

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Highlawn Orthomed Inc.
(Applicant)

- and -

Erie Insurance Company Of New York
(Respondent)

AAA Case No. 17-20-1187-9670

Applicant's File No. 116919

Insurer's Claim File No. A00002752871

NAIC No. 16233

ARBITRATION AWARD

I, John O'Grady, the undersigned arbitrator, designated by the American Arbitration Association pursuant to the Rules for New York State No-Fault Arbitration, adopted pursuant to regulations promulgated by the Superintendent of Insurance, having been duly sworn, and having heard the proofs and allegations of the parties make the following **AWARD**:

Injured Person(s) hereinafter referred to as: assignor

1. Hearing(s) held on 07/11/2022
Declared closed by the arbitrator on 07/11/2022

Naomi Cohn Esq. from Ursulova Law Offices P.C. participated in person for the
Applicant

Desiree Ortiz Esq. from Robyn M. Brilliant, P.C. participated in person for the
Respondent

2. The amount claimed in the Arbitration Request, **\$1,080.99**, was NOT AMENDED at the oral hearing.
Stipulations WERE made by the parties regarding the issues to be determined.

Unless otherwise indicated in Sections 2 above and 3 below, in which case the dispute between the parties will be addressed in this Award, the parties stipulated and agreed that (i) Applicant has met its prima facie burden by submitting evidence that payment of no-fault benefits are overdue, and proof of its claim was mailed to and received by Respondent; (ii) Respondent's denial of the subject claim was timely issued; and (iii) the amount claimed does not exceed the maximum permissible charges under the fee schedule applicable to the disputed services.

3. Summary of Issues in Dispute

The proof in the following hearings will be considered together because of the similarity of claims, in particular the provision of similar items of durable medical equipment and the contentions regarding the medical necessity of it:

Highlawn Orthomed Inc./assignor 1 and Erie Insurance Company of New York, AAA Case Number 172011879654, hearing held scheduled for July 11, 2022 of 4:15 PM;

Highlawn Orthomed Inc./assignor 2 and Erie Insurance Company of New York, AAA Case Number 172011879665, hearing held scheduled for July 11, 2022 of 4:30 PM; and

Highlawn Orthomed Inc./assignor 3 and Erie Insurance Company of New York, AAA Case Number 172011879670, hearing held scheduled for July 11, 2022 of 4:45 PM.

CASE SUMMARY

Applicant, as assignee of an eligible injured person, a 51-year-old female, seeks reimbursement of the following charge(s) following a motor vehicle accident on July 18, 2020: durable medical equipment (DME) delivered on August 18, 2020.

Respondent timely denied the claim(s) relying on the October 7, 2020 peer review by Dr. Bo Headlam.

ISSUE(S)

Whether respondent makes out its initial burden to show that the medical treatment was not medically necessary and, if so, whether applicant's proof is sufficient to overcome that demonstration.

4. Findings, Conclusions, and Basis Therefor

The three arbitrations referenced above all arise out of a motor vehicle accident on July 18, 2020.

The assignor in AAA Case Number 172011879654 is a 40-year-old female who was provided durable medical equipment (DME) including a cervical collar, cervical pillow, foam mattress, lumbar seat cushion, lumbosacral support, water circulating pump and wrist hand finger orthosis on August 18, 2020.

The assignor AAA Case Number 17201187966 is a 43-year-old male who was provided DME cervical collar, cervical pillow, foam mattress, lumbar seat cushion, lumbosacral support, water circulating pump, knee support, orthopedic car seat support and shoulder orthosis on August 13, 2020; and

the assignor in AAA Case Number 172011879670 is a 51-year-old female who was provided DME including a cervical collar, cervical pillow, foam mattress, lumbar seat cushion, lumbosacral support, water circulating pump and knee support on August 13, 2020.

In supporting its defense to the claim for assignor 1, AAA Case Number 172011879654, respondent relies on the peer review by Dr. Stuart Stauber. He explains with reference to the records of treatment of the assignor and to materials relied upon in his profession why each of the items provided was not medically necessary. Specifically he says that:

Based upon my review of the medical records and my 38 years of experience as an Internist, the range of motion and muscle testing was not medically necessary. In fact, such testing is not medically necessary and would not change the diagnosis or treatment plan. The results of the computerized range of motion testing would not alter the diagnosis or treatment plan in any way. Also, if the treating physician was concerned about the accuracy of the range of motion measurements, a conventional goniometer/inclinometer could have been utilized during the clinical examination. Of note, is that ROM testing is a basic procedure incorporated in the routine clinical examination. There was no need for an additional referral for computerized ROM testing. Also, there is no conclusive medical evidence that using computerized ROM testing will alter the diagnosis, prognosis or treatment. For instance, in one study it was found that ROM was not even a valid predictor of disability in sub-acute or chronic low back pain have a tendency to be more effective in patients with whiplash injury" (Spine 2001; 26 (4): E64- E7J: The Efficacy of Conservative Treatment In Patients with Whiplash Injury). Lastly, in another study the authors randomly assigned patients to two groups: one group received a cervical collar and the second group received an early mobilization program (i.e. exercise program), and it was found that, "No differences were found between the two groups for pain, range of movement or activities of daily living at all of the follow up intervals. The collar treatment group took significantly longer to return to work after injury. " The authors conclude that, "Treatment with a soft collar was found to have no obvious benefit in terms of functional recovery after injury and was associated with a prolonged time period off work. This study supports the use of an early mobilization regime following soft tissue injuries of the neck." Therefore, for the reasons noted above, and based on the research data, I am unable to recommend reimbursement for the cervical collar."

It should be noted that 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 a cervical pillow (roll pillow), their 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 a cervical pillow did not provide any advantages to the subjects with regards to pain reduction and sleep time. In fact, it is noted in the article that "The duration of sleep was significantly shorter for the roll pillow." It is further concluded that there is little research regarding the utility of cervical pillows to reduce pain and improve sleep. (Archives of Physical Medicine & Rehabilitation, 1997, 71;

193-198 Critical pain: A Comparison of Three Pillows) For these reasons, I find that the use of a cervical pillow was not necessary for the management of this case.

Additionally, the medical necessity for the foam mattress provided to the claimant has also not been established in that, there is 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 so 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." In this same article, the authors compare three different mattress types, and while there were some differences noted between the mattresses, it is concluded that the "differences were small." (Spine, 2008 Volume 31, Number 7, p. 701 - 708, Better Backs by Belter Beds?). In yet another article, it was found that a medium firm mattress was better than a hard, firm mattress, so the dispensing of a bed board is not advantageous. There is also a commentary published in a journal regarding the overall utility of mattresses: "Don't I recommend a firm mattress for someone with

chronic low back pain. And, despite the findings of Kovan et al., don't recommend a medium 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." (Commentary by North Hadler, MD: Med/11111 firm mattress reduced pain related disability more than a firm mattress in chronic, not specific low back pain. Evidence Based Medicine 2004; 9:119). Therefore, for the reasons noted above I find that the dispensing of the foam mattress was unnecessary.

