

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Golden Healthcare Chiropractic Diagnostic PC (Applicant)	AAA Case No.	17-24-1369-5935
- and -	Applicant's File No.	NA
	Insurer's Claim File No.	0748651437 2N1
Allstate Fire & Casualty Insurance Company (Respondent)	NAIC No.	29688

ARBITRATION AWARD

I, Thomas Awad, 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: MMBV

1. Hearing(s) held on 02/04/2025
Declared closed by the arbitrator on 02/04/2025

Rajesh Barua from Law Offices of Hillary Blumenthal LLC (Union City) participated virtually for the Applicant

Juliya Khodik from Law Offices of John Trop participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$100.29**, 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, MMBV, a 48 year old female was involved in a motor vehicle accident on 3/15/24. At issue in this case is \$100.29 for chiropractic treatment performed on 8/23/24. The issue presented is whether the Applicant's claims charge fees within the limits set by the New York State Workers' Compensation Fee Schedule adopted by the Superintendent of Insurance (Department of Financial Services).

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. I reviewed the documents contained in MODRIA for both parties and make my decision in reliance thereon.

The Assignor, MMBV, a 48 year old female was involved in a motor vehicle accident on 3/15/24. At issue in this case is \$100.29 for chiropractic treatment performed on 8/23/24. Respondent partially paid the claim based on provisions a MagnaCare contract and the 12 unit rule. The issue presented is whether the Respondent properly paid the claim.

It should be noted that this case appeared before me on the same day as two other linked cases that involved the same issues and attorneys. The 3 cases are 17-24-1360-3057, 17-24-1369-3080 and 17-24-1369-5935. I advised the attorneys that I would consider the evidence in all cases in determining each individual case.

12 Unit

The bill was partially paid based on the assertion that the claim is limited by the RVU cap. Respondent's Explanation Of Medical Bill Payment states that the basis for the reduced payment is:

When multiple procedures and/or modalities are performed on the same day, the maximum number of relative value units is limited to 12.0 or the amount billed, whichever is less for all providers combined. (New York Workers' Compensation Medical Fee Schedule, Ground Rule 11; Chiropractic Fee Schedule, Physical Medicine Ground Rule 3; Acupuncture Fee Schedule, Medicine Ground Rule 1B; Physical Therapy and Occupational Therapy Fee Schedule, Physical Medicine Ground Rule 3)

Respondent denied payment in full or issued partial payment based on the 12 unit rule, which provides that no more than 12 units of physical medicine procedures and modalities may be billed by all providers combined on any one date of service.

The evidence indicates that for these two bills Respondent made partial payments to a chiropractor, Golden Healthcare Chiropractic Diagnostic and Applicant (physical therapist). Respondent argues that the plain language of the Ground Rules limit payments to 12 RVU per day regardless of the number of providers. For at least one of the bills, the Respondent does not assert that it paid a portion of the twelve units to another provider. The argument is that the Applicant billed more than the allowable 12 units. Applicant argued that it billed the correct amount.

I am permitted to take judicial notice of the New York State Workers' Compensation fee schedule. My review indicates that the Respondent accurately calculated the amount for 12 units. Respondent previously paid the proper amount.

PPO

It should also be noted that for the denial also involved calculations based on a PPO contract.

Respondent in support of its position that these bills were covered under an agreed-upon PPO contract submits the PPO contract and amended PPO contract between the Applicant and MagnaCare which established that the Applicant would accept reduced reimbursement for its services pursuant to a mutually accepted fee schedule.

In support of its defense the Respondent submits the affidavit of Nydia Flores which states that she is employed by Brighton Health Plan Solutions, DBA MagnaCare Administrative Services, LLC, ("MagnaCare") as the Manager of Casualty Support. The affiant states in part:

7. MagnaCare has consented to the Respondent's access of the MagnaCare network, and Steven Kokulak, Esq; President of Casualty Solutions was personally responsible for making the decision to grant the Respondent this access, through COVENTRY. This assertion, in of itself, should be sufficient proof that the Respondent was and continues to be a valid MagnaCare Payor.

The affiant explains the relationship between the Applicant and MagnaCare in great detail. The contract contains a fee schedule that includes rates, payment timeframes and other obligations. The affidavit concludes that the "Provider submitted an application to MagnaCare to become a member of the PPO and was accepted. The Provider should be bound to accept the MagnaCare fee schedule rates of payment from this customer, until the date of termination. "

The Respondent also submits the affidavit of Miriam Encarnacion who states that the affidavit is based upon the business records of Coventry Health Care Workers Compensation, Inc. ("Coventry"). The affiant attest that Coventry is responsible for providing documentation to Allstate and its affiliates supporting PPO Network agreements between Coventry and its sub-client networks, including MagnaCare. MagnaCare and Coventry entered into a Network Access Agreement, as amended, whereby Coventry contracted for auto network services on behalf of itself and its affiliates (the "Coventry/Magnacare agreement"). Ms. Encarnacion provides an explanation of the contractual relationship between the parties.

The Applicant argues that the Respondent's evidence does not establish privity of contract between the parties. I disagree. The evidence has demonstrated that there was an agreement between MagnaCare and Applicant at the time the services at issue were provided.

The proof indicates that the Applicant's principal, was part of a PPO contract. As such the Applicant agreed to accept payment at the corresponding MagnaCare fee schedule rate from entities contracted with MagnaCare to provide reimbursement for services provided by the Applicant. Applicant has failed to show that the services contested herein were not subject to the PPO rates on the date they were rendered. Thus, by

entering into the PPO contract the Applicant is entitled to the benefits of being a PPO provider. However, with that benefit Applicant has to assume the burden of accepting the lower rates. In so holding I concur with my colleagues Arbitrator James Hogan 17-24-1351-8388, John Langell 17-24-1361-8894 and Wendy Bishop 17-23-1311-4941.

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

02/11/2025
(Dated)

Thomas Awad

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:
03551b79559692fe90e6aa808090aa3f

Electronically Signed

Your name: Thomas Awad
Signed on: 02/11/2025