the applicant interest set forth below. 07/09/2020 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

In the instant matter Applicant is awarded interest pursuant to the no-fault regulations. 11 NYCRR 65-3.9 (a) provides that Interest shall be calculated "at a rate of two percent per month, calculated on a pro rata basis using a 30 day month." Pursuant to 11 NYCRR 65-3.9 (c), "if 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 Department of Financial Services regulations, interest shall not accumulate on the disputed claim or element of claim until such action is taken." Applicant electronically submitted its claim for arbitration on 7/9/20, more than thirty days after claims became due and owing. Therefore, interest shall run effective 7/9/20.

C. Attorney's Fees

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

An attorney's fee of 20% shall be paid on the sum of the awarded claim plus interest, subject to a maximum of $1,360.00.

D. The respondent shall also pay the applicant forty dollars ($40) to reimburse the applicant for the fee paid to the Designated Organization, unless the fee was previously returned pursuant to an earlier award.

This award is in full settlement of all no-fault benefit claims submitted to this arbitrator.

State of New York
SS :
County of Nassau

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

08/02/2021
(Dated)

Kevin R. Glynn

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:
49ffe9ab7651578f71bfc40031a2fce5

Electronically Signed

Your name: Kevin R. Glynn
Signed on: 08/02/2021