Based on the review of records, I also find the lumbar orthosis control and back cushion to be unnecessary. I say this because lumbar supports do not have a statistically significant effect on rotation. There are also no evidence 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 (Spine 2000; 25 (16): 2101-2113). In fact, evidence suggests there is harm associated with prolonged lumbar support, which decreases strength, trunk musculature; and leads to a false sense of security, heat and skin irritation and general discomfort. A review of five randomized clinical trials involving over 1200 people identified no difference between acute and chronic pain using the assistive devices such as lumbar support. LSO and back cushion (Lumbar Support for Prevention and Treatment of Low Back Pain; Cochrane Review, 2008, Issue J, p. 1-23). In fact, the authors conclude in this comprehensive review that "There was little or no difference between individuals with low back pain who used supports and those who received no treatment or education on lifting techniques in back pain prevention or reduction of sick leave." It is further concluded that four reviewed studies indicated. "there was little or no difference between patients with acute or chronic back pain who used back supports and those who received no treatment in short-term pain reduction or overall improvement." Therefore, for the reasons noted above, I find that the back support was medically necessary in this case.

While the use of a standard heating may provide therapeutic benefit, there is no scientific evidence indicating that the 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 (National Guideline clearinghouse: Management of acute low back pain. United States Department of Health and Human Services. P. 1-11). 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 burn, 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. United States Department of Health and Human Services. P. 1-11). Therefore, for the reasons noted above, I find the use of this device was not medically necessary.

The claimant was provided a referral for a hand/wrist support without explanation. There were no objective findings substantiating a need for this item. According to the AMA, "Medical Necessity" is defined as follows: "Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness injury, disease or its symptoms in a manner that is (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the convenience of the patient, physician, or other health care provider." (American Medical Association, 2011).

In supporting its defense to the claim for assignor 2, AAA Case Number 172011879665, respondent relies on the peer review by Dr. Bo Headlam who says that the cervical pillow, lumbar support, shoulder orthosis, LSO, water circulating pump, cervical collar, foam mattress, orthopedic car seat support, lumbar seat support, and knee orthosis (custom fitted) delivered to the claimant on 08/13/20 and 09/04/20 were not medically justified.

Prescriptions were provided by Dr. Paulus in relation to the above-listed items on 07/29/20 and 08/28/20. However, the physician did not provide specific documentation explaining why these medical supplies were necessary specifically for the assignor. Also, it must be documented that the patient was instructed in the proper use of the items with emphasis on safety, effectiveness, sites of application and things like duration and frequency of use. Without such documentation, medical necessity is not established.

The cervical pillow, foam mattress, orthopedic car seat support, and lumbar seat support are considered luxury items designed for the claimant's comfort and not primary medical devices since "Medical equipment is equipment primarily and customarily used for medical purposes and is not generally useful in the absence of illness or injury" - please see Durable Medical Equipment (DME) published by Apollo Managed Care Consultants, 4meditlon, updated 2008). Also, according to this source, egg crate

mattress pads are covered only for relatively immobile bed ridden claimants, a scenario, which clearly did not apply In this claimant's case. Conclusive medical evidence Is absent concerning the effectiveness of cervical pillows in relieving cervical spine pain during sleep.

LSO support is only indicated in cases of fracture, significant instability, or for a patient who is status-post recent surgery. Prescribing an LSO in other cases is not recommended as such support limits mobility, whereas the goal of rehabilitation ts to increase mobility.

"The role of corsets (lumbosacral orthoses, braces, back supports, and abdominal binders) in the treatment of patients with low back pain is controversial) at best. Use of a corset for a short period (a few weeks) may be indicated In patients with osteoporotic compression fractures." (American Family Physicians, American Academy of Family Physicians, Vol. 61/ No. 6 (March 15, 2000), Diagnosis and Management of Acute Low Back Pain, Atul T. Patel, MD and Abna A Ogle, M.D.)

Additionally, "there is moderate evidence that lumbar supports are not more effective than no intervention or training in preventing low-back pain, and conflicting evidence whether they are effective supplements to other preventive interventions. It remains unclear whether lumbar supports are more effective than no or other interventions for treating low-back pain". Please see: van Duijvenbode I, Jellema P, van Poppel MJ van Tulder MW. Lumbar supports for prevention and treatment of low back pain.

Cochrane Database of Systematic Reviews 2008, Issue 2. Art. No.: CD001823. DOI: 10.1002/14651858.CD001823.pub3.

According to ODG Treatment. Integrated treatment/ disability duration guidelines, Neck and Upper Back (acute and chronic), updated 01/30/12, Cervical collars are not recommended for neck sprains. Patients diagnosed with WAD (whiplash associated disorders), and other related acute neck disorders may commence normal, pre-injury activities to facilitate recovery. Reset and immobilization using collars are less effective, and not recommended for treating whiplash patients. May be appropriate where post-operative and fracture indications exist".

Shoulder orthosis, knee support, and knee orthosis (custom fitted) (the sites were not indicated) are not medically necessary. There are no fracture, dislocation or Instability recorded. Joint support may have been counterproductive in the claimant's rehabilitation in this clinical situation. An important goal of physical therapy is to increase the range of motion to normal or functional limits as when as to return muscle strength to pre-injury status. In addition, according to National Guidelines Clearinghouse, The diagnosis and management of soft tissue knee injuries: internal derangements, New Zealand Guidelines Group (NZGG), 2003 Jul, "Bracing is generally not required for the conservative management of soft tissue knee injuries."

In regard to the water circulating pump, according to the available documentation, the claimant was started on a course of physical therapy program with modalities as well as chiropractic and acupuncture treatments. Such concurrent treatment would be sufficient

to treat the patient's condition and providing the medical supply in question here was not necessary. This medical device lacks the effectiveness and safety that similar in-office treatments provide.

According to Durable Medical Equipment DMEJ published by Apollo Managed Care Consultants, 4th edition, (updated 2008). medical necessity of the durable medical equipment is defined as follows: "Equipment is necessary when it can be expected to make meaningful contribution to the treatment of the patient's illness or injury."

Therefore, based on the above conclusions, the items delivered to the claimant on 08/13/20 and 09/04/20 were unnecessary.

In supporting its defense to the claim for assignor 3, AAA Case Number 172011879670, respondent relies on another peer review by Dr. Bo Headlam who makes largely the same remarks that he made with respect to the claims in AAA Case Number 172011879665.

Applicant submitted rebuttals by Dr. Suresh Paulus for each claim. Dr. Paul's was not treating physician Responding to Dr. Stuart Stauber Dr. Paulus comments that "The role of corsets (Lumbosacral orthosis, braces, back supports, and abdominal binders) in the treatment of patients with low back pain is controversial at best. Use of a corset for a short period (a few weeks) may be indicated in patients with osteoporotic compression fractures." (American Family Physicians, American Academy of Family Physicians, Vol 61/ No. 6 (March 15, 2000), Diagnosis and Management of Acute Low Back Pain, Atul T. Patel, MD and Abna A. Ogle, M.D.)

Additionally, "there is moderate evidence that lumbar supports are not more effective than no intervention or training in preventing low-back pain, and conflicting evidence whether they are effective supplements to other preventive interventions. It remains unclear whether lumbar supports are more effective than no or other interventions for treating low-back pain". Please see: van Duijvenbode I, Jellema P, van Poppel M, van Tulder MW. Lumbar supports for prevention and treatment of low back pain.

