

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Motion Medical Diagnostics, PC (Applicant)	AAA Case No.	17-21-1226-1901
	Applicant's File No.	21-007717
- and -	Insurer's Claim File No.	272 PP IIK5110 002
The Standard Fire Insurance Company (Respondent)	NAIC No.	19070

ARBITRATION AWARD

I, Eileen Hennessy, 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-L.C.

1. Hearing(s) held on 03/21/2023, 06/02/2023, 09/08/2023
Declared closed by the arbitrator on 09/08/2023

Jared Mallimo from The Licatesi Law Group, LLP participated virtually for the Applicant

Rishita Jani from Law Offices of Tina Newsome-Lee participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$685.00**, was AMENDED and permitted by the arbitrator at the oral hearing.

Applicant amended the amount at the hearing from the original amount of \$685.00 to \$557.96.

Stipulations WERE NOT made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute

The record reveals that the Assignor-L.C., a 26-year-old female, claimed injuries as a driver of a motor vehicle involved in an accident that occurred on 8/10/2021. Applicant seeks reimbursement for a disability examination conducted on 8/27/2021. Respondent denied the claim based on the bill exceeding the applicable Fee Schedule. The issue to

be determined is whether Respondent properly denied payment of the services based on the applicable Fee Schedule?

4. Findings, Conclusions, and Basis Therefor

Applicant seeks reimbursement for a disability examination. 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 at the hearing held via Zoom. There were no witnesses. I reviewed the documents contained in MODRIA for both parties and make my decision in reliance thereon.

11 NYCRR 65-4.5 (o) (1) (Regulation 68-D), reads as follows: The arbitrator shall be the judge of the relevance and materiality of the evidence offered and strict conformity to legal rules of evidence shall not be necessary. The arbitrator may question any witness or party and independently raise any issue that the arbitrator deems relevant to making an award that is consistent with the Insurance Law and Department Regulations.

FEE SCHEDULE

It is well established that a healthcare provider must limit its charges according to the applicable fee schedule. Goldberg v. Corcoran, 153 AD2d 113, 117-18 (App Div, 2d Dept 1989). Amended Regulations section 65-3.8(g)(1) states proof of the fact, and amount of loss sustained pursuant to Insurance Law section 5106(a) shall not be deemed supplied by an applicant to an insurer and no payment shall be due for such claimed medical services under any circumstances: (i) when the claimed medical services were not provided to an injured party; or (ii) for those claimed medical service fees that exceed the charges permissible pursuant to Insurance Law sections 5108(a) and (b) and the regulations promulgated thereunder for services rendered by medical providers. This subdivision applies to medical services rendered on or after April 1, 2013.

It is respondent's burden to come forward with competent evidentiary proof to support its fee schedule defenses. See Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co., 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 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 N.Y. Misc. LEXIS 1109 (App. Term, 1 Dep't, per curiam, 2006). A 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 N.Y. Misc. LEXIS 544 (App. Term, 2d Dept. 2004).

An insurer's unilateral decision to re-code or change a medical provider's billed CPT codes, to reimburse disputed medical services at a reduced rate, or to deny a claim in its entirety, is ineffectual when unsupported by a peer review report or by other proof setting forth a sufficiently detailed factual basis and medical rationale for the code changes, fee reductions and denials. *See Amaze Medical Supply v. Eagle Insurance Company*, 2 Misc 3d 128A (App Term 2d and 11th Jud Dist 2003). A lay person is not qualified to evaluate the CPT codes or to change if the code is used by a health provider in its bills. *See Abraham v. Country-Wide Ins. Co.*, 3 Misc. 3d. 130A (App. Term 2d. Dept. 2004). Once the insurer makes a prima facie showing that the amounts charged by a provider were in excess of the fee schedule, the burden shifts to the provider to show that the charges involved a different interpretation of such schedule or an inadvertent miscalculation or error. *Cornell Medical, P.C. v. Mercury Casualty Co.*, 24 Misc. 3d 58, 884 N.Y.S.3d 558 (App. Term 2d, 11th & 13th Dists. 2009).

Judicial notice of the New York Fee Schedule is taken. *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 Jud Dists. 2011); *Natural Acupuncture Health, P.C. v. Praetorian Ins. Co.*, 30 Misc.3d 132(A) (App Term, 1st Dept. 2011).

