American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Mount Sinai Medical Supply Inc. (Applicant)	AAA Case No.	17-17-1073-1956
	Applicant's File No.	N/A
- and -	Insurer's Claim File No.	0597203300101010
	NAIC No.	
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

I, James Hogan, 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: EIP

1. Hearing(s) held on 04/26/2018
   Declared closed by the arbitrator on 04/26/2018

   Catherine Roberts from Gene Sigalov Esq. participated in person for the Applicant

   Dustin Mule' from Geico Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 2,804.65**, was NOT AMENDED at the oral hearing.
   Stipulations WERE made by the parties regarding the issues to be determined.

   The parties have agreed that the Applicant has established its prima facie case.

   The parties have agreed that the Respondent's denials were timely.

   The parties have agreed that the amount in controversy is in accordance with the fee schedule.

   The parties have agreed that if there is an award, interest will start to accrue from the date of the Initiation Letter - 9/21/17.

3. Summary of Issues in Dispute

The EIP, a 28 year old male, was injured in a collision on 5/17/17. This claim is for DME issued to the EIP on 5/31/17 in the form of a cervical orthopedic pillow, lumbar cushion, LSO, cervical collar, thermophore, water pump, bed board and mattress. These items were dispensed pursuant to a prescription from Dr. Baldonado dated 5/23/17. The total amount of the Applicant's claim is $1,517.32 for this DOS.

Then on 6/23/17, the Applicant provided a TENS/EMS unit, a TENS/EMS belt, an infrared lamp and a whirlpool. These items were provided pursuant to a prescription from Dr. Baldonado dated 6/23/17. The total amount of the Applicant's billing for this DOS is $1,287.33.

The total amount of the Applicant's claim is $2,804.65.

On 7/20/17, the Respondent issued an NF-10 denying the Applicant's claim for DOS 5/31/17 and the billing in the amount of $1,517.32 based upon a peer review by Stuart Stauber, MD, who opined that the DME at issue was not medically necessary.

On 8/4/17, Respondent issued an NF-10 re DOS 6/23/17 and billing in the amount of $1287.33 based upon a negative peer review by Damion A. Martins, MD, who opined that the DME at issue is not medically necessary.

Dr. Baldonado has filed rebuttals to the peer review reports.

4. Findings, Conclusions, and Basis Therefor

This decision is based upon my review of the electronic file maintained by the American Arbitration Association, and the arguments of the parties set forth in the hearing.

SUMMARY OF THE CASE:

The EIP, a 28 year old male, was injured in a collision on 5/17/17. This claim is for DME issued to the EIP on 5/31/17 in the form of a cervical orthopedic pillow, lumbar cushion, LSO, cervical collar, thermophore, water pump, bed board and mattress. These items were dispensed pursuant to a prescription from Dr. Baldonado dated 5/23/17. The total amount of the Applicant's claim is $1,517.32 for this DOS.

Then on 6/23/17, the Applicant provided a TENS/EMS unit, a TENS/EMS belt, an infrared lamp and a whirlpool. These items were provided pursuant to a prescription from Dr. Baldonado dated 6/23/17. The total amount of the Applicant's billing for this DOS is $1,287.33.

The total amount of the Applicant's claim is $2,804.65.

On 7/20/17, the Respondent issued an NF-10 denying the Applicant's claim for DOS 5/31/17 and the billing in the amount of $1,517.32 based upon a peer review by Stuart Stauber, MD, who opined that the DME at issue was not medically necessary.

On 8/4/17, Respondent issued an NF-10 re DOS 6/23/17 and billing in the amount of $1287.33 based upon a negative peer review by Damion A. Martins, MD, who opined that the DME at issue is not medically necessary.

Dr. Baldonado has filed rebuttals to the peer review reports.

The Respondent uploaded a Supplemental Submission on 3/16/18. As per 11 NYCRR 65-4.2(b)(3)(iv) "Any additional submissions may be made only at the request or with approval of the arbitrator." Since the Supplemental Submission was late, and uploaded without permission, **it was not considered.**

Applicant's submission:

The Applicant has provided a copy of its billing, and a prescription from Dr. Baldonado for the DME at issue, along with corresponding Denials from the Respondent.

The Applicant's submission also contains a copy of the Peer Review/Addendum from Dr. Martins dated 7/31/17 and the peer review from Dr. Stauber, dated 7/18/17.

Also provided are copies of Delivery Receipts for the DME at issue, signed by the EIP on 5/31/17 and 6/23/17.