Cochrane Database of Systematic Reviews 2008, Issue 2. Art. No.: CD001823. DOI: 10.1002/14651858.CD001823.pub3.

According to ODG Treatment, Integrated treatment/ disability duration guidelines, Neck and Upper Back (acute and chronic), updated 01/30/12, "Cervical collars are not recommended for neck sprains. Patients diagnosed with WAD (whiplash associated disorders), and other related acute neck disorders may commence normal, pre-injury activities to facilitate recovery. Reset and immobilization using collars are less effective, and not recommended for treating whiplash patients. May be appropriate where post-operative and fracture indications exist".

Knee support (the site was not indicated) is not medically necessary. There is no fracture, dislocation or instability recorded. Joint support may have been

counterproductive in the claimant's rehabilitation in this clinical situation. An important goal of physical therapy is to increase the range of motion to normal or functional limits as well as to return muscle strength to pre-injury status. In addition, according to National Guidelines Clearinghouse, The diagnosis and management of soft tissue knee injuries: internal derangements, New Zealand Guidelines Group (NZGG), 2003 Jul, "Bracing is generally not required for the conservative management of soft tissue knee injuries.

In regard to the water circulating pump, according to the available documentation, the claimant was started on a course of chiropractic and acupuncture treatments. Such concurrent treatment would be sufficient to treat the patient's condition and Dr. Stauber stated that frequent active mobilization exercises decrease symptoms more than a gradual mobilization program. Dr. Stauber also stated that soft cervical collar for the immediate period after injury is not the best treatment for neck pain or whiplash. Several reviews have also found no difference in pain, global perceived effect, or participation in daily activities with the use of cervical supports. It should be noted that there have been several studies that address the efficacy of cervical collars compared with other treatments (mainly exercise and mobilization) for neck pain due to whiplash injury. Also, as evident from the evaluation, dated 7/30/2020 the patient had complaints of neck pain with stiffness and restriction of motion radiating to the both extremities, aggravation of pain by performing activities of daily living including, carrying, coughing, flexing neck, grasping, lifting heavy objects, lying down, lying on the side, overhead maneuvers, reaching, sneezing and turning neck along with decreased range of motion and severe tenderness and spasm; which indicated painful conditions for which the cervical collar was prescribed in this case.

Further, a 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 in flexion, extension, lateral bending and rotation. Acute phase treatment of neck pain in the physical therapy outpatient setting includes moist heat, gentle massage and temporary immobilization with a cervical collar that holds the neck in slight flexion. Also, literature supports use of cervical collar in whiplash injuries. In clinical practice, the patient with whiplash injury is often discharged with a soft cervical collar and analgesia for pain relief. (Curr Rev Musculoskelet Med. Jun 2008; 1(2): 114-119).

Moreover, many injuries to the spine, including the neck, are undiagnosed at first. These include soft tissue damage (especially to tendons and ligaments) and hidden fractures. This is why many doctors will prescribe splints, braces or collars to hold the joints in place just in case there are hidden injuries which may show later. For injuries which were not treated early, treatment of the resulting conditions may be needed later. Untreated trauma can lead to osteoarthritis, permanent misalignment, and spinal stenosis. (Pain In The Neck, by Wesley Vaughn | Nov 18, 2016 | Sleep Issues) With respect to the Cervical Pillow:

Dr. Stauber stated that 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. Dr. Stauber also cited a literature which concluded

that there is little research regarding the utility of cervical pillows to reduce pain and improve sleep. I would note that a cervical pillow is recommended for those with neck injuries (present here), whiplash (present here), fibromyalgia, arthritis, neck tension or other injuries and disorders affected by a cervical misalignment. 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.

The result of a study shows that compared to conventional pillows, this experimental semi-customized cervical pillow was effective in reducing low-level neck pain intensity, especially in the morning following its use in a 4 week-long study. (J Can Chiropr Assoc. 2004 March; 48(1): 20-28).

Cervical support and sleeping positions are an integral part of that philosophy. Another aspect of providing cervical pillows is that they extend the practice beyond the appointment time. A specially selected and individually tested pillow with good shape, comfort and support to the neck lordosis can reduce neck pain and headache and give a better sleep quality. (Neck pain and pillows - A blinded study of the effect of pillows on non-specific neck pain, headache and sleep; Advances in Physiotherapy 8(3):122-127 · July 2009; DOI: 10.1080/14038190600780239)

One small randomized controlled trial from Sweden found that cervical pillows could be useful for both neck pain and poor sleep. Proper neck positioning during sleep is important. (Neck Pain; Alexandra Ilkevitch MD, J. Adam Rindfleisch MPhil, MD; Integrative Medicine (Fourth Edition), 2018).

Dr. Stauber stated that in one study patients were supplied with a cervical pillow (roll pillow), their 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 should be noted that the cervical pillow is incomparable to

a water-based pillow as the former is a device primarily medical in nature and specifically designed to provide modality to particular area. However, Dr. Stauber promotes a water-based pillow squarely from an insurance-based perspective. A lack of medical necessity cannot be established for the DME simply because some other home remedies, which do not require reimbursement, or are more convenient to the insurance company. Indeed, this is a direct violation of the American Medical Association's definition of medical necessity.

With respect to the Foam Mattress:

Dr. Stauber stated that there is 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. However, I would further note that the foam mattress is incomparable to the patient's original bed as the former is a device primarily medical in nature and specifically designed to provide modality to particular area. However, Dr. Stauber promotes the patient's original bed

squarely from an insurance-based perspective. A lack of medical necessity cannot be established for the DME simply because some other home remedies, which do not require reimbursement, or are more convenient to the insurance company. Indeed, this is a direct violation of the American Medical Association's definition of medical necessity.

It should be noted that in this case, this patient had mid back and lower back pain along with spasm and tenderness; hence, the foam mattress was prescribed as it facilitates relaxation of muscles, minimizes pain, and enhances comfort. Expert articles widely support the use of foam mattress to alleviate back pain. Here, the patient required positioning of the body in ways not feasible with an ordinary bed in order to alleviate back pain the patient was suffering.

Also, 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 in those with back pain by replacing mattresses based on sleeping position. (Appl Ergon. 2010 Dec; 42(1):91-7)

Moreover, it was medically necessary for this patient to facilitate relaxation of muscles, and accordingly, minimizing discomfort due to the lower back pain the patient was suffering from after the accident. The following literature supports the effect of firmness of mattress in the treatment of lower back pain:

- Effect of firmness of mattress on non-specific low-back pain: randomized, double blind, controlled, multicentre trial. Kovacs FM; Abaira V; Pena A; Martin-Rodriguez JG; Sanchez-Vera M; Ferrer E; Ruano D; Guillen P; Gestoso M; Muriel A; Zamora J; Gil del Real MT; Mufraggi N Lancet 2003 Nov 15;362(9396):1599-604.