ANALYSIS

Applicant seeks reimbursement for a disability examination conducted on 8/27/2021 (\$685.00 amended to \$557.96), which was billed under CPT code 99456. Respondent denied the claim stating, "CPT CODES 99455 AND 99456 ARE USED TO REPORT SPECIFIC SERVICES THAT OCCUR WHEN COMPLETING EVALUATIONS FOR WORK RELATED EXAMINATIONS. SINCE THE INJURED PARTY WAS EITHER NOT EMPLOYED AT THE TIME OF THE LOSS OR DID NOT LOSE TIME FROM WORK, WE MUST DENY PAYMENT OF THESE CPT CODES", leaving an amended balance of \$557.96.

Applicant submits an affidavit of Certified Professional Coder (CPC) Michael D. Miscoe, CPC, dated 8/2/2022, and an IHC report for an unrelated claim by Joyce Ehrlich, dated 8/9/2022. Applicant summarizes the affidavit of Mr. Miscoe in pertinent part, stating, "Mr. Miscoe clarifies that by express code description, CPT 99456 indicates that the evaluation performed may be for 'EITHER a 'work related' OR 'medical' disability examination." Miscoe Aff., ¶ 31-32. Citing to the CPT Assistant [CPT Assistant, vol. 23, Issue 8, p 14 (August 2013)], Mr. Miscoe explains that same "makes clear that this service need not be related to a work injury, that there are no specific requirements for the history or examination and that the purpose of the evaluation is the making of a disability determination to include calculation of impairment. When performed by a physician other than the treating physician, the treatment plan element is a requirement for recommendations regarding treatment from the consulting physician to the treating physician that ordered the test." Miscoe Aff., ¶¶ 35 & 36."

Respondent relies on the affidavit of Monica L. Brett, CPC, dated 3/15/2023, which references the sources she relies on, including the CPT Assistant, and discusses the services in detail. Respondent argued that Applicant's billing was in excess of the fee schedule. Disability examinations are performed for the purposes of obtaining a disability certificate or for obtaining life insurance and are not generally performed as a part of no-fault claims. Applicant is not entitled to reimbursement for code 99456 in the absence of any evidence that the patient required the examination for disability or life insurance purposes. Ms. Brett notes in pertinent part:

5. In dispute in this arbitration is a bill in the total amount of \$685.00 for a medical disability examination provided to EIP [Assignor-L.C.] on August 27, 2021 by Applicant MOTION MEDICAL DIAGNOSTICS, PC. The bill was entered into TRAVELERS claim system under claim #IIK5110 and catalogued as bill control number or "BCN" 10985200. I reviewed BCN#10985200 for reimbursement in compliance with the applicable fee schedule and I submit this affidavit as a supplement to TRAVELERS arbitration submissions. The claim and bill were denied since EIP was either not employed at the time of the loss or did not lose time from work. Since the bill and records described hereafter were submitted with Respondent's conciliation submission, they are not being included with this affidavit.
6. The medical disability examination was performed by a New York physician and the EIP is insured under a New York No-Fault Insurance Policy, therefore, the New York Worker's Compensation Fee Schedule is applicable. Applicable portions of the New York Fee Schedule are attached as Exhibit "A".
7. Review of the bill and supporting medical records submitted determined that applicant MOTION MEDICAL DIAGNOSTICS, PC billed incorrectly for the charges by utilizing the incorrect CPT codes for the service provided.
8. Applicant billed for the examination under CPT codes; 99455 and 99456. Under the New York Worker's Compensation Medical Fee Schedule Evaluation and Management section, CPT code 99456 is used to report evaluations to establish baseline information prior to life or disability insurance certificates being issued. When using this code, no active management of the problem is undertaken by the encounter. The need for these certificates is not related to the injuries sustained in the motor vehicle accident

9. In addition to the foregoing reason for denial, the amount charged and sought to be reimbursed exceeds the amount permitted under the applicable Workers' Compensation Fee schedule and is not reimbursable as billed. The provider billed \$685.00. However, there is nothing noted as to how they determined that dollar amount. It does not show how they maintained relative consistency with other codes in the schedule as noted in Ground Rule #3. There are no outpatient codes in the Evaluation and Management section of the New York State Worker's Compensation Fee Schedule with a relative value of 45.48 RVU ($\$685.00 / \$15.06 = 45.48$ RVU).

