

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Health East Ambulatory Surgical Center ,	AAA Case No.	17-20-1186-6043
South Dean Orthopaedics , Health East	Applicant's File No.	NA
Medical Group , Barry Hughes, P.A. , Health	Insurer's Claim File No.	198034287-007
East Medical Alliance , Bergen Anesthesia	NAIC No.	Self-Insured
Group LLC , Alliance Medical Goods Services		
(Applicant)		

- and -

Avis Budget Group
(Respondent)

ARBITRATION AWARD

I, Andrew Horn, 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, eligible injured person, EIP.

1. Hearing(s) held on 05/05/2021
Declared closed by the arbitrator on 05/05/2021

Olivia Offens, Esq., of counsel, from Orak & Associates participated by telephone for the Applicant

Joshua Shack, Esq., from Rubin, Fiorella, Friedman & Mercante LLP participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 19,483.68**, was NOT AMENDED at the oral hearing.
Stipulations WERE made by the parties regarding the issues to be determined.

The parties stipulated that the claims were timely denied.

3. Summary of Issues in Dispute

In dispute are Applicants Health East Ambulatory Surgical Center, South Dean Orthopaedics, Health East Medical Group, Barry Hughes, P.C., Health East Medical Alliance, Bergen Anesthesia Group, LLC, and Alliance Medical Goods Services' claims as the assignees of a 36-year-old man allegedly injured as a pedestrian struck by a motor vehicle on July 19, 2019.

Applicant Health East Ambulatory Surgical Center's claim, comprised of 11 bills, seeks reimbursement for the ambulatory surgical facility fees incurred as a result of arthroscopic surgery to assignor's right shoulder and an ultrasound-guided nerve block on October 22, 2019, cervical epidural steroid injections (ESIs) and epidurography on November 4, 2019 and January 31, 2020, and a lumbar ESI and epidurography on December 20, 2019.

Applicant South Dean Orthopaedics' claim, comprised of four bills, seeks reimbursement for the right shoulder surgery and associated services by Dr. Thomas Scilaris on October 22, 2019.

Applicant Health East Medical Group's claim, comprised of six bills, seeks reimbursement for the epidural steroid injections and associated services performed by Dr. Anson Moise on November 4, 2019, December 20, 2019 and January 31, 2020.

Applicant Barry Hughes, P.A.'s claim, comprised of four bills, seeks reimbursement for the physician assistant's services during the right shoulder surgery on October 22, 2019.

Applicant Health East Medical Alliance's claim, comprised of five bills, seeks reimbursement for the anesthesia provided during the right shoulder surgery on October 22, 2019 and the cervical ESI procedure performed on November 4, 2019.

Applicant Bergen Anesthesia Group, LLC's claim, comprised of two bills, seeks reimbursement for the anesthesia provided during the ESI procedures on December 20, 2019 and January 31, 2020.

Applicant Alliance Medical Goods' claim, comprised of a single bill, seeks reimbursement for a shoulder orthosis provided on October 22, 2019.

The providers' assignor resided in The Bronx, New York; the services were rendered in Englewood, New Jersey.

Respondent Avis Budget Group denied the claims on the grounds that the services were medically unnecessary according to peer reviews by its board-certified orthopedic surgeon Dr. Robert Cristofaro, its anesthesiologist Dr. Jason R. Cohen, and its physician Dr. Michael E. Tawfello, and were billed in excess of the applicable fee schedules.

4. Findings, Conclusions, and Basis Therefor

1.

In opining that the right shoulder arthroscopic surgery and associated services and expenses were medically unnecessary, Dr. Cristofaro, a Diplomate of the American Board of Orthopedic Surgery, stated that the MRI findings - a labrum tear and partial rotator cuff tear - did not necessitate "immediate surgical intervention," and there was "no evidence provided (as to) whether the claimant received physical therapy sessions in the concerned region," or any cortisone injections, which, in his opinion, "could have resolved the symptoms."

While Respondent's orthopedist acknowledged that anesthesia "was necessary for the (surgical) procedure to (be) perform(ed) ... painlessly and efficiently," he maintained that, "as the right shoulder arthroscopy was not medically necessary, the associated services including the intra-operative anesthesia services was also not medically necessary."

With respect to the shoulder orthosis, which was provided post-operatively, he contended that "the claimant required physical therapy and mobilization, rather than ... immobilizing and restricting" the shoulder.