On 5/23/17, the EIP had an initial evaluation with Dr. Baldonado. This evaluation is on a preprinted form where the examiner checks off items, enters handwritten notes and circles other items. Some of the handwritten notes are very difficult to read, if not illegible. Some of the handwriting is superimposed on top of printed matter, making it impossible to read.

The EIP reported being involved in an MVA on 5/17/17. He was taken to the hospital from the accident site. He complained of injuries to his neck, bilateral shoulders and lower back.

The physical examination indicates that the EIP was complaining of intermittent headaches along with dizziness, nausea and light sensitivity. The headaches were rated as 7-8/10.

He also complained of chest pain which was intermittent in the anterior chest wall and rated at 7-8/10.

The examination of the cervical spine notes that the pain is rated at 9/10. There was decreased range of motion, with pain. The range of motion is quantified is reduced in all planes. The neck pain and stiffness radiated to the bilateral shoulders. There was tenderness noted at the C4-5 level.

Cervical Compression Test and Cervical Distraction Test were positive.

There is no examination of the thoracic spine recorded.

As to the lumbosacral spine examination, pain is rated at 8/10. The range of motion is quantified as decreased in all planes, with pain. There is low back pain and stiffness radiating to the bilateral extremities. Tenderness was noted from L4-5 through L5-S1. There were levels with increased paravertebral muscle tone on the left. No step-off is appreciated.

Spinal Percussion Test was positive; SLR was positive.

The examination of the upper extremities was rated at 7/10; the examination revealed tenderness over the right forearm. There is a notation that the active and passive movements are restricted and painful upon palpation.

The examination of the lower extremities was rated as 8/10 and revealed tenderness over the left leg.

Anterior Drawer sign was positive.

The neurological examination indicates that the cranial nerve examination was normal; the coordination examination was normal; motor muscle testing was 4/5 throughout; no muscle atrophy was noted; DTRs were "as noted."

The neck pain radiates to the bilateral shoulders.

The low back pain radiates to the bilateral extremities and toes. There was numbness and weakness present.

The sensory examination of the upper extremities found a decreased response to light touch and pinprick in the bilateral C5 - C6, bilaterally.

The sensory examination of the lower extremities revealed decreased responses to light touch and pinprick at the bilateral L5 - S1, bilaterally.

The Recommendations include: 1) x-rays of the cervical spine, lumbar spine, and bilateral shoulders; 2) MRI/CT scan of the cervical, and lumbar; 3) physical therapy evaluation and treatment at the rate of 5 times per week; 4) consultation with a neurologist and an orthopedist; 5) Physical Capacity Test; 6) Computerized range of motion and muscle testing; 7) re-evaluation in 4 weeks.

The Diagnostic Impressions were: 1) cervical sprain/strain; 2) cervical radiculopathy; 3) R/O cervical radiculitis; 4) low back pain, paraspinal myofasciitis; 5) lumbosacral sprain/strain; 6) R/O lumbar radiculitis; 6) thoracic sprain/strain; 7) bilateral shoulder pain; 8) bilateral shoulder derangement.

I note that this examination does not indicate that any DME was going to be prescribed for the EIP.

Respondent's submission:

The Respondent's position is that the Applicant's claims were properly denied based upon peer reviews done by Dr. Stauber and Dr. Martins.

The Respondent's submission contains a copy of the Applicant's billing, and the prescriptions for the DME signed by Dr. Baldonado.

Peer Review:

Stuart Stauber, MD, did his peer review on 7/18/17. The purpose of the review was to determine the medical necessity for DME issued by the Applicant on 5/31/17 in the form of a cervical orthopedic pillow, thermophore, mattress, bed board, water pump, cervical orthosis collar, LSO and lumbar cushion.

He lists a number of records that he has reviewed. These include a report from Dr. Baldonado dated 5/23/17. Also reviewed was a Physical Therapy Evaluation also dated 5/23/17.

Dr. Stauber recounts the EIP's accident history and summarizes his treatment thereafter.

In the "Conclusion" section of his report, Dr. Stauber states that following the injuries such as those sustained by the EIP, the physician would be appropriate with x-rays ordered to rule out any suspected fracture and the patient may be given medication and therapy for approximately 8 weeks. Following that type of conservative care, if a subsequent assessment notes any deterioration in the condition or progressive worsening neurological deficits, an MRI may be indicated. Following a review of those results, the patient may then be referred for interventional pain management or surgery. "However, the standard of care and medicine does not involve the routine use of durable medical equipment such as those provided for the claimant."