- Medium-firm mattresses reduced clinically diagnosed back pain, shoulder pain, spine stiffness, and positively affected sleep quality and that even subjects with minor sleep disturbances benefited significantly in sleep quality and efficiency with medium-firm bedding systems. Furthermore, Hadler and Evans concluded that medium-firm mattresses served to reduce low back pain more so than firm mattresses. (Changes in back pain, sleep quality, and perceived stress after introduction of new bedding systems, Bert H. Jacobson, Ali Boolani, and Doug B. Smith, J Chiropr Med. 2009 Mar; 8)

With respect to the LSO and Lumbar Seat Cushion:

Dr. Stauber stated that a review of five randomized clinical trials involving over 1200 people identified no difference between acute and chronic pain using the assistive devices such as lumbar support, LSO and back cushion. Also, Dr. Stauber noted that "there was little or no difference between patients with acute or chronic back pain who used back supports and those who received no treatment in short-term pain reduction or overall improvement". I would note that the LSO is used in primary care to reduce pain and improve mobility. (Practical Pain Management, 13 Articles in Volume 11, Issue #6 last updated on: September 2, 2011). This device is ordered to facilitate healing

following an injury by limiting improper mobility and muscular activity in the lumbar region. Lumbar Support is meant to provide even, gentle support for distracted lumbar vertebrae, paraspinal muscles, and ligaments, to alleviate pain and prevent compression on intervertebral nerve roots, muscle spasm, and stiffness. The mechanism of support diminishes pain, spasm and allows musculature to relax in turn decreasing pain and allowing a greater painless range of motion.

Also, in this case, the patient had complaints of lower back pain with stiffness and restriction of motion and middle back pain along with decreased range of motion, tenderness and spasm; as well as aggravation of pain by bending back and down, getting up from seated position, going up and down the stairs, jumping, lying down, lumbar rotation, lying on the side, prolonged sitting, running, standing, sneezing and walking. Thus, the LSO and lumbar cushion were prescribed to prevent further damage to the lumbar spine.

Moreover, the literatures support the efficacy of the LSO in lower back pain conditions the patient was suffering:

- Aetna considers an LSO medically necessary to facilitate healing following an injury to the spine or related soft tissues.
(http://www.aetna.com/cpb/medical/data/1_99/0009.html).

- "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." (Source: www.mdguidelines.com and Workplace Injury of the Week: Lumbar Sprains & Strains- a research article published on Jun 22, 2010)

- "A lumbosacral corset may relieve acute or subacute low back pain by increasing intraabdominal pressure." (Journal of Contemporary Neurology, Volume 1996, Article 7 December 1996).

- A lumbosacral corset may also be used to help control muscle spasms. (Lumbosacral Spine Sprain/Strain Injuries Treatment & Management, Updated: Mar 11, 2015, online available at <https://emedicine.medscape.com/article/95444-treatment>).

Furthermore, the lumbar cushion provides relief for lower back pain, unloading of the intervertebral discs and transmitting pressure to soft tissue regions. Maintenance of proper lumbar lordosis is an additional benefit of use. A lumbar cushion is a specially designed ergonomic lumbar orthopedic cushion that sits in the small of the back providing relief and management of low back pain such as sprains and strains, herniated or ruptured discs, sciatica, or traumatic injury aggravated by prolonged periods of sitting in one position (present here) at a desk, in a car, lying in bed, or sitting in a wheelchair.

Typically, a lumbar cushion is contoured to conform to the natural curve of the lower back when seated. Using extra cushions to have proper posture will help in the end. The

lumbar cushion is a specially designed support pillow used for providing added support to the lower back, thus relieving or reducing lower back pain aggravated by prolonged periods of sitting.

Moreover, properties of supporting surfaces of a seat have an influence on postural control. Centre of pressure (COP) displacement parameters reflect both the balance controlling process and movements of the centre 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.

Dr. Stauber stated that evidence suggests there is harm associated with prolonged lumbar support, which decreases strength, trunk musculature; and leads to a false sense of security, heat and skin irritation and general discomfort. I would note that the LSO and lumbar cushion are safe enough to use at home. Arguments regarding the potential harm during the use of LSO and lumbar cushion are equally unfounded. As indicated above, when used properly, the prescribed DME have clear therapeutic and palliative value. Any type of treatment or prescribed devices or medications can cause harm if used excessively or otherwise improperly. This is a very broad and general statement that should be approached from a risk-benefit ratio point of view. The risk with a great majority of DME is extremely low and, virtually non-existent.

With respect to the Water Circulating Pump:

Dr. Stauber stated that the use of a water circulating unit is considered experimental in nature because they have not been proven to produce outcomes superior to standard hot packs or electric heating pads. It should be noted that the water circulating pump is incomparable to standard hot packs or electric heating pads as the former is device primarily medical in nature and specifically designed to provide modality to particular area with facility to increase or lower the heat per requirement. Moreover, contending equitability between these two options, and that standard hot packs or electric heating pads have been preferable in this case, indirectly concedes that the water circulating pump does indeed provide analgesic benefits. However, Dr. Stauber promotes standard hot packs or electric heating pads squarely from an insurance-based perspective. A lack of medical necessity cannot be established for the DME simply because some other home remedies, which do not require reimbursement, or is more convenient to the insurance company. Indeed, this is a direct violation of the American Medical Association's definition of medical necessity.

Moreover, I would note that the water circulation heat pad with pump is the 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. Also, there are studies that have found that the heat therapy effectively treats musculoskeletal pain. For example, a study on the efficacy of thermal modalities for neck and back strains found that such modalities improve pain severity (Garra 2010). As per the Merck Manual, 18th Edition, section 22, chapters 336-336e.

The mechanism by which heating device helps patients while they attend to their daily activities is synergistic to the physical therapy they receive in the office several times a

week. This creates additional benefit and speeds up the recovery process. Water circulation heat pad, specifically, and heat therapy in general has very low potential for any dangerous or unwanted side effects. There are no reports of any bad outcomes after use of heat therapy in the literature. There are many publications including retrospective randomized studies showing statistically significant benefits of various heat treatments. Literature supports heat treatment alone and in combination with other modalities of physical therapy. After the initial simple instructions the patient can use heating device safely at home since any potential side effects are extremely rare:

- Continuous low-level heat wraps therapy for treating acute nonspecific low back pain. Nadler SF; Steiner DJ; Erasala GN; Hengehold DA; Abeln SB; Weingand KW Archives of Physical Medicine and Rehabilitation. 2003 Mar; 84(3):329-34.

- Overnight use of continuous low-level heat wraps therapy for relief of low back pain. Nadler SF; Steiner DJ; Petty SR; Erasala GN; Hengehold DA; Weingand KW Archives of Physical Medicine and Rehabilitation. 2003 Mar; 84(3):335-42.

Continuous low-level heat wrap therapy provides more efficacy than Ibuprofen and acetaminophen for acute low back pain. Nadler SF Spine (Phila Pa 1976) -15-May-2002; 27(10): 1012-7

With respect to the Wrist Hand Finger Orthosis:

Dr. Stauber stated that there were no objective findings substantiating a need for a hand/wrist support. It should be noted that the wrist hand finger orthosis is ordered to facilitate healing following an injury by limiting improper mobility and muscular activity in the wrist and hand region. Wrist/hand supports and braces provide support and protection for a variety of wrist and hand injuries and pain. It provides supports suitable for problems such as carpal tunnel syndrome, rsi, arthritis, tendonitis, sprain and strain and ligament instability and many more. Wrist orthopedic braces are extremely light to wear providing warmth and compression and are more supportive for the more serious wrist injuries.

