

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Bakhra Supply Inc  
(Applicant)

- and -

Geico Insurance Company  
(Respondent)

AAA Case No.

17-24-1331-6115

Applicant's File No.

GM23-681034,  
GM23-696038

Insurer's Claim File No.

0684394400000002

NAIC No.

35882

### ARBITRATION AWARD

I, Debbie Thomas, 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 07/23/2024  
Declared closed by the arbitrator on 07/23/2024

Koenig Pierre from Law Offices of Gabriel & Moroff, P.C. participated virtually for the Applicant

Michael Morra from Geico Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$3,189.03**, was NOT AMENDED at the oral hearing.  
Stipulations WERE NOT made by the parties regarding the issues to be determined.
3. Summary of Issues in Dispute

Applicant seeks reimbursement in the amount of \$3,189.03 for durable medical equipment ("DME"), specifically, Cervical Traction Equipment, Custom-Fitted Lumbosacral Orthosis, Off the Shelf Lumbosacral Orthosis, Lumbar Cushion, Mattress, Bed Board, Cervical Collar, and Cervical Pillow supplied on August 15, 2023 and September 9, 2023 to Assignor, M.B., a 43-year-old male who was the driver of a motor vehicle involved in an accident on June 10, 2023. Respondent denied the claim based on the peer review reports of Shruti Patel, M.D., and Michael Tawfelllos, M.D., which determined that the DME was not medically necessary. The issue presented is whether the DME supplied by Applicant was medically necessary.

#### 4. Findings, Conclusions, and Basis Therefor

The within award is based upon this arbitrator's review of the record as well as oral argument at the time of the hearing of this matter.

Under Sec. 5102 of the New York Insurance Law (McKinney 1985), No-Fault first party benefits are reimbursement for all medically necessary expenses on account of personal injuries arising out of the use or operation of a motor vehicle.

It is well settled that a healthcare provider establishes its *prima facie* entitlement to No-Fault benefits as a matter of law by submitting evidentiary proof that the prescribed statutory billing forms had been mailed and received and that payment of No-Fault benefits were overdue. *Westchester Medical Center v. Lincoln General Insurance Company*, 60 A.D.3d 1045, 877 N.Y.S.2d 340 (2 Dept. 2009); *see also Mary Immaculate Hospital v. Allstate Insurance Company*, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004). Respondent's denial indicating receipt of the proof of claim shows that Applicant mailed the proof of claim forms to the Respondent (*see, Ultra Diagnostic Imaging v. Liberty Mutual Insurance Co.*, 9 Misc.3d 97). The evidence is sufficient to make out a *prima facie* case of entitlement to recovery of Applicant's bill.

The burden then shifted to the insurer to come forward with sufficient evidence to rebut the presumption of medical necessity which attached to the providers' claim forms. *See, West Tremont Med. Diagnostic, PC v. Geico Ins. Co.*, 13 Misc.3d 131(A) (N.Y. App. Term 2006).

When an insurer relies upon a peer review report to demonstrate that a particular service was not medically necessary, the peer reviewer's opinion must be supported by sufficient factual evidence or proof and cannot simply be conclusory. As per the holding in *Jacob Nir, M.D. v. Allstate Insurance Co.*, 7 Misc.3d 544 (2005), the peer reviewer must establish a factual basis and medical rationale to support a finding that the services were not medically necessary, including setting forth generally accepted standards in the medical community. The opinion of the insurer's expert, standing alone, is insufficient to carry the insurer's burden to prove that the services were not medically necessary. *See CityWide Social Work & Psychological Services, PLLC v. Travelers Indemnity Co.*, 3 Misc.3d 608, 777 N.Y.S.2d 241 (N.Y. Civ. Ct. Kings Co. 2004).

Once Respondent meets this burden of proof then the burden shifts back to Applicant to present competent medical proof as to the medical necessity for the disputed billing by a preponderance of the credible evidence. *West Tremont Medical Diagnostic, P.C. v. GEICO*, 13 Misc.3d 131[A], 824 N.Y.S.2d 759 (Table), 2006 WL 2829826 (App. Term 2d & 11th Jud. Dists. 9/29/06); *A. Khodadadi Radiology, P.C. v. N.Y. Central Fire*

*Mutual Insurance Company*, 16 Misc. 3d 131[A], 841 N.Y.S.2d 824, 2007 WL 1989432 (App. Term 2d & 11th Dists. 7/3/08). Ultimately, the burden of proof rests with the Applicant (See: Insurance Law §5102). See *Be Well Medical Supply, Inc. v. New York Cent. Mut. Fire Ins. Co.*, 18 Misc3d 139(A) (App. Term 2d & 11th Dists. Feb. 21, 2008).