In opining that the cervical and lumbar ESIs and associated services on November 4, 2019 and December 20, 2019 were not medically warranted, Dr. Cohen, a Diplomate of the American Board of Anesthesiology, stated that an epidural steroid injection is indicated for the treatment of radicular pain due to disc herniations, disc protrusions or bulges or spinal stenosis, which had failed "a course of supportive non-interventional care which can include observation, oral medications, physical therapy and/or activity modification." He further contended that, "(r)adiculopathy must be documented" and "corroborated by imaging studies and/or electrodiagnostic testing."

Inasmuch as he contended that there was no subjective cervical radiating pain, positive Spurling's test, or other evidence of cervical radiculopathy noted by Dr. Nicolas El-Khoury on August 1, 2019, no subjective radiating lumbar pain, positive Straight Leg Raise test, or other evidence of lumbar radiculopathy noted by Dr. Orsuville Cabatu on July 11, 2019 or August 29, 2019, no disc protrusions or spinal stenosis found on the MRIs, and no indication of decreased deep tendon reflexes or other neurological findings consistent with radiculopathy by Dr. Moise, he concluded that the utilization of ESIs deviated from the standard of care.

In opining that the (repeat) cervical ESI performed on January 31, 2020 was not medically necessary, Dr. Tawfello stated that, according to the 2017-2018 NIA Clinical Guidelines, there must be "(d)ocumented proof that the prior injection had a positive response by significantly decreasing the patient's pain (at least 30% reduction in pain after initial injections or significant documented functional improvement)," and the "patient is actively engaged in other forms of active conservative non-operative

treatment (unless pain prevents the patient from participating in conservative therapy)," or, with respect to "(r)epet injections after the initial diagnostic phase, ... at least 50% relief or functional improvement for at least 2 months."

While he acknowledged that, in "the report dated 11/20/2019 by Anson Moise, M.D., the claimant reported an 85% improvement for ... two weeks," such a period of improvement did not, in his estimation, fulfill the required two-month prerequisite.

The peer reviewer further contended that the criteria was not met as "there was no evidence that the claimant was involved in any form of conservative care such as physical therapy, acupuncture, and chiropractic treatment before proceeding to the repeat CESI."

Since the peer reviewers "demonstrated a factual basis and a medical rationale for (their) determination(s) that there was no medical necessity for the services at issue here," "the burden shifted to (the provider) to present (its) own evidence of medical necessity See Cappello v. Global Liberty Ins. Co. of N.Y., 57 Misc.3d 143(A) (App Term 1st Dept. 2017).

Given that they determined that the underlying services were medically unnecessary, by extension there is a lack of medical necessity for the surgical facility fees incurred as a result of the surgery and injections. See New Horizon Surgical Ctr., LLC v. Allstate Ins. Co., 2016 NY Slip Op 51124(U) (App Term 2d, 11th & 13th Dists. July 13, 2016).

In order for an applicant to prove that the disputed expenses were medically necessary, it must meaningfully refer to, or rebut, the conclusions set forth in the peer reviews. See High Quality Medical, P.C. v. Mercury Ins. Co., 26 Misc.3d 145(A) (App Term 2d, 11th & 13th Dists. 2010); Pan Chiropractic, P.C. v. Mercury Ins. Co., 24 Misc.3d 136(A) (App Term 2d, 11th & 13th Dists. 2009).

Standing alone, an injured person's "subjective complaints of pain cannot overcome objective medical tests." Arnica Acupuncture, P.C. v. Interboard Ins. Co., 137 A.D.3d 421(1st Dept. 2016).

It is ultimately the provider who must prove, by a preponderance of the evidence, that the services were reasonable and necessary. See Dayan v. Allstate Ins. Co., 49 Misc.3d 151(A) (App Term 2d Dept. 2015); Park Slope Med. & Surgical Supply, Inc. v Travelers Ins. Co., 37 Misc.3d 19, 22 n (App Term 2d, 11th & 13th Dists. 2012).

To refute Dr. Cristofaro's peer review, Applicants rely principally upon a rebuttal by Dr. Scilaris who cited to the NIH Guidelines, which provide that arthroscopy is recommended for a torn labrum and a torn rotator cuff, such as those sustained by assignor hereunder. While he contended that there are no standard requirements for a patient with an MRI-confirmed rotator cuff tear to undergo any particular amount of physical therapy, he aptly pointed out that the injured person in fact underwent a course of conservative treatment including acupuncture, chiropractic care and physical therapy for three months without resolution of the right shoulder condition.

In response to the peer reviewer's contention that partial rotator cuff tears did not necessarily require surgical intervention, the treating orthopedist contended that they do "because if left untreated they will get worse with time."