He then says that the cervical collar is not medically necessary. "I say this because frequent active mobilization exercises decrease symptoms more than a gradual mobilization program. In fact, in one study the authors concluded that active movement 'combined with mechanical diagnosis and therapy is more effective in reducing pain than a standard program of initial rest, recommended use of a soft collar, and gradual self-mobilization.'" (Spine, 2000: Early Intervention in Whiplash-Associated Disorders). Thus, a soft cervical collar for immediate period after injury is not the best treatment for neck pain or whiplash.

He then sites to another article found in Spine, in 2001, entitled The Efficacy of Conservative Treatment of Patients with Whiplash Injury, for the proposition that it appears that 'rest makes rusty' whereas active interventions have a tendency to be more effective in patients with whiplash injury.

Dr. Stauber refers to another article, this one in 2004 in Injury, entitled "Early management and outcome following soft tissue injuries of the neck - a randomized controlled trial." "The authors conclude that 'Treatment with a soft collar was found to have no obvious benefit in terms of functional recovery after neck injury and was associated with a prolonged time period off work. This study supports the use of an early mobilization regimen following soft tissue injuries of the neck." Dr. Stauber concludes that he is unable to recommend reimbursement for the cervical collar.

He then addresses the LSO saying that it was unnecessary. Statistically, they do not have a significant effect on rotation and there is no evidence that lumbar supports reduce the electromyogram activity of erector spinae muscles or increase the intra-abdominal pressure. Therefore, the authors conclude that the hypothesis that lumbar supports decrease the back muscle force by means of a decrease in electromyogram of back muscles or an increase in IAP is not supported by the available evidence. In support of this statement, he refers to a 2000 article found in Spine.

He then refers to a 2008 article found in Cochrane Review "Lumbar Support for Prevention and Treatment of Low Back Pain" stating that in this clinical trial of over 1200 people there was no difference between acute and chronic pain using assistive devices such as lumbar support, LSO and back cushion. Dr. Stauber opined that the LSO was not medically necessary and that the lumbar back cushion was not medically necessary.

He then addresses the medical necessity of the cervical pillow and opines that it was not medically necessary. "…there is no conclusive evidence that providing a patient with an item such as a cervical pillow provides any significant benefit to the patient with regards to reduction of pain or recovery time, in fact, in one study, patients were supplied with the cervical pillow (roll pillow), the usual pillow, or a water-based pillow. It was found that the water-based pillow was superior to a cervical pillow and the standard pillow.

It was also found that the use of the cervical pillow did not provide any advantages to the subjects with regard to pain reduction and sleep time. In fact, it is noted in the article that '*The duration of sleep was significantly shorter for the role pillow.'* It is further concluded that there is little research regarding the utility of cervical pillows to reduce pain and improve sleep.

Dr. Stauber notes that the use of a standard heating pad may provide therapeutic benefit and there is no scientific evidence indicating that use of a water circulating unit will provide any superior benefit to a standard heating pad. Essentially, the use of such a device is considered experimental in nature because they have not been proven to produce outcomes superior to standard hot packs or electric heating pads. Also, the recommended treatment for acute low back pain is "reassurance, stay active, avoid bed

rest, and ice for pain." There is no recommendation for heat in the management of acute lumbar pain. In support of this statement, Dr. Stuaber refers to National Guideline Clearinghouse: Management of acute low back pain.

He continues, saying, "Also, 'at-home' applications of heat and cold are not recommended in the treatment of acute cervical pain, particularly when there is risk to the patient of burns, etc. In fact, in a comprehensive review of the literature, it is concluded that heat and cold are considered unsupported by research evidence. (***National Guideline Clearinghouse: Neck and Upper Back Complaints."*** "Therefore, for the reasons noted above, I find the use of this device not medically necessary."

Dr. Stauber then refers to the medical necessity for the mattress and bed board. He says that the medical necessity has not been established and there was no documentation of any complaints of difficulty finding a comfortable sleeping position or visual inspection of the claimant's bed. If the base of the claimant's bed was already solid, this item would offer no benefit. Even more importantly is that the research literature does not support the use of prescription mattresses or bed boards. In fact, in one review it is noted that although studies have 'indicated that some mattresses can have a positive or negative effect on back pain, no overall conclusion can be drawn.' He refers to a 2008 article found in Spine, "Better Backs by Better Beds?" He then says that the authors compared 3 different mattress types and that while there were some differences noted between mattresses, it concluded that the differences were small.

He refers to another article, this one dated 2004 found in Evidence-Based Medicine, which was a commentary where the author opined "Don't recommend a firm mattress for someone with chronic low back pain. And, despite the findings of Kovacs, et al., don't recommend immediate firm mattress either. The ideal mattress, if such exists, is still unknown… based on the evidence, little more than over the counter analgesics and advice to stay active should be offered." Dr. Stauber concluded that the bed board and mattress were not necessary.