In support of its contention that the DME supplied by Applicant was not medically necessary, Respondent relies upon the peer review reports of Shruti Patel, M.D. and Michael Tawfelllos, M.D.

Dr. Patel notes that Assignor is a 43-year-old male who was the driver of a motor vehicle that was struck from the driver's side that T-boned on June 10, 2023. He suffered alleged injuries to the neck and lower back at the time of the MVA. He did not suffer a loss of consciousness. He was seen at NYU Langone Health Tisch Hospital on June 12, 2023.

Post MVA, Assignor saw Khondeker M. Rahman, M.D. and Shamshad M. Hussain, RSA on June 29, 2023 for complaints of pain. He complained of pain in the neck and back. Examination of the cervical spine revealed tenderness and decreased ROM. Examination of the lumbar spine revealed tenderness, spasms, and decreased ROM. Straight leg raising test was positive. Diagnoses of sprain of ligaments of cervical spine, sprain of ligaments of lumbar spine, traumatic cervical myofascitis, and traumatic paralumbar myofascitis were made. He was advised to undergo physical therapy. MRI of the cervical spine and MRI of the lumbar spine were recommended. He was prescribed Cyclobenzaprine, Naproxen, and Lidocaine Ointment.

As a part of the diagnostic work up, Assignor underwent an MRI of the cervical spine without contrast on July 15, 2023 that showed straightening of cervical lordosis. At C3-4, broad-based central disc herniation is present, resulting in compression and impingement of the ventral CSF space. AP diameter of disc protrusion measures 2.2 mm. Transverse dimension of protruded portion of disc measures 10 mm. AP diameter of canal measures 9.1 mm. Narrowing of left neural foramen with possible impingement of the exiting nerve roots and narrowing of right neural foramen. At C4-5, broad-based central disc herniation is present, resulting in compression and impingement of the ventral CSF space. AP diameter of disc protrusion measures 2.2 mm.

Transverse dimension of protruded portion of disc measures 10 mm. AP diameter of canal measures 10.3 mm. Narrowing of left neural foramen with possible impingement of the exiting nerve roots and narrowing of right neural foramen. At C5-6, broad-based central disc herniation is present with annular tear, resulting in compression and impingement of the ventral CSF space AP diameter of disc protrusion measures 2.2 mm.

Transverse dimension of protruded portion of disc measures 10 mm. AP diameter of canal measures 9.8 mm. Narrowing of left neural foramen with possible impingement of the exiting nerve roots and narrowing of right neural foramen.

Further, he underwent an MRI of the lumbar spine without contrast on July 15, 2023 that showed normal alignment of lumbar spine. At L3-4, broad-based central disc herniation is present, resulting in compression and impingement upon the ventral thecal sac. AP diameter of disc protrusion measures 2.2 mm. Transverse dimension of protruded portion of disc measures 10 mm. AP diameter of dural sac measures 11.9 mm.

Narrowing of left neural foramen. At L4-5, broad-based central disc herniation (extrusion) is present, resulting in moderate compression upon the ventral thecal sac. Transverse dimension of extruded portion of disc measures 10 mm. AP diameter of disc extrusion measures 9.0 mm. CC dimension of extruded portion of disc measures 11.3 mm. Narrowing of left neural foramen with possible impingement of the exiting nerve roots and narrowing of right neural foramen. At L5-S1, broad-based central disc herniation is present, resulting in compression and impingement upon the ventral thecal sac. AP diameter of disc protrusion measures 2.2 mm. Transverse dimension of protruded portion of disc measures 10 mm. AP diameter of dural sac measures 15.5 mm.

Narrowing of neural foramina bilaterally with possible impingement of the exiting nerve roots.

He underwent an ultrasound of the bilateral paraspinal muscles of the cervical, lumbar spine, and left paraspinal muscles of the sacroiliac spine on August 16, 2023 that showed abnormal echogenicity of the bilateral paraspinal muscles of the cervical, lumbar spine, and left paraspinal muscles of the sacroiliac spine, which may be due to muscle spasms, inflammation, trauma, strain, facet subluxation, spinal misalignment or developing of fibrotic changes as well as muscle guarding/chronic muscle spasm. No cystic lesions nor muscle tears were noted.