Moreover, I would encourage the peer reviewer to review the patient's evaluation report, dated 7/30/2020 which clearly indicated complaints of pain in the left hand and left wrist along with limited range of motion, cystic lesion, tenderness and swelling. The patient also reported aggravation of pain by performing activities of daily living including, carrying, grasping, lifting heavy objects, opening bottles, pushing, pulling and reaching. Therefore, the wrist hand finger orthosis was prescribed in this case as a wrist-hand-finger orthosis (WHFO) is a general name for a brace that encompasses the fingers, wrist, hand and forearm. There are many types and may or may not contain articulated joints. Its design depends on the type of control or correction that is to be applied. There are two types of WHFOs: static and dynamic. Static WHFOs are used for preventing contractures, immobilizing and positioning, while dynamic WHFOs are used to assist with daily activities and allows for varying degrees of motion at the fingers and/or wrist. The orthosis can be made of high temperature thermoplastics or leather and foam.

Some examples of conditions that would benefit from a WHFO include: arthritis, cerebral palsy, carpal tunnel syndrome, fracture/trauma, hand contractures, multiple sclerosis, nerve palsies, peripheral neuropathy, quadriplegia, stroke and trauma. Hence, it is medically indicated in this case. Of note, the peer reviewer also referenced to the National Guideline Clearinghouse 'NGC' by the Work Loss Data Institute which have not been adopted as a standard of care in No-Fault claims. These aforementioned guidelines should not be considered as an authority to support the denial of the services at issue.

Also, reports using citations from the Cochrane Review Library are not acceptable as they are not proper/actual citations, merely an aggregate of published and unpublished sources.

As can be seen in the itemization above for each item prescribed and supplied, literature exists in support of their respective use and benefits. Accordingly, arguments that there is no authoritative literature in support are not true. Even assuming this were true, this is not a medically sound or sufficient reason to forego medical supplies. As discussed above; there is a medical utility to the use of these devices and the fact that there is no single accepted and global treatment protocol with respect to soft tissue injuries lends itself to further deference to the treating provider.

Addressing the claims of the assignor 2 AAA Case Number 172011879665, Dr. Paulus addresses Dr. Headlam's peer review and states that In this case, the patient had traumatic injuries to the neck, mid-back; lower back, bilateral shoulders and bilateral knees due to the 7/18/2020 accident. The patient's examination revealed neck pain with stiffness, lower back pain with stiffness, left shoulder pain and right shoulder pain along with moderate to severely decreased range of motion, moderate to severe muscle spasm and tenderness and swelling. The pain was aggravated by performing activities of daily living including, bending down, carrying, coughing, flexing neck, getting up from seated position, going down the stairs, grasping, going up the stairs, lifting heavy objects, lifting, lying down, prolonged sitting, pushing, standing, sneezing, turning neck and walking. The patient had moderate slow, painful and antalgic gait. These findings are sufficient to warrant the need of DME. As part of the rehabilitation and treatment program the following assistive- supportive orthopedic devices and portable physiotherapeutic equipment was prescribed for everyday use at home. It is my professional opinion that all of the prescribed items will benefit for the symptoms and pathology presented by the patient, and it will help to achieve full restoration of neuro-muscular skeletal functions.

Based upon a review of the aforementioned documents, taking into consideration the patient's history, the history of the injury, the patient's complaints, the clinical findings and a review of the medical history, and in accordance with the generally accepted standards of care in the relevant medical community, the devices provided by the Highlawn Orthomed, Inc., on 8/13/2020 were medically necessary, within a reasonable degree of medical certainty.

Peer Review:

Dr. Bo Headlam denied the medical necessity of the abovementioned devices based on the conclusion in the peer review report. I respectfully disagree with the conclusion and find that the devices provided to this patient were medically necessary.

With respect to the Back Cushion and Orthopedic Car Seat:

Dr. Headlam stated that lumbar cushion was considered a luxury item designed for the patient's comfort and not primary medical devices. I would note that the back cushion should not be considered as the luxury item as the back cushion provides relief for lower back pain, unloading of the intervertebral discs and transmitting pressure to soft tissue regions. Maintenance of proper lumbar lordosis is an additional benefit of use. Typically, a back cushion is contoured to conform to the natural curve of the lower back when seated. Using extra cushions to have proper posture will help in the end.

The lumbar cushion is a specially designed ergonomic lumbar orthopedic cushion that sits in the small of the back providing relief and management of low back pain such as sprains and strains (present here), herniated or ruptured discs, sciatica, or traumatic injury aggravated by prolonged periods of sitting in one position at a desk, in a car, lying in bed, or sitting in a wheelchair.

Properties of supporting surfaces of a seat have an influence on postural control. Centre 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 car seat as it is an imperative requirement for use in standard automobiles for drivers with mild to severe upper or lower back injuries. It provides support and stability to the back while driving. Car seat prescribed to this patient was medically necessary to support and maintain the correct alignment of the spine; thus, decrease the level of discomfort due to the back pain when seated while driving.

The effectiveness and medical nature of car seat is discussed on following literatures.

- A survey of protective cushion usage in individuals with spinal cord injury while traveling in a motor vehicle and on a commercial airliner. J Spinal Cord Med. 2014 Jan 21.
- Disparity of a seat cushion and its influence on postural control. Int J Occup Saf Ergon. 2013; 19(4):573-81.

With respect to the Cervical Collar:

Dr. Headlam cited ODG guidelines and noted that reset and immobilization using collars are less effective, and not recommended for treating whiplash patients. May be appropriate where post-operative and fracture indications exist. It should be noted that the abovementioned conditions are not the only indications for the use of the cervical collar. The cervical collar is ordered to facilitate healing following an injury by limiting

improper mobility and muscular activity in the neck. The cervical collar is for the 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 in flexion, extension, lateral bending and rotation. Acute phase treatment of neck pain in the physical therapy outpatient setting includes moist heat, gentle massage and temporary immobilization with a cervical collar that holds the neck in slight flexion.

The medical literature supports the efficacy of this item in treatment. Soft cervical collar is 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. Several studies suggest that soft and hard cervical collars may play a role in the conservative management of cervical radiculopathies.

· When should a cervical collar be used to treat neck pain? Curr Rev Musculoskelet Med. 2008 June; 1(2): 114-119.

Also, the candidacy of a patient for surgery is irrelevant when determining the necessity of DME as such devices are not limited to surgical candidates. One of the goals of any conservative therapy, including DME is to minimize the number of patients becoming surgical candidates by facilitating the healing process quicker and allowing other therapeutic modalities to work.