"It Should be noted that there is no conclusive evidence that providing a patient with an item such as a thermophore (i.e. heating pad) provides any significant benefit to the patient with regards to reduction of pain or recovery time. There is also risk involved in patients using heating devices in the home." He then cites to an article found in National Guideline Clearinghouse: "Neck and Upper Back Complaints" and says there is no conclusive evidence that providing this device would provide any significant or additional benefit to the patient that would not have been obtained to an office-based, physical therapy program.

Dr. Stauber concludes that the DME at issue, provided 5/31/17, should be disallowed.

Based upon this review, Respondent issued its NF-10 denying this portion of the Applicant's claim on 7/20/17.

Peer Review / Addendum:

Damion A. Martins, MD, generated his peer review report on 7/31/17. The purpose of the review was to determine the medical necessity for the EMS unit, heating lamp, and whirlpool provided by the Applicant on 6/23/17 and billed in the amount of $1,287.32.

There is a list of medical records that were reviewed. These include the 6/23/17 follow-up evaluation by Dr. Baldonado.

Dr. Martins recounts the EIP's accident history and the findings of Dr. Baldonado on 5/23/17. He notes that on that date the EIP was given a prescription for physical therapy. He also notes that on 6/9/17 the EIP underwent nerve conduction studies. He was then seen by Dr. Baldonado again on 6/23/17. There was no change in the neurologic examination and there was improvement noted in the patient's function, sitting, standing and walking and "due to marked improvement of symptoms, the patient was advised to continue following therapies." On that date, the EIP received the medical supplies including the EMS unit, heating lamp, belt and whirlpool.

In the "Discussion" section of his report, Dr. Martins says that the DME at issue was not medically necessary.

Electrostimulation/TENS is not recommended as a stand-alone treatment but may be a component of a comprehensive treatment plan. TENS treatment should include at least instructional sessions for the proper application and use. Indications include muscle spasm, atrophy and control of concomitant pain in the office setting. Minimal TENS unit parameters should include a pulse rate, pulse width and amplitude modulation. Consistent, measurable, functional improvement must be documented and a determination made of the likelihood of chronicity prior to the provision of a home unit. TENS treatment should be used in conjunction with active physical therapy (optimal 3 sessions).

He then says that a systematic review has found no significant difference with EMS/TENS vs. sham stimulation in pain relief. He refers to 5 randomized clinical trials involving 421 people and there was no difference found in people using EMS/TENS and controlled pain measures using a visual analog scale. He then refers to another recent review which found no long-term efficacy of TENS on muscle spasm or pain (… *pain unpleasantness in the TENS group was never different from the placebo-TENS group. These results suggest that TENS reduces both the sensory-discriminative and motivational-affective components of low back pain in the short term but that much of the reduction in the effective component may be a placebo* [**Marchand et al, Pain, 1993; 54:99-106]** and **TENS for Chronic Low Back Pain; Cochrane Review, Issue 4, 2001]**) There is also inconsistent evidence to support the use of TENS as a single treatment in the management of chronic LBP. (Citing to a 2008 article found in Cochran Database).

"It is well established that E-stim and Transcutaneous electrical nerve stimulator (TENS) does not meet the definition for medical necessity for the following indications for acute or sub-acute pain after MVA."

He then cites to a 2004 article from the British Medical Journal Clinical Evidence Handbook stating "Systemic reviews showed no significant improvement in soft tissue strain-sprain injuries with the use of a whirlpool therapy. In fact, a well-designed systematic review has shown no improvement versus placebo. "A Cochrane database search found one systematic review (search date 1998) of conservative treatment for sciatica caused by disc herniation, which identified no RCTs on the use of ice/whirlpool for herniated lumbar discs and LBP (Vroomen et al, J. Spinal Disord, 2000).

"There was no evidence that use of this whirlpool is more beneficial given the fact that the claimant was advised to start physical therapy at the initial evaluation. In fact, supervised hydrotherapy would be superior to the use of home devices. There was also no indication in the medical record how the whirlpool will be beneficial to this claimant or how it would be used to alleviate the claimant symptoms or hasten functional recovery."