He also disputed Dr. Cristofaro's suggestion with respect to the need for the performance of cortisone injections prior to surgery since "they do not actually repair anything (especially tears) within the joint and only sometimes temporarily mask ... symptoms" and are ineffective in "improving range of motion." (Dr. Scillaris did not address the peer reviewer's objection to the shoulder orthosis).

To refute Dr. Cohen and Dr. Tawfellos' peer reviews, the providers rely primarily on a rebuttal by Dr. Moise who vigorously disputed the contention that there was no evidence of radiculopathy corroborated by electrodiagnostic studies. He aptly pointed out that MRIs revealed disc herniations at C3-C4 and C5-C6 with central and foraminal narrowing and both herniations abutting the spinal cord, a disc bulge at C4-C5, and a disc herniation at L5-S1 impinging upon the thecal sac, and EMG/NCVs revealed right C5-C6 radiculopathy and a right L5 nerve root irritation. He also noted that, when assignor presented to him on September 25, 2019, he complained of "constant" neck pain "associated with parasthesias bilaterally up to the upper extremity," and "constant" back pain "associated with parasthesias bilaterally down to the lower extremity," and his examination found a positive Spurling's sign and positive Straight Leg Raising on the right.

Likewise, when assignor was followed up by Dr. Cabatu on November 1, 2019, the neurological examination revealed decreased reflexes and muscle strength.

Thus, given the disc herniations on the MRIs and positive Spurling's and SLR tests, which were also indicative of the presence of disc protrusion or nerve root impingement, he maintained that the ESIs on November 4, 2019 and December 20, 2019 were performed consistent with accepted practice.

Regarding the services rendered on January 31, 2020, Dr. Moise pointed out that, contrary to Dr. Tawfellos' statement that there was no evidence of conservative treatment prior to the repeat ESI, Dr. Cabatu on December 6, 2019 advised assignor to continue physical therapy along with medication. Moreover, he maintained that the remaining criteria was satisfied since assignor reported an 85% reduction in pain and the second injection was performed almost two months after the first.

The conflicting medical expert opinions adduced by the parties sufficed to raise an issue as to the medical necessity of the treatment underlying the provider's first-party No-Fault claim. See DRD Med., PC v. Global Liberty Ins. Co. of N.Y., 2020 NY Slip Op 50385(U) (App Term 1st Dept. April 3, 2020); Advanced Orthopedics, PLLC v. New York Cent. Mut. Fire Ins. Co., 42 Misc.3d 150(A) (App Term 2d, 11th & 13th Dists. 2014).

After careful consideration of the record, I find that, after Respondent made its showing that the services in question were not medically necessary, Applicants established by a preponderance of credible evidence that their performance did not deviate from accepted

medical practice, except with respect to the peer reviewer's objection to the shoulder orthosis, which was not meaningfully addressed, let alone refuted, by the provider.

Accordingly, while Respondent's denial of Alliance Medical Goods Service's claim is upheld, its remaining denials predicated upon a lack of medical necessity are vacated.

2.

An insurer is only required to pay for services in the amounts prescribed by the relevant fee schedule, see Oleg's Acupuncture, P.C. and Hereford Ins. Co., 58 Misc.3d 151(A) (App Term 2d, 11th & 13th Dists. 2018), but has the burden to establish that the amounts charged exceed the permitted amounts, see Rogy Med. P.C. v. Mercury Cas. Co., 23 Misc.3d 132(A) (App Term 2d, 11th & 13th Dists. 2009).

By statute and regulation, the fee schedules established by the New York State Workers' Compensation Board are expressly made applicable to claims under No-Fault Law. See Insurance Law §5108; 11 NYCRR §68.0, §68.1 (a) (1).

I am permitted to take judicial notice of, among other things, the workers' compensation fee schedule. See Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co., 61 A.D.3d 13, 20 (2d Dept. 2009); LVOV Acupuncture, P.C. v. Geico Ins. Co., 32 Misc.3d 144(A), (App Term 2d, 11th & 13th Dists. 2011); Natural Acupuncture Health, P.C. v. Praetorian Ins. Co., 30 Misc.3d 132(A) (App Term 1st Dept. 2011).

"(W)hen services are rendered outside of New York but in a jurisdiction which utilizes a fee schedule, the insurer complies with Section 68.6 by paying the permissible charge for the particular medical service, that is the amount permitted by that jurisdiction's fee schedule." Surgicare Surgical v. National Interstate Ins. Co., 46 Misc.3d 736 (Civ. Ct. Bronx Co. 2014), aff'd 50 Misc.3d 85 (App Term 1st Dept. 2015).