Moreover, many injuries to the spine, including the neck, are undiagnosed at first. These include soft tissue damage (especially to tendons and ligaments) and hidden fractures. This is why many doctors will prescribe splints, braces or collars to hold the joints in place just in case there are hidden injuries which may show later. For injuries which were not treated early, treatment of the resulting conditions may be needed later. Untreated trauma can lead to osteoarthritis, permanent misalignment, and spinal stenosis, all causes of chronic neck pain. (Pain in The Neck, by Wesley Vaughn | Nov 18, 2016 | Sleep Issues)

With respect to the LSO:

Dr. Headlam stated that an LSO was only indicated in cases of fracture, significant instability or for a patient who was status-post recent surgery. Prescribing an LSO in other cases is not recommended as such support limits mobility, whereas the goal of rehabilitation is to increase mobility. It should be noted that fracture, instability and post-surgery are not the only indications for the prescription of the LSO. LSO is used in primary care to reduce pain and improve mobility. (Prospective Study of a Lumbar Back Brace in an Interventional Pain Practice; By Richard M. Rosenthal, MD and Shawn Spencer, BS; 13 Articles in Volume 11, Issue #6 Last updated on September). This device is ordered to facilitate healing following an injury by limiting improper mobility and muscular activity in the lumbar region. Lumbar Support is meant to provide even, gentle support for distracted lumbar vertebrae, paraspinal muscles and ligaments, to alleviate pain and prevent compression on intervertebral nerve roots, muscle spasm and stiffness. The mechanism of support diminishes pain, spasm and allows musculature to

relax in turn decreasing pain and allowing greater painless range of motion. As mentioned above, the candidacy of a patient for surgery is irrelevant when determining the necessity of DME as such devices are not limited to surgical candidates.

Also, orthotic devices are different from total immobilization. They allow sufficient amount of movement. In fact, used properly, these devices will provide proper support to better enable the patient to perform activities of daily living. These devices assume the role that otherwise is played by patient's own musculature. In case of injury to the spine or intervertebral structures, paravertebral musculature around the spinal column involuntarily contract in order to restrict painful movements. The restriction in movement originates not from any external devices, but from pain that starts the reflexory pathway restricting any movements that would result in further pain. The mechanism of this syndrome is analogous to an electrical short circuit. Collars, braces and corsets support the spine and allow the muscles to relax and turn, thereby promoting the movement, not restricting it.

In this case, the patient's evaluation report, dated 7/29/2020 revealed lower back pain with stiffness along with decreased range of motion and moderate to severe muscle spasm and tenderness. The pain was aggravated by performing activities of daily living including, bending down, carrying, cgetting up from seated position, going down the stairs, grasping, going up the stairs, lifting heavy objects, lifting, lying down, prolonged sitting, pushing, standing, sneezing, and walking. I believe all these findings indicated the need for the use of the LSO in this patient's treatment plan. Thus, the LSO was prescribed to prevent further damage to the lumbar spine.

Dr. Headlam cited a literature and noted that the role of corsets (lumbosacral orthoses, braces, back supports and abdominal binders) in the treatment of patients with low back pain is controversial at best. However, I would note that the literature supports the use of the LSO in lower back pain. In support of my contention I submit the following:

- The back brace is a uniquely designed device for use by patients with both acute and chronic pain. It allows reasonable flexibility but does restrict trunk motion for flexion-extension and lateral bending movements, which is one of the ways that these devices may work to prevent LBP. (Prospective Study of a Lumbar Back Brace in an Interventional Pain Practice; By Richard M. Rosenthal, MD and Shawn Spencer, BS; 13 Articles in Volume 11, Issue #6 Last updated on September).
- According to Orthopedic Medicine, Principles and Practice, Third Edition, Volume 2, A lumbosacral corset may also be used to help control muscle spasms (Jesse C. DeLee, MD; David Drez, Jr., MD, Mark D. Miller, MD)
- "Treating physicians and patients often believe that wearing an orthosis for longer periods weakens the trunk muscles. Research on this subject yields controversial data, some of which show that these muscles become stronger." The Orthotic Treatment of Acute and Chronic Disease of the Cervical and Lumbar Spine; Kourosh Zarghooni, Dr. med., Frank Beyer, Dr. med., Jan Siewe, Dr. med., and Peer Eysel, Prof. Dr. med. Dtsch Arztebl Int.; 2013 Nov; 110(44): 737-742).

- Aetna considers the LSO medically necessary to facilitate healing following an injury to the spine or related soft tissues. (http://www.aetna.com/cpb/medical/data/1_99/0009.html).

- "Lumbar orthosis reduces the load of the trunk muscles during performance." (Quantitative analysis of the effect of lumbar orthosis on trunk muscle strength and muscle activity in normal subjects; Kawaguchi Y, Gejo R, Kanamori M, Kimura T.; J Orthop Sci. 2002;7(4):483-9.).

- A spinal orthotic device (commonly referred to simply as an orthotic or an orthosis) is an external apparatus that is applied to the body to limit the motion of, correct deformity in, reduce axial loading on, or improve the function of a particular spinal segment of the body

With respect to the Cervical Pillow:

Dr. Headlam cited an article which noted that medical equipment was equipment primarily and customarily used for medical purposes and was not generally useful in the absence of illness or injury. Also, Dr. Headlam stated that conclusive medical evidence was absent concerning the effectiveness of cervical pillows in relieving cervical spine pain during sleep. It should be noted that the patient was provided with this device based on the review of the medical records. The evaluation report revealed neck pain with stiffness along with decreased range of motion, severe tenderness and muscle spasm. These findings were sufficient for the prescription of the cervical pillow in this case.

In support of medical effectiveness of cervical pillow in treatment of neck pain; I would state that as early as 1956, Ruth Jackson, MD, stated, "The cervical contour pillow has been one of the greatest adjuncts in the treatment of cervical spine disorders." The result of a study show that compared to conventional pillows, this experimental semi-customized cervical pillow was effective in reducing low-level neck pain intensity, especially in the morning following its use in a 4-week long study. (J Can Chiropr Assoc. 2004 March; 48(1): 20-28.) A recent national survey of doctors revealed many reasons why the recommendation for quality cervical pillows is an important part of every chiropractic practice. Cervical pillows are effective in addressing numerous patient complaints. For most chiropractors, cervical pillows fit nicely into their chiropractic philosophy. Cervical support and sleeping positions are an integral part of that philosophy. Another aspect of providing cervical pillows is that they extend the practice beyond the appointment time. Dr. J.L. Higley of Virginia explained that at his practice they see "better outcomes with neck problems using cervical pillows." Dr. Mark Thornton of Florida noted that using cervical pillows "reduces or eliminates acute and chronic neck pain, diminishes patient recovery time, and allows for an improved night's sleep." (Donald M. Petersen Jr., BS, HCD(hc), FICCC(h), March 2011; Cervical Pillows for Every Patient?)

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 behavior of cervical pain, sleep quality and pillow comfort in side sleepers

Susan J. Gordon, Karen Grimmer-Somers, Patricia Trott With respect to the Water Circulating Pump: Dr. Headlam stated that in regard to the water circulating pump, according to the available documentation, the patient was started on a course of physical therapy program with modalities as well as chiropractic and acupuncture treatments. Such concurrent treatment would be sufficient to treat the patient's condition and providing the medical supply in question here was not necessary. This medical device lacks the effectiveness and safety that similar In-office treatments provide. First, it should be noted that the goal of prescribing DMEs to facilitate the healing process quicker, and allowing other therapeutic modalities to work. The use of medical supplies for home use is supplemental to in-office treatment not duplicate. Thus, they are quite useful for patients, such as this one, who benefit from their use on those days and at those times when the patient is not receiving in-office treatment. Any treatment for the same problem that uses a different mechanism to alleviate the problem is usually considered complementary, not excessive. The use of these devices is very helpful during certain activities which otherwise the patient could not participate in due to pain and stiffness. Use of medical devices along with the office based treatment creates additional benefit and speeds up the recovery process.