"Superficial heat can be applied in various manners that raise the body temperature for the reduction of pain, inflammation, and/or effusion resulting from injury." "However, there is insufficient evidence to evaluate the effects of infrared heating lamps for soft tissue pain. (Cochrane Database of Systematic Reviews, Superficial heat or cold for low back pain, 2009) One RCT identified by another systematic review provided limited evidence that infrequent infrared heat may be less effective at increasing self-perceived improvement after 2 weeks compared with 3 sessions of spinal manipulations a week. Another systematic review identified no RCTs comparing heat versus placebo or no treatment for sciatica caused by lumbar disc herniation." (Referring to the aforementioned article by Vroomen). A well-designed clinical trial has shown that infrared heat lamps are no better than placebo treatment of low back pain (Acupuncture Electrotherapy, 1981).

Dr. Martins then says that for those circumstances where this intervention is used for treatment of acute back pain, it is recommended to only be provider-based treatment and only performed in conjunction with an active exercise program (physical therapy) with frequency not to exceed 4 visits.

"There is no indication in the medical records how the heat lamp would be beneficial to this claimant or how its use would alleviate the claimant's symptoms or hasten functional recovery."

Dr. Martins concludes that the DME at issue was not medically necessary and that reimbursement should be disallowed.

Based upon this review, on 8/4/17 Respondent issued its NF-10 denying the Applicant's claim for DOS 6/23/17.

The Respondent's submission contains copies of the articles referred to in the peer reviews.

Reports/documents in Respondent's submission:

The Respondent's submission contains a copy of the EIP's initial examination with Dr. Baldonado dated 5/23/17. (see above)

On 6/23/17, the EIP had a re-evaluation by Dr. Baldonado. He presented with complaints of pain in the left knee, right ankle, neck and bilateral shoulders.

His overall pain scale was 8/10. He complained of headaches; pain and stiffness in the neck which was still rated at 8/10 and radiated to the bilateral shoulders. He also had pain and stiffness in the mid back which was still rated at 8/10 and pain and stiffness in the low back which was still rated at 8/10. The pain from the low back radiated to the bilateral legs.

The EIP also complained of bilateral shoulder pain rated at 8/10 and right ankle pain rated at 8/10.

There is a section of the report entitled "DISABILITY AND FUNCTIONAL ACTIVITY." This indicates that previously the EIP could sit for 30 minutes but now 15 minutes; there is no indication how long he could stand previously but now he can stand for 15 minutes. As to walking, there is no indication how long he could walk previously but now he can walk 5 blocks.

This evaluation does not contain a physical examination.

There is a recommendation for continued physical therapy at the rate of 3 times per week for 4 weeks.

"Due to marked improvement in symptoms, the patient is advised to continue the following therapies on as needed basis" - **there are no therapies indicated.**

There is also a section of this report for DME and nothing is indicated.

The physical therapy recommendations indicate hot packs, exercises and ultrasound to the cervical spine, shoulders, left knee and right ankle.

The report also indicates that MRIs were going to be prescribed for the cervical spine and the left knee.

The Diagnostic Impression was: 1) status post motor vehicle accident; 2) cervical paraspinal muscles and ligaments sprain/strains (whiplash injury); 3) cervical disc bulge/herniation/displacement; 4) shoulder/upper arm muscle and ligament sprains/strains; 5) ankle/foot pain.

The Respondent's submission contains copies of physical therapy progress notes. These are dated from 5/23/17 through 6/29/17.

There are also Physical Therapy Evaluations dated 5/23/17 and 6/26/17.

The Respondent's submission contains an initial acupuncture evaluation from Pinecone Acupuncture, PC dated 5/19/17. Also provided are Acupuncture Treatment Notes.

The Respondent's submission contains an initial chiropractic examination dated 5/19/17 from Roseville Family Chiropractic, PC. Chiropractic progress notes have been provided.

On 6/9/17, the EIP had a computerized Muscle Strength Test and a Computerized Range of Motion Study.

The Respondent's submission contains a copy of the Initial Examination Report of the EIP by Dr. Baldonado dated 5/23/17.

There is also a copy of a Physical Therapy Prescription dated 5/23/17 signed by Dr. Baldonado.

The Respondent has provided copies of Physical Therapy Progress Notes dated from 5/23/17 through 6/5/17. Also provided is a Physical Therapy Initial Evaluation dated 5/23/17.

There is a copy of the report for muscle testing done on 6/9/17 and range of motion testing done on 6/14/17.

The Respondent has provided copies of the articles referred to in the peer reviews.

Rebuttal to peer review:

Alexander Baldonado, MD, filed rebuttals to the peer reviews on 8/28/17.

He recounts the EIP's accident history and his findings on his 5/23/17 initial evaluation. Based upon those findings, the physician formed his initial diagnosis and prescribed a cervical orthopedic pillow, mattress, lumbar cushion, lumbar orthosis, cervical orthosis collar, thermophore, water pump and bed board to use at home. These devices were provided to the patient on 5/31/17. He opines that these devices were medically necessary.