10. More specifically, the relative value of Evaluation and Management Outpatient Consultation services in the New York State Worker's Compensation Medical Fee Schedule range from 10.15 to 27.23 RVU. Notably, in accordance with Ground Rule #3 (Exhibit "A") and to remain consistent in relativity with other unit values shown in the schedule, since the reports provided also did not support a comprehensive history and comprehensive examination, the calculations utilizing the correct CPT code of 99243 are as follows:

CPT code 99243 - $16.49 \text{ RVU} \times \$15.06 \text{ (Region 4 EM rate)} = \248.34

If services were to be paid, this would be the maximum amount reimbursable.

11. Based upon my experience as a Certified Professional Coder and Quality Assurance/Medical Appeals Analyst in the Specialized Medical Audit Review Team with full familiarity of CPT coding and utilization of the New York fee schedule, I state that the charges billed by MOTION MEDICAL DIAGNOSTICS, PC exceeded the amount allowed.

Respondent submits multiple arbitration decisions which concluded that code 99456 is specifically designated for a work related or medical disability examination, which would only be performed if there were a need for a life insurance or disability certificate.

In *Motion Medical Diagnostics, PC and Nationwide Affinity Insurance Company of America*, AAA Case No. 17-21-1220-0605, heard on 9/28/2022, Arbitrator Alison Berdnik addressed this issue and determined in pertinent part:

Respondent's defense is twofold. First, Respondent contends that:

A portion of the current procedure has been included in the calculation of the daily RVU cap that applies to all providers treating the same patient on the same day for the same accident as stated in the New York State Medical Fee Schedule Ground Rules. The cap is now exhausted.

The Explanation of Review ("EOR") accompanying Respondent's NF-10 also asserts the following:

Based on the NY Workers' Compensation Fee-Schedule, E & M Section, Rule #8: 99455 and 99456 are to be used to report evaluations in order to establish baseline information for insurance certification and/or work-related or medical disability. The American Medical Association's CPT guidelines state that these codes are 'used to report evaluations performed to establish baseline information prior to life or disability insurance certifications being issued.' These codes are not valid for NY No-Fault claims. Also, the code billed is a By Report (BR) code. Based on the fee-schedule rules, the fee for BR procedures is to be consistent in relativity with the closest similar procedure that has a value in the schedule. The service performed is equivalent to a standard E&M office visit with the following components: History, exam & medical decision making. Therefore, the closest similar procedure in the fee-schedule is 99204.

Applicant has billed for its evaluation under CPT code 99456, which maintains a "by report" or "BR" designation, and is defined under the Fee Schedule as follows:

Work related or medical disability examination by other than the treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report.

Ground Rule 8 of the Evaluation and Management section of the Fee Schedule provides the following instruction:

Special Evaluation and Management Services (99450-99456)

This series of codes reports provider evaluations performed to establish baseline information for insurance certification and/or work-related or medical disability.

In Cross Island Chiropractic Evaluations, PC and State Farm Mut. Auto. Ins. Co., AAA case No.: 17-21-1202-8068, Arbitrator Meryem Toksoy was also asked to consider that Applicant's use of CPT code 99456. In denying Applicant's claim, Arbitrator Toksoy noted the following:

There are two codes for reporting a work related or medical disability exam, CPT 99455 and 99456, both of which are listed in the Evaluation and Management section of the Chiropractic Fee Schedule.

Arbitrator Toksoy subsequently provides detailed citation to the CPT Assistant discussing the above codes:

CPT Assistant, Special Evaluation and Management Services Added to CPT 1995, Summer 1995 issue, page 14:

*A new series of codes, Basic Life and/or Disability Evaluation Services and Work Related or Medical Disability Evaluation Services, was added to CPT in 1995. **These codes were added to report specific services that occur when completing evaluations for life insurance and/or disability claims, as well as work related or other medical disability examinations.***

The life insurance industry estimates that about \$5 billion is paid each year for medical examinations and evaluations performed on applicants for life insurance. In addition, the role of the independent medical examiner is important when accidental medical trauma covered by casualty carriers has occurred. It is a specific type of examination and evaluation that is financed as the cost of doing business (the "expense" side of a life/disability insurer), rather than from the funds for the treatment of the injured policy holder (the "loss" side).

These services are separate and distinct from other evaluation and management services. These codes are to be used to report evaluations performed in order to establish baseline information, prior to life or disability insurance certificates being issued. The service is performed in an office or other setting and applies to both new and established patients. When using these codes, NO active management of the problem(s) is undertaken during the encounter.