Also, it should be noted that the patient's examination revealed neck pain with stiffness, lower back pain with stiffness, left shoulder pain and right shoulder pain along with moderate to severely decreased range of motion, moderate to severe muscle spasm and tenderness and swelling. The pain was aggravated by performing activities of daily living including, bending down, carrying, coughing, flexing neck, getting up from seated position, going down the stairs, grasping, going up the stairs, lifting heavy objects, lifting, lying down, prolonged sitting, pushing, standing, sneezing, turning neck and walking. The patient had moderate slow, painful and antalgic gait. These findings were sufficient to warrant the need of Water Circulating Pump in this case.

The water circulation unit is the hot/cold 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.

Active cooling devices are designed to provide a steady low temperature, which, in addition to convenience, might provide a unique benefit compared to the more variable temperature achieved with simple application of ice or passive cooling devices. (Cooling Devices Used in the Home Setting, DME-07, Page 2; <http://blue.regence.com/trgmedpol/dme/dme07.pdf>)

Studies have found that heat therapy effectively treats musculoskeletal pain. For example, a study on the efficacy of thermal modalities for neck and back strains found that such modalities improve pain severity (Garra 2010). As per the Merck Manual, 18th Edition, section 22, chapters 336-336e.

Water circulation pad, specifically, and heat therapy in general has very low potential for any dangerous or unwanted side effects. There are no reports of any bad outcomes after use of heat therapy in the literature. There are many publications including retrospective randomized studies showing statistically significant benefits of various heat treatments. Literature supports heat treatment alone and in combination with other modalities of physical therapy. After the initial simple instructions, the patient can use heating device safely at home since any potential side effects are extremely rare.

- Continuous low-level heat wraps therapy for treating acute nonspecific low back pain. Nadler SF; Steiner DJ; Erasala GN; Hengehold DA; Abeln SB; Weingand KW Archives of Physical Medicine and Rehabilitation. 2003 Mar; 84(3):329-34.

- Overnight use of continuous low-level heat wraps therapy for relief of low back pain. Nadler SF; Steiner DJ; Petty SR; Erasala GN; Hengehold DA; Weingand KW Archives of Physical Medicine and Rehabilitation. 2003 Mar; 84(3):335-42.

- Continuous low-level heat wrap therapy provides more efficacy than Ibuprofen and acetaminophen for acute low back pain. Nadler SF Spine (Phila Pa 1976) -15-May-2002; 27(10): 1012-7

With respect to the Bed Board and Mattress:

In regards to the egg crate mattress and bed board, Dr. Headlam futilely attempts to show that the items cannot be classified as durable medical equipment. Dr. Headlam provides the definition of durable medical equipment as outlined by Apollo Managed Care Consultants, 4th edition, (updated 2008), yet fails to specifically apply this definition to the devices. Upon reviewing this definition, it is apparent that these devices do not violate any of the terms set forth. Dr. Headlam stated that egg crate mattress pad is covered only for relatively immobile bed ridden claimants, a scenario which clearly did not apply in this patient's case. Dr. Headlam stated that bed board and mattress are considered a luxury item designed for the patient's comfort and not primary medical devices. It should be noted that, immobile and bed ridden patients" is not the sole, but one of the consideration for prescription of egg crate mattress and bed board. The first step in the treatment of lower back pain is often bed rest. Resting allows the inflammation to subside and control the symptoms of muscle spasm etc that can occur in a fully weight-bearing position. In order to alleviate pain at the time of sleeping bed board and mattress were prescribed. 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 spine 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.

After reviewing the medical records for the patient, I must conclude that the bed board and mattress prescribed were medically necessary for this patient to facilitate the relaxation of muscles, and accordingly, minimizing discomfort due to the pain the

patient was suffering from after the accident. The following literature supports the effect of firmness of mattress and bed board in the treatment of lower back pain.

MFM constructed with layers of viscoelastic polyurethane and high- resilience polyurethane foams may have an effect in decreasing cervical, dorsal and lumbar pain in older adults, independently of BMI, age, nicturia, polypharmacy and use of psychotropic medication, since the first week of use. The medium firmness mattress may reduce the sleep latency since the first night of use, compared with HFM, additional studies of longer duration are recommended. (Effects of an adapted mattress in musculoskeletal pain and sleep quality in institutionalized elders, Victor Ancuelle, Rodrigo Zamudio, Andrea Mendiola, Daniel Guillen, Pedro J Ortiz, Tania Tello, and Darwin Vizcarra, updated on 2015 Nov; 8)

· Medium-firm mattresses reduced clinically diagnosed back pain, shoulder pain, spine stiffness, and positively affected sleep quality and that even subjects with minor sleep disturbances benefited significantly in sleep quality and efficiency with medium-firm bedding systems. Furthermore, Hadler and Evans concluded that medium-firm mattresses served to reduce low back pain more so than firm mattresses. (Changes in back pain, sleep quality, and perceived stress after introduction of new bedding systems, Bert H. Jacobson, Ali Boolani, and Doug B. Smith, J Chiropr Med. 2009 Mar; 8)

Based on the above discussion, I find that the bed board and mattress were indeed used for medical purpose for treatment of this patient's injuries. The patient was prescribed these devices in conjunction with the office-based therapy to prevent re-injury and bring his to the pre-accident state.

With respect to the Shoulder Orthosis and Knee Orthosis:

Dr. Headlam stated that there was no fracture, dislocation or instability recorded. Joint support may have been counterproductive in the patient's rehabilitation in this clinical situation. I would note the abovementioned conditions are not the only indications for the prescription of the shoulder and knee orthosis.

Knee Orthosis: Braces are commonly used for the management of musculoskeletal injuries. With improvements in design and application, the knee brace has gained recognition by many as a treatment and prevention modality. (Am J Phys Med Rehabil. 2007 Aug; 86(8):678-86.). Knee Support provides support to knee and releases pressure or discomfort due to injury.

Also, knee braces are recommended for treatment of numerous conditions and in various settings not limited to conditions involving knee instability. For example, they are indicated for treatment of knee sprains, knee strains, joint swelling, meniscus tears, osteoarthritis, patellar tendonitis, patellofemoral pain, and Osgood-Schlatter disease. They are also recommended for use in order to prevent further injuries to a previously injured knee, for acute knee ligament or growth plate injuries or when required to perform activities of daily living.

The efficiency of knee orthosis in the treatment of knee injuries is discussed in the following literatures:

- Current evidence and clinical applications of therapeutic knee braces. Chew KT, Lew HL, Date E, Fredericson M. Alexandra Hospital, Sports Medicine Center, Department of Orthopaedic Surgery, Singapore. American Journal of Physical Medicine and Rehabilitation. 2007 Aug; 86(8):678-86.
- Knee orthosis. First part: evaluation of physiological properties based on a review of the literature. Thoumie P, Sautreuil P, Mevellec E. Service de rééducation neuro-orthopédique, hôpital Rothschild, 75571 cedex 12, Paris, France. Ann Readapt Med Phys. 2001 Dec; 44(9):567-80.
- Knee braces: current evidence and clinical recommendations for their use. Paluska SA, McKeag DB. University of Pittsburgh Medical Center- Shadyside, Pennsylvania, USA. American Family Physician. 2000 Jan 15; 61(2):411-8, 423-4.