Dr. Baldonado reiterates part of his physical examination findings, focusing on the testing. "Hence, in my opinion, these multiple subjective complaints and my objective findings warranted the prescription of the above-mentioned DME."

He then notes that Dr. Stauber denied reimbursement for the above mentioned devices based on his conclusions in the peer review report.

As to the cervical collar, Dr. Baldonado refers to a 2005 article found in the New England Journal of Medicine stating investigators have advocated the use of short-term immobilization with either a hard or soft cervical collar or cervical traction equipment to aid in pain control.

"Cervical collar is for usage of the dynamic orthosis, incorporates the benefits of warmth, support and relief from minor muscle spasm and cervical strain. It provides limitations of full-motion inflection, extension, lateral bending and rotation. Acute phase treatment of neck pain and physical therapy outpatient setting includes moist heat, gentle massage and temporary immobilization with a cervical collar that holds the neck and slight flexion. "

In support of this statement he refers to a 2013 article that appears to have been generated in Mexico. "An article states that 'The days of disability and recovery will lower in patients who did not use the collar." (sic)

Arbitrator's note: this reference seems to go contra to the point that Dr. Baldonado was attempting to make.

Dr. Baldonado then opines that the medical literature supports the efficacy of this item in treatment. Soft cervical collars are useful in patients who find it useful for symptom relief. Cervical collars have a well-established role in the acute management of trauma patients to prevent instability of the cervical spine. He lists a number of studies in support of this proposition.

"When should a cervical collar be used to treat neck pain?" Curr Rev Musculoskelet Med, 2008, June; 1(2); 114 - 419.

"Everyday Aids and Appliances: Collars and corsets." Br Med J (Clin Res Ed) 1988 January 23; 296 (6617): 276.

"Mistovich, Joseph J.: Brent Q. Hafen, Keith J Karren (2000) (in English). Brady Prehospital Emergency Care (6 Ed.). Upper Saddle River, NJ: Prentice-Hall. Pp. 662.

As to the LSO, Dr. Stauber cited some journal articles to support his argument that there was insufficient evidence to support the efficacy of an LSO. This does not mean that lumbar supports are not useful, to the contrary, it only means that Dr. Cohen (sic) just did not refer to other journal articles assessing the utility of lumbar supports.

He goes on to describe what a lumbar support is meant to do and says "While statistically significant trials are difficult to design and execute, there is a sufficient body of literature supporting this therapy." "A lumbosacral corset may relieve acute or subacute low back pain by increasing intra-abdominal pressure." He cites to website in support of this statement.

He cites to another website for the statement "Treating physicians and patients often believe that wearing and orthosis for longer periods weakens the truck muscles.

Research on this subject is controversial data, some of which show that these muscles become stronger."

He refers to yet another website stating "Lumbar orthosis reduces the load of the trunk muscles during performance."

Then he refers to another website saying "In addition to modification of activity and the use of other modalities, sprains and strains may be treated with physical therapy, short-term immobilization with a brace (corset), and trigger point injections."

Dr. Baldonado concludes that the LSO was used for medical purposes for the treatment of the patient's low back pain and it was medically necessary.

As the **lumbar cushion,** he says that this device provides relief for lower back pain, unloading of the intervertebral discs and transmitting pressure to the soft tissue regions.

"Properties of supporting surfaces of a seat have an influence on postural control. Center of pressure (COP) displacement parameters reflect both the balance controlling process and movements of the center of a mass of entire body. The results of the study showed that foam cushion ensures better postural control. Int J Occup Saf Ergon, 2013; 19(4): 573-81."

The next item reviewed is the **cervical pillow**. Dr. Baldonado refers to an article by Ruth Jackson, MD dated 1956 who stated "The cervical contoured pillow has been one of the greatest adjuncts in the treatment of cervical spine disorders." He goes on to cite a study found in the 2004 Journal of the Canada Chiropractic Association as to the effectiveness of a semi-customized cervical pillow in reducing low level neck pain intensity.

Dr. Baldonado discusses that chiropractors recommend cervical pillows as they are effective in addressing numerous patient complaints. He refers to Dr. Higley of Virginia who explained that at his practice, patients with neck pain who utilize the cervical pillow have better outcomes. He also refers to Dr. Thornton of Florida who says that using cervical pillows "reduces or eliminates acute and chronic neck pain, diminishes patient recovery time, and allows for in improved night's sleep. (Donald M. Peterson Jr., BS, HCD(hc). FICC(h), March 2011; Cervical Pillows for Every Patient?)"