As per the most recent office visit note by Khondeker M. Rahman, M.D. dated 07/26/2023, Assignor continued to complain of pain in the neck and lower back. Examination of the cervical spine revealed tenderness with spasms and decreased ROM. Examination of the lumbar spine revealed tenderness, spasms, and decreased ROM. Straight leg raising test was positive. He was advised to continue physical therapy. Also, he was recommended cervical traction with pump and LSO APL (custom fitted) on August 9, 2023.

With regard to the Cervical Traction Equipment, neck pain is often a common complaint post motor vehicle accident. Standard of care for neck pain is to consider conservative management with physical therapy, patient education and reassurance, proper posture and sleep modification, heat and cold pack, pharmacologic therapy with NSAID.

Cervical traction is often not recommended for acute, subacute or chronic cervicothoracic pain or radicular syndromes as many studies have noted that it is not successful when compared to conservative therapy.

Traction has been used as one of the ideal conservative methods to elongate the intervertebral disc space. In spite of the theoretical benefits associated with traction, its clinical outcomes have not been superior to those of other conservative treatments. Systematic reviews have provided little support for traction in neck pain management.

Overall analysis showed that, compared to controls, reduction in pain intensity after traction therapy was achieved in patients with cervical radiculopathy. However, the quality of evidence was generally low and none of these effects were clinically meaningful.

Cervical traction lacks quality evidence to continue its use for neck or cervical radiculopathy. Standard of care for cervical neck pain is to start with conservative management including NSAID, short course of steroid if severe pain is noted, avoidance of provocative activities, and physical therapy. As per the most recent office visit note by Dr. Rahman, dated July 26, Assignor continued to complain of pain in the neck and lower back. Examination of the cervical spine revealed tenderness with spasms and decreased ROM. Cervical traction has not shown to improve symptoms of pain or radiculopathy. The symptoms could be treated with conservative management, and are not in ordinance of standard of care. Therefore, cervical traction would not be medically necessary in this case.

With regard to the LSO, lumbar supports are often not recommended in prevention or treatment of low back pain. Studies have not shown any evidence of its efficacy in treatment of pain. Standard of care for back pain remains to be conservative therapy with physical therapy and NSAID use for anti-inflammatory if no contraindication is noted. Lumbar support has only shown some evidence in management of compression fractures, and instability. Lumbar instability is described as degeneration of the disc which leads to decrease in height and displacement of the disc from its anatomical position. X-ray imaging is often done to see the changes in bone structure.

These are indicated for chronic recurrent pain, muscular insufficiencies and lumbar instability.

The effectiveness of spinal orthoses cannot be determined on the basis of the current literature. A major limitation is the lack of standardized nomenclature. The lack of differentiation of the causes of pain is another weakness in many scientific papers. This limitation cannot be overcome by statistical methods or meta-analyses.

No definitive evidence was found to support the use of orthoses after surgery, in lumbar radiculopathy, or after whiplash injuries of the cervical spine. No definitive evidence as yet supports the use of orthoses after spinal interventions or in painful conditions of the cervical or lumbar spine.

Several patients with spinal pain are encountered in clinical practice. Spinal orthoses are expected to alleviate pain and improve patients' lifestyle. Nevertheless, studies on the clinical efficacy of orthoses are neither quantitatively nor qualitatively sufficient to reach a solid conclusion. Therefore, additional investigations are required to issue guidelines on the appropriate use of spinal orthoses.

Standard of care support treatment with lumbar support if compression fracture or instability is present. However, reviewing the documentation provided, in this case, there is no instability related to the lumbar spine or concern for compression fracture. Examination of the lumbar spine revealed tenderness, spasms, and decreased ROM. Straight leg raising test was positive. Assignor was advised to continue physical therapy. Assignor was complaining of low back pain and had tenderness and decreased range of motion during physical examination. The management proposed in this case would deviate from standard of care and is not supported by studies, therefore, the medical necessity for the LSO has not been established.

Dr. Tawfellos notes that Assignor underwent EMG/NCV of Lower Extremities on September 5, 2023 that showed evidence of the left L4-5 and L5-S1 lumbosacral Radiculopathy. There was no evidence of peripheral neuropathy of the lower extremities.

He underwent an EMG/NCV of the Upper Extremities on September 5, 2023 that showed no evidence of lumbosacral spine radiculopathy. The evidence was consistent with the bilateral mild carpal tunnel syndrome.