Shoulder Orthosis: Shoulder orthosis device provides stability to the shoulder during movement to reduce discomfort. Shoulder support provides upward pressure on the forearm/elbow for better alignment of the glenohumeral joint for functional healing of the capsular and ligamentous structures of the shoulder. Shoulder Immobilizer for the glenohumeral joint (shoulder) uses a figure-eight design abduction restrainer, with a sling and swathe to keep the joint from further injury as it is healing. The swathe component readily attaches to the desired position of the sling; maintains GH (shoulder) joint in an internally rotated position. Furthermore, on the basis of current clinical knowledge, the use of rehabilitative shoulder brace and unloading brace has been well accepted. The shoulder brace is in fact considered useful in the treatment of shoulder injuries and disease.

Moreover, shoulder orthosis is helpful in reducing discomfort and improving acute shoulder injury and loss of range of motion. Injury causes pain and disability in the shoulder. This device held up the shoulder while still allowing the range of motion needed. By letting the arms move; this aids in the full recovery of a mild shoulder injury without loss of muscle use. Shoulder support was intended to alleviate discomfort and pain experienced by the patient while away from a clinical setting and, as importantly, to safeguard from regression the gains of clinical treatment.

"In order to manage shoulder instability without surgical intervention, a combination of immobilization and physical therapy is often used. Physical therapy protocols may either follow a period of immobilization of about 3 weeks in internal or external rotation of the shoulder or be initiated immediately. The overall goal of physical therapy is to progress through glenohumeral strengthening and stabilization, thus reducing the probability of recurrent instability. Return to full activity is mostly allowed when there is symmetrical shoulder strength of the scapulothoracic and glenohumeral joints, as well as functional shoulder range of motion. (Nonoperative treatment of five common shoulder injuries A critical analysis by Jonas Pogorzelski, M.D., M.H.B.A., Erik

M. Fritz, M.D., Jonathan A. Godin, M.D., M.B.A., Andreas B. Imhoff, M.D., and Peter J. Millett, M.D., M.Sc.corresponding author, Published online 2018 Feb 19.)

Also, the number of pathologies requiring the use of a shoulder orthosis are significant and range from acute to chronic and from injury to disability. Shoulder Orthosis function to limit excessive glenohumeral flexion and extension and prevent re injury. (Principles and Components of Upper Limb Orthoses; Jared Howell, in Atlas of Orthoses and Assistive Devices (Fifth Edition), 2019). The indications for shoulder orthosis include:

- All conditions requiring fixation of the arm in an abduction position
- Conservative/post-operative shoulder
- Frozen shoulder
- Injuries/ruptures of the rotator cuff
- Pre- and post-operative following trauma and/or joint replacement
- Subacromial bursitis/impingement

In summary, shoulder support helps by:

- Relieving pain
- Resting the injured tissues by taking some of the stressful loads
- Protecting the injured structures from further injury
- Allowing for initial tissue healing
- Preventing future injury by support or joint stabilization

As can be seen in the itemization above for each item prescribed and supplied, literature exists in support of their respective use and benefits. Accordingly, arguments that there is no authoritative literature in support are not true. Even assuming this were true, this is not a medically sound or sufficient reason to forego medical supplies. As discussed above, there is a medical utility to the use of these devices and the fact that there is no single accepted and global treatment protocol with respect to soft tissue injuries lends itself to further deference to the treating provider.

Of note: the peer reviewer referenced the Official Disability Guidelines "ODG" by the Work Loss Data Institute which have not been adopted as a standard of care in No-Fault claims. These guidelines should not be considered as authority to support the denial of the services at issue.

Dr. Paulus makes very similar remarks in response to Dr. Headlam's peer review regarding assignor 3 in AAA Case Number 172011879670.

It is well settled that an applicant for no-fault benefits establishes its prima facie entitlement to payment by proof of the submission to the defendant of a claim form, proof of the fact and the amount of the loss sustained, and proof either that the defendant had failed to pay or deny the claim within the requisite 30-day period, or that the defendant had issued a timely denial of claim that was conclusory, vague or without merit as a matter of law. Ave T MPC Corp. v. Auto One Ins. Co., 32 Misc.3d 128(A), 934 N.Y.S.2d 32 (Table), 2011 N.Y. Slip Op. 51292(U), 2011 WL 2712964 (App. Term 2d, 11th & 13th Dists. July 5, 2011). (see also Insurance Law §5106[a]).

In evaluating the medical necessity of services where the proof of each party, particularly the conclusion, is contradictory, consideration must be given to the evidentiary burdens. Respondent must prove first that the services were not medically necessary. That proof must come from someone qualified by education, training and experience to give such opinion. A peer review report must set forth a factual basis to establish, prima facie, the absence of medical necessity and a conclusory assertion that certain procedures were medically unnecessary fail to create a triable issue of fact, Choicenet Chiropractic PC v Allstate, 2003 NY Slip Op 50672U, 2003 N.Y. Misc. LEXIS 314 (App. Term, 2nd and 11th Jud Dists 2003; Amaze Medical Supply v Allstate Ins. Co., 3 Misc. 3d 43, 779 N.Y.S.2d 715, 2004 NY Slip Op 24119 (App Term 2d and 11th Jud Dists 2004).

An opinion offered by respondent is more likely to withstand the opinion of a treating medical provider when it includes:

1. some reference to the standards in the applicable medical community for the services and treatment in issue;
2. an explanation as to when such services and treatment would be medically appropriate, preferably with an understandable objective criteria; and
3. an explanation of why it was not medically necessary in the instance at issue.

If the proof of the respondent is found to meet its burden, the proof of the applicant must be considered in opposition to it, mindful that it is likely offered by the provider who actually performed examinations, established treatment and diagnostic plans, made diagnoses and performed medical services.

In coming to a conclusion regarding the medical necessity of the large amount of DME provided in these cases, the following considerations are paramount:

1. All three assignors were involved in the same motor vehicle accident;

2. All three assignors suffered what are generally referred to as "soft tissue" injuries;
3. All three assignors were given a large number of items of medical equipment, and the DME provided to each was almost identical; and
4. All three assignors were given mattresses although none of the three were bedridden;

Drs. Stauber and Headlam adequately establish respondent's initial burden to show that there was no medical necessity for the DME provided by citing to materials relied upon in their profession and explaining why each item was not appropriate for the injuries suffered. Applicant's proof is insufficient to overcome that demonstration. The large amount of medical equipment provided, and the similarity of equipment provided to three different patients all injured in the same motor vehicle accident, suggests that the equipment was provided for some reason other than medical necessity. Second, although Dr. Paulus' rebuttals are wordy, it is not the amount of words that establishes the medical necessity. Is wordy rebuttals do not overcome the impression given by the large amount DME provided to three different parties and the supporting peer reviews by Dr. Stauber or Headlam. In all, I am convinced by the peer reviews that respondent establishes that each item of DME was not medically necessary and I am not convinced by Dr. Paulus' rebuttals that any item was medically necessary. The claim is denied in its entirety.

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 Nassau

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

07/13/2022
(Dated)

John O'Grady

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

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Electronically Signed

Your name: John O'Grady
Signed on: 07/13/2022