As per Dr. Baldonado, cervical pillow is a therapeutic mechanism designed to properly align the spine, serving to reduce muscle tension and spasm and to diminish pain in the cervical spine and head. In addition to its method of cradling, the cushioning apparatus also facilitates an open airway, free from obstruction. "Pillow use: The behaviour of cervical pain, sleep quality and pillow comfort in side sleepers. Susan J. Gordon, Karen Grimmer-Somers, Patricia Trott."

He then talks about the **water circulation heat pad with pump** - hot water therapy aqua-relief system is an automatic hot/cold therapy system that delivers instant heat through patented wraps that go around your feet and hands to provide greater circulation and reduce pain. Heat can relax tightness or spasm in muscles.

There is a list of articles and I note that the first 2 are from the 2003 Archives of Physical Medicine and Rehabilitation and deal with "Continuous low-level heat wraps therapy for treating acute nonspecific low back pain" and "Overnight use of continuous flow-level heat wrap therapy for relief of low back pain."

The next article is dated 1976 and deals with "Continuous low-level heat wrap therapy provides more efficacy than Ibuprofen and acetaminophen for acute low back pain."

The next article is dated 2001 and is from France and dealt with "Methodological reflections on 20 randomized clinical hydrotherapy trials in rheumatology."

He then refers to 2006 article found in the Cochrane Database Syst Review. This article appears to be from Australia and is about "Superficial heat or cold for low back pain."

Dr. Baldonado then addresses the **bed board and mattress**. The egg mattress facilitates relaxation of muscles, minimizes pain and enhances comfort. Bed board provides extra comfort and padding. The foam pad offers necessary support and proper neck and spinal alignment if placed on top of a firm mattress. Expert articles widely support use of egg crate mattress to alleviate acute back pain. Here, the patient required positioning of the body in ways not feasible with an ordinary bed in order to alleviate neck and back pain the patient was suffering.

He then cites to a website for the proposition that the only time during which the muscles, ligaments and other structures in the spine can completely relax is while sleeping. "And when a person suffers from a back injury or disorder, it's especially important to sleep well in order to help the healing process."

"Also, it was concluded that sleep surfaces are related to sleep discomfort and that is indeed possible to reduce pain and discomfort and to increase sleep quality and those with back pain by replacing mattresses based on sleeping position. (sic) (Appl Ergon, 2010, Dec; 42(1):91-7)."

He lists articles which he says supports the effect of firmness of mattress in the treatment of low back pain. Listed is a 2003 article from Lancet. "Based on the above discussion, I find that the bed board and egg crate mattress was indeed used for medical purposes for treatment of this patient's lower back injury. Hence, the device properly fits in the definition of medical necessity and durable medical equipment."

Dr. Baldonado then discusses the **thermophore.** He says that "moist heat increases circulation and speeds recovery by in fresh blood cells and removing waste." (sic) He refers to a 1992 article found in the American Family Physician in support of this statement.

He refers to other articles stating that conservative treatment consisting of rest, application of ice or heat and anti-inflammatory drugs is usually effective. He also

discusses the fact that the increase in blood flow to the tissues to help deliver oxygen, loosen the patient's muscles, relieve spasm, alleviates pain and discomfort and generally makes the patient more comfortable and less stiff.

In support of his argument, he again refers to the 2003 article found in the Archives of Physical Medicine and Rehabilitation, "Continuous low-level heat wrap therapy for treating acute nonspecific low back pain." He also refers to that same publication for an article dealing with "Overnight use of continuous low-level heat wrap therapy for relief of low back pain."

At the end of this report, Dr. Baldonado lists a number of "General References."

As to the DME prescribed on 6/23/17, the EMS unit, the EMS belt, the infrared lamp and Whirlpool; Dr. Baldonado opines that these items were medically necessary.

Again, he recounts the EIP's accident history and his findings on 5/23/17. Based upon that examination he prescribed physical therapy and referred the patient for various diagnostic tests. The patient started physical therapy, acupuncture and chiropractic.

On 6/29/17, (sic) the patient presented for a re-evaluation. "At that time, the patient complained of continued pain in the neck, shoulders and back. Therefore, the patient was recommended to continue with ongoing course of conservative treatment. In conjunction with office-based treatment, I prescribed EMS unit, EMS belt, inferred lamp and whirlpool to use at home. These devices were provided to the patient on 6/23/2017." (I note that the date of the re-evaluation was 6/23/17)

Dr. Baldonado speaks to the need for the EMS unit and the placement belt. He says that the literature widely supports EMS and other electro stimulating units for pain in the cervical and lumbar regions. He cites to some articles in support of his contention.