Consequently, since the services were in New Jersey, a jurisdiction which utilizes a fee schedule, "the prevailing fee in the geographic location of the provider" is the amount permitted by the New Jersey Ambulatory Surgery Center (ASC) fee schedule.

However, 11 NYCRR § 68.6, as amended, which pertains to services performed on and after January 23, 2018, provides that "a professional health service reimbursable under Insurance Law section 5102(a)(1) ... performed outside this State with respect to an eligible injured person that is a resident of this state" shall be paid by the insurer at "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."

Effective October 1, 2015, the New York State Workers' Compensation Board moved from the Products of Ambulatory Surgery (PAS) based ambulatory surgery fee schedule to the Enhanced Ambulatory Patient Groups (EAPG) methodology. "Under the EAPG payment methodology, reimbursement is related to the actual services provided based on patient diagnosis and the CPT/HCPCS codes reported on the claim," which "are grouped into APG code groups according to the procedure and/or diagnosis." While "(e)ach APG

has an average 'weight' based on the group's average cost," "(o)ther factors, including the provider's location and certain 'add-on' costs, also affect the total allowable reimbursement." Dynamic Surgery Center, LLC and Geico Ins. Co., AAA Case No. 17-18-1095-1046 (arb. Drew M. Gewuerz Feb. 12, 2019).

Stephanie A. Brown, a Certified Professional Coder (CPC) and Certified Professional Medical Auditor, undertook a review of the subject bills at the request of the insurer.

With respect to the facility fees for the four dates of service and the fees billed by the surgeon for the right shoulder arthroscopic surgery, Ms. Brown maintained that the permissible allowances set forth in the New York Medical Fee Schedule were less than those billed or set forth in the New Jersey fee schedules.

She proposed that the total facility fee for the surgery was \$3,026.24 based on reimbursement for CPT code 29825 under APG 37 and that no additional reimbursement was warranted for codes 29820, 29822 and 29826 as they were "consolidated per EAPG Guidelines."

She explained that, "(b)ased on the NCCI Policy Manual for Medicare Services," code 64415 was "billed in error" and that "code 29822 should not be reported along with the procedure code 29825" as these codes "may not be billed with the primary procedure CPT code 29825" since a "less complex service is included in the complex service and is not separately reportable" "(u)nless services are performed at separate patient encounters or at separate anatomic sites."

Ms. Brown further noted that the "NCCI Edit also has a modifier indicator of '0' which mean modifiers are not allowed to override the NCCI edit." While she acknowledged that, according to the AMA CPT Manual, modifier 59 is "used to identify procedures/services ... that are not normally reported together, but are appropriate" when documentation establishes "a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries)," she contended that, "(f)rom an NCCI perspective, the definition of different anatomic sites includes different organs, different anatomic regions, or different lesions in the same organ," and "(a)rthroscopic treatment of a shoulder injury in adjoining areas of the ipsilateral shoulder constitutes treatment of a single anatomic site." Consequently, she determined that the facility's use of modifier 59 was "not appropriate."

In a rebuttal, Applicants' law firm pointed out that the description of modifier 59 included in the CPT Manual does not automatically preclude its use if the services are performed at the same body part since it carves out exceptions for separate incisions and separate procedures or surgeries.

According to the operative report, two portals were created with separate incisions and four separate procedures were performed: decompression (29826), synovectomy (29820), lysis of adhesion (29825), and debridement (29822), in addition to the nerve block (64415).

As the disputed surgical procedures were, in the words of Applicants' attorney, "separate unrelated procedures performed on the same day by the same physician," she maintained that the facility should be paid at the full allowable amount for the highest-priced procedure, which was identified as code 29826, and at half the allowable amounts for the remaining procedures.

After careful consideration of both parties' arguments, I am not persuaded that the facility fees sought in arbitration for the surgery were excessive.

While Applicants' attorney agreed with Respondent's coder that the fees for codes 29820, 29822, 29825 and 29826 should be calculated utilizing the New York Fee Schedule, it contended that the allowable fee for the nerve block was less (\$258.95) under the New Jersey Northern fee schedule, and, therefore, that that fee schedule should be applied. I agree.

On the other hand, I find Ms. Brown persuasive with respect to the calculation of facility fees incurred as a result of the ESIs. While both parties agreed that reimbursement in the amount of \$1,012.38 would be due under the New Jersey Fee Schedule, the coder contended that under the New York Fee Schedule the proper allowance is \$976.38 since code 62323 is the "Significant Procedure" performed for the purpose of establishing the appropriate EAPG code and code 72275 (epidurography) is "listed as Ancillary and considered inclusive to the "Significant Procedure," and hence entitled to "no additional reimbursement."