Assignor also underwent an ultrasound report of the Cervical Spine, Lumbar Spine, and Left SI joint on September 12, 2023 that showed abnormality of the paraspinal soft tissues of the cervical, lumbar, and sacroiliac spine, as described above. No evidence of facet subluxation, or dislocation. No evidence of muscle tears, masses, hematomas, cysts, or metastatic disease.

Regarding Lumbar-Sacral Orthosis (LSO) and Lumbar Cushion, Dr. Tawfellos notes that according to the medical standard of care, preventative use of a lumbar support is not advised. The overall quality of the available evidence is low, and there is no clear evidence of efficacy for the use of lumbar supports in the prevention or treatment of uncomplicated low back pain, whether short-term or long-term. There is significant and persistent evidence that lumbar supports are ineffective in preventing neck and back discomfort. Furthermore, lumbar support orthoses are often only indicated to treat

certain types of lumbar instability, which is defined as hypermobility with an anterior-posterior translation deviation of more than 50% from neutral.

A randomized control trial of 61 adults with chronic low back pain revealed that adults with uncomplicated chronic low back pain (>12 weeks) in the treatment group, who were prescribed a back brace, in addition to education and exercise instruction, did not have significant differences in pain scores over time compared with a control group who were treated with education and exercise instructions alone. However, patients in the treatment group had pain-related disability, function, and quality of life scores, that worsened statistically significantly over time compared with the control group participants.

Another study cited by Dr. Tawfellos did not show evidence to support the benefits of lumbar supports for low back pain or lumbar functionality versus placebo intervention.

According to the medical standard of care, lumbar support orthoses are typically only indicated as treatment for certain types of significant lumbar instability, which is defined as hypermobility of spinal vertebrae with an anterior-posterior translation/deviation of more than 50% from neutral. After a review of the current literature, there is not enough clinical evidence showing significant improvement of pain and disability to warrant the use of a lumbar support or lumbar bracing in patients having low back pain without significant lumbar instability. Furthermore, there is significant and persistent clinical evidence indicating that lumbar bracing is ineffective in the prevention and treatment of uncomplicated low back pain. Examples of complicated low back pain where lumbar bracing would be useful are patients with symptoms of neurogenic claudication, progressive neurological deficit, or bladder/bowel dysfunction.

For this clinical case, there is no documentation in the medical records to indicate that Assignor had significant lumbar instability necessitating the use of a lumbar support orthosis. There also is no documentation in the medical records indicating that he had symptoms of neurogenic claudication, progressive neurological deficit, or bladder/bowel dysfunction. As a result, the criteria had not been met according to the medical standard of care to indicate the necessity of lumbar bracing and lumbar cushion for this claimant.

With regard to the Bed Board and Mattress, pressure relieving mattresses are used in the hospital setting to reduce pressure ulcers due to immobility. Conventionally, bed transfer boards are used for spinal cord injuries to transfer from one bed to another platform.

Data is inconclusive in supporting that changing the surface upon which a patient sleeps leads to a clear and definable improvement in conditions of acute or chronic pain. The prescription of pressure mattress is not the medical standard of care. Regarding the bed

board, these are used to transfer patients in incidence of spinal cord injury in hospital settings and are not for in home use. Therefore, this was not prescribed according to the medical standard of care.

Regarding Cervical Collar, these are often used to immobilize the neck in individuals who have had cervical spine surgery. It is also used to treat neck pain caused by either acute trauma or persistent pain. If the collar is worn for an extended amount of time, it may cause soft tissue contractures, muscle atrophy and deconditioning, loss of proprioception, thickening of subscapular tissues, and coordination, as well as psychological dependency.

There are many documented adverse effects with hard collars including, pain, breathing restriction, tissue ischemia, difficult nursing care, increased risk of aspiration, and high costs. While hard collars are an important part of acute injury and spine stabilization, they are not routinely used to manage pain.

Dr. Tawfello cites to a study which showed that the positioning of the soft cervical collar in a cohort of patients with acute WAD, following a rear-end car collision, is an independent potential risk factor for returns to the ED. Clinically, the use of the collar is a non-recommended practice and seems to be related to an increased risk of delayed recovery. The management of WAD in the acute phase should include earlier multimodal care with structured education, advice to stay active, and exercise.

Given that cervical immobilization is not recommended, and in fact cervical mobilization increases the recovery state of neck sprains, the cervical collar as well as cervical pillow orthoses are not medically recommended or necessary.

Applicant submits a rebuttal to the peer review reports by Arun K. Agrawal, M.D.