He then discusses the medical necessity for the infrared lamp and the whirlpool.

I note that for all of the DME items, he does not refer to the condition of the EIP for which these items are being prescribed. He talks in generalities as to the efficacy of the treatment involved.

At the hearing:

Applicant argued that this is a "doc v doc" situation and as such, the advantage should go to the treating doctor.

Respondent relied upon the peer review and addendum. The DME was prescribed too soon.

FINDINGS:

The Applicant has established its prima facie case.

This claim is for DME issued to the EIP on 5/31/17 in the form of a cervical orthopedic pillow, lumbar cushion, LSO, cervical collar, thermophore, water pump, bed board and mattress. These items were dispensed pursuant to a prescription from Dr. Baldonado dated 5/23/17. The total amount of the Applicant's claim is $1,517.32 for this DOS.

Then on 6/23/17, the Applicant provided a TENS/EMS unit, a TENS/EMS belt, and infrared lamp and a whirlpool. These items were provided pursuant to a prescription from Dr. Baldonado dated 6/23/17. The total amount of the Applicant's billing for this DOS is $1,287.33.

The total amount of the Applicant's claim is $2,804.65.

On 7/20/17, the Respondent issued an NF-10 denying the Applicant's claim for DOS 5/31/17 and the billing in the amount of $1,517.32 based upon a peer review by Stuart Stauber, MD, who opined that the DME at issue was not medically necessary.

On 8/4/17, Respondent issued an NF-10 re DOS 6/23/17 and billing in the amount of $1287.33 based upon a negative peer review by Damion A. Martins, MD, who opined that the DME at issue is not medically necessary.

Dr. Baldonado has filed rebuttals to the peer review reports.

I note that the DME at issue was prescribed by Dr. Baldonado just after the initial evaluation on 5/23/17. The EIP was prescribed physical therapy but, obviously, the therapy had not yet initiated when the DME was prescribed. Therefore, there was no way to determine how the EIP was responding to the physical therapy.

The 2nd set of DME was prescribed after the re-evaluation of the EIP by Dr. Baldonado on 6/23/17. I note that there is no physical examination recorded on this report.

The purpose of a peer review is to determine whether the services or DME provided to the claimant was/were medically necessary. The peer reviewer generally sets forth the standard of care in the medical community and offers his/her opinion as to why the services or DME do not meet that standard and then buttresses that opinion with authoritative articles found in textbooks, journals, and/or treatises.

Dr. Baldonado has filed rebuttals to the peer reviews. I note that the DME at issue which was prescribed on 5/23/17 was a cervical pillow, lumbar cushion, LSO, cervical collar, thermophore, water pump, bed board and mattress. Then on 6/23/17, he prescribed a TENS/EMS unit and a EMS placement belt in addition to an infrared lamp and a whirlpool.

In his rebuttal, Dr. Baldonado refers to each of the DME items prescribed and offers his opinion as to why they were medically necessary. I note that in his discussion, he does not refer to his specific physical examination findings of the EIP other than in his general summary of the examination at the start of the rebuttal report.

I note that the Applicant has not provided copies of the articles or web sites relied upon by Dr. Baldonado in his rebuttals.

In reviewing the citations, I see that some appear to deal with items or conditions which were not the subject of this claim.

I also see that a number of the references are not from the United States, and many are 15+ years old.

My interpretation of the responsibility of the peer reviewer is to determine whether the DME dispensed was in accordance with the current standard of care and the United States. Many of the articles relied upon by Dr. Baldonado, in his rebuttal, do not meet that criteria.

The most disturbing aspect of this claim is that Dr. Baldonado prescribed the first batch of DME at the initial evaluation without giving the EIP an opportunity to engage in physical therapy and other conservative treatment. He simply prescribed these items which appears to be his routine procedure for new patients.

Then, on the follow-up evaluation, which did not record any type of physical examination, he deemed it appropriate to prescribe additional DME.

In his rebuttal, he does not reference any physical complaints or conditions of the EIP to mandate the prescribing of the additional items.

After reviewing documentation contained in the file and listening to the arguments of the parties at the hearing I have concluded that the Respondent has successfully rebutted the Applicant's prima facie case.

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 New York
SS :
County of Suffolk

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

04/30/2018
(Dated)

James Hogan

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:
72b326d64cee3fbfc452cf9aa16dc915

Electronically Signed

Your name: James Hogan
Signed on: 04/30/2018