If other evaluation and management services and/or procedures are performed on the same date, the appropriate evaluation and management or procedure code(s) can be reported in addition to these codes. In this case Modifier -25 should be appended to the evaluation and management service, if performed on the same date.

Basic Life and/or Disability Evaluation Services

99450 *Basic life and/or disability examination that includes: measurement of height, weight and blood pressure; completion of a medical history following a life insurance pro forma; collection of blood sample and/or urinalysis complying with "chain of custody" protocols; and completion of necessary documentation/certificates.*

99455 *Work related or medical disability examination by the treating physician that includes: completion of a medical history commensurate with the patient's condition; performance of an examination commensurate with the patient's condition; formulation of a diagnosis, assessment of capability and stability and calculation of impairment; development of future medical treatment plan; and completion of necessary documentation/certificates and report.*

99456 *Work related or medical disability examination by other than the treating physician that includes: completion of a medical history commensurate with the patient's condition; performance of an examination commensurate with the patient's condition; formulation of a diagnosis, assessment of capability and stability, and calculation of impairment; development of future medical treatment plan; and completion of necessary documentation/certificates and report.*

For Example: A patient makes an appointment to see his family physician for a physical examination, required to qualify for a new life insurance policy. The physician completes a medical history, as required by the Life Insurance Company, which consists of an abbreviated examination of height, weight, and blood pressure, as well as collection of specimen samples required for laboratory tests. The physician also completes several forms, provided by the life insurance company, to certify that the information is complete. If this is the only service provided, then the physician should use CPT 99450 for this evaluation and management service. The ICD-9 diagnosis coded

would be V70.3, 'other medical examination for administrative purposes.' This is located in the index under 'Examination,' subterm 'Medical,' subterm 'Insurance certification.'

If a physician, through the course of a basic life examination on an established patient, finds a patient to be severely overweight with high blood pressure and counsels the patient for 25 minutes during the visit, on weight control, diet, and exercise, the physician may then report an additional code for the counseling. In this case, 99214-25 will be coded in addition to 99450. CPT code 99214 is chosen because counseling domination (more than 50%) the evaluation and management portion of the visit (excludes services provided that are described in this section), therefore time is considered the key or controlling factor to qualify for a particular level of E/M services. The preventive medicine individual counseling code is NOT appropriate because the patient had pre-existing symptoms (overweight, high blood pressure). Refer to the guidelines on page 37 in CPT 1995 and the CPT Assistant article in Winter 1994, for further clarification on reporting preventive medicine individual counseling.

CPT Assistant, Frequently Asked Questions: Evaluation and Management: Special E/M Services, August 2013 issue, page 13:

Question: What is the proper way to report evaluation services related to a worker's compensation injury for new and established patients?

Answer: Code 99455, Work related or medical disability examination by the treating physician, and 99456, Work related or medical disability examination by other than the treating physician, are used to report evaluations performed to establish baseline information prior to the issuance of life or disability insurance certificates. This service is performed in the office or other setting, and applies to both new and established patients. When using these codes, no active management of the problem(s) is undertaken during the encounter. These codes are not intended to be used for active E/M services due to work-related injuries. If other E/M services and/or procedures are performed on the same date, the appropriate E/M or procedure code(s) should be reported in addition to codes 99455 and 99456. Modifier 25 may be appended to the E/M service code. Codes 99455 and 99456 would not be used if the complete services as identified for disability evaluations are not performed. Instead, the appropriate code from the 99201-99215 code series may be used to identify the services rendered.

Following her in-depth analysis, Arbitrator Toksoy denied Applicant's claim as follows:

Based on the code description for 99456, the CPT Assistant articles wherein the AMA explains the purpose of this type of exam, and the report for the services that took place on 03-01-21, I find that it was improper of the Applicant to use CPT 99456.