Although Applicants' attorney acknowledged that "72275-TC is not reimbursable for an ASC in New Jersey," she conclusorily stated, without citation to any authority, that a fee was recoverable under the New York Fee Schedule.

Regarding Applicant South Dean Orthopaedics' claim, I find that Respondent's CPC correctly calculated the fees for codes 29822, 29825, and 29826 to be, respectively, \$864.63, \$1,873.55 and \$451.21 pursuant to the New York Fee Schedule. She also contended that, according to "the Complete Global Service Data for Orthopaedic Surgery 2018, CPT code 29820 ... is not to be reported when billed along with CPT code 29822 ... as it is considered to be inclusive" to that code.

Although Applicants' attorney referred to Ground Rule 5 of the New York Workers' Compensation Surgery Fee Schedule, which provides that payment is to be made for "multiple procedures, unrelated to the major procedure and adding significant time or complexity," there is no basis in the record for me to determine that the synovectomy was "unrelated" to the debridement and added "time or complexity" to that procedure.

Consequently, I find that Applicant Health East Ambulatory Surgical Center is entitled to be paid a total of \$7,701.88 for the facility fees incurred as a result of the shoulder surgery on October 22, 2019 and \$976.38 for the each of the facility fees incurred on November 4, 2019, December 20, 2019, and January 31, 2020, for a total of \$10,631.02 (11 bills).

Applicant South Dean Orthopaedics is entitled to be paid a total of \$3,189.39 for the services rendered on that date October 22, 2019 (four bills).

Insofar as Respondent presented no evidence establishing that the remaining fees were not in accordance with the applicable fee schedules, I find that Applicant Health East Medical Group is entitled to be paid \$1,987.98 for its six bills; Barry Hughes, P.A. is entitled to be paid \$480.11 for his four bills; Health East Medical Alliance is entitled to be paid \$1,262.69 for its five bills; and Bergen Anesthesia Group, LLC is entitled to be paid \$415.94 for its two bills.

In sum, Applicants are awarded \$17,967.13.

This award is in full disposition of all No-Fault benefit claims submitted to 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 applicant is AWARDED the following:

A.

Medical	From/To	Claim Amount	Status

	Health East Ambulatory Surgical Center	10/22/19 - 10/22/19	\$7,701.88	Awarded: \$7,701.88
	Health East Ambulatory Surgical Center	11/04/19 - 11/04/19	\$1,012.32	Awarded: \$976.38
	Health East Ambulatory Surgical Center	12/20/19 - 12/20/19	\$1,012.32	Awarded: \$976.38
	Health East Ambulatory Surgical Center	01/31/20 - 01/31/20	\$1,012.32	Awarded: \$976.38
	South Dean Orthopaedics	10/22/19 - 10/22/19	\$4,487.05	Awarded: \$3,189.39
	Health East Medical Group	11/04/19 - 11/04/19	\$665.18	Awarded: \$665.18
	Health East Medical Group	12/20/19 - 12/20/19	\$657.62	Awarded: \$657.62
	Health East Medical Group	01/31/20 - 01/31/20	\$665.18	Awarded: \$665.18
	Barry Hughes, P.A.	10/22/19 - 10/22/19	\$480.11	Awarded: \$480.11
	Health East Medical Alliance	10/22/19 - 10/22/19	\$1,084.43	Awarded: \$1,084.43
	Health East Medical Alliance	11/04/19 - 11/04/19	\$178.26	Awarded: \$178.26
	Bergen Anesthesia Group LLC	12/20/19 - 12/20/19	\$207.97	Awarded: \$207.97
	Bergen Anesthesia Group LLC	01/31/20 - 01/31/20	\$207.97	Awarded: \$207.97
	Alliance Medical Goods	10/22/19 -	\$111.07	Denied

	Services	10/22/19		
Total			\$19,483.68	Awarded: \$17,967.13

- B. The insurer shall also compute and pay the applicant interest set forth below. 11/30/2020 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Insofar as Applicants did not file for arbitration within 30 days of receipt of Respondent's denials, the statutory tolling provision applies. Accordingly, the insurer shall pay interest on the claims totaling \$17,967.13 from November 30, 2020, the date arbitration was initiated, until such time as payment is made.

C. Attorney's Fees

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

The insurer shall pay the applicant an attorney's fee, subject to a maximum fee of \$1,360.00, in accordance with 11 NYCRR § 65-4.6(d).

- 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 The Bronx

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

08/25/2021
(Dated)

Andrew Horn

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:
ec6351bce37e7f898e48c77449e952e2

Electronically Signed

Your name: Andrew Horn
Signed on: 08/25/2021