Arbitrator Toksoy's analysis is both instructive and persuasive. Applicant's self-serving identification of its evaluation report as an "injury certification report and impairment summary" is a mischaracterization and, in my view, an attempt to circumvent the maximum permissible rates of reimbursement prescribed by the Fee Schedule. Based upon the fee schedule ground rules it is clear that code 99456, which the Applicant used to bill for the examination, cannot be used for reimbursement of first party benefits in a no-fault claim. CPT codes 99455 and 99456 are used to report evaluations performed to establish baseline information prior to life or disability insurance certificates being issued. There is no indication that Applicant's examination was performed for the purpose of issuing any insurance certificates. Clearly that was not the purpose of the examination in this case. Compensation is sought under no-fault insurance for medical expenses incurred as a result of a motor vehicle accident, not in connection with procuring life or disability insurance. I am not persuaded that the examination performed is what was contemplated by the Workers' Compensation Board when it established CPT codes 99455 and 99456. Rather, in my view, Applicant billed for its services using CPT code 99456 in an attempt to charge a fee well in excess of those allowed had Applicant billed using an appropriate code from one of the E&M codes the 99201-99215 code series as directed by the CPT Assistant.

Applicant's counsel argued that Respondent's partial payment is a concession that payment is due and owing to Applicant. I respectfully disagree. In support of its defense, Respondent offers an affidavit by Russell Arnold, a Certified Professional Coder employed with Respondent. Mr. Arnold refers to the ground rule for By Report (BR) services. He explains why it was appropriate for the Respondent to process the bill using the Relative Value Units (RVUs) assigned to CPT 99204, a code which has an allowance of \$107.16 for chiropractors. Mr. Arnold discusses, in detail, how Respondent's application of the 18-unit rule reduced the payment amount to \$51.18. Respondent also offers an Explanation of Review pertaining to treatment rendered to the Claimant by Broadway Chiropractic Health on the same date on which Applicant rendered its service, which demonstrates that Applicant's claim was appropriately reduced in order to account for the Ground Rule 2 of the Physical Medicine section of the Chiropractic Fee Schedule (the "18 Unit Rule".) Respondent could have simply denied Applicant's claim outright based upon Applicant's billing in excess of the

appropriate fee schedule. However, giving Applicant the benefit of every doubt, Mr. Arnold concluded that Applicant's evaluation was most consistent in relativity with CPT code 99204 and, subject to the 18 Unit Rule, recommended reimbursement accordingly.

I am also not persuaded that Applicant's submission of additional affidavits prepared by Mr. Arnold in other cases where Mr. Arnold was asked to consider the appropriate rate of reimbursement for evaluations performed under CPT code 99456 warrants a higher rate of reimbursement in this case. I agree with Respondent's counsel that the additional affidavits prepared by Mr. Arnold establish the appropriate rate of reimbursement for the particular evaluations performed under those particular circumstances. In other words, counsel argued, Mr. Arnold's different determinations as to the appropriate rate of reimbursement for those other exams demonstrates that Mr. Arnold is not simply "rubber stamping" the bills reviewed. Rather, he takes into consideration the specifics of each bill and corresponding examination report and makes a determination whether reimbursement is appropriate under CPT code 99203, 99204 or 99212 (or any additional E&M codes available to chiropractors under the Fee Schedule.)

Therefore, comparing the relevant evidence submitted by the parties, and the oral arguments presented by counsel during the hearing, I find that Applicant is not entitled to any additional reimbursement for the service at issue.

I concur with and adopt my learned colleagues reasoning. As noted by Arbitrator Berdnik, "Based upon the fee schedule ground rules it is clear that code 99456, which the Applicant used to bill for the examination, cannot be used for reimbursement of first party benefits in a no-fault claim. CPT codes 99455 and 99456 are used to report evaluations performed to establish baseline information prior to life or disability insurance certificates being issued. There is no indication that Applicant's examination was performed for the purpose of issuing any insurance certificates. Clearly that was not the purpose of the examination in this case. Compensation is sought under no-fault insurance for medical expenses incurred as a result of a motor vehicle accident, not in connection with procuring life or disability insurance. I am not persuaded that the examination performed is what was contemplated by the Workers' Compensation Board when it established CPT codes 99455 and 99456. Rather, in my view, Applicant billed for its services using CPT code 99456 in an attempt to charge a fee well in excess of those allowed had Applicant billed using an appropriate code from one of the E&M codes the 99201-99215 code series as directed by the CPT Assistant".

Accordingly, Applicant's claim is 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 NY

SS :

County of Nassau

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

09/27/2023

(Dated)

Eileen Hennessy

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:
ccea2a9bd00bbbe7a9b1334b151cf0ea

Electronically Signed

Your name: Eileen Hennessy
Signed on: 09/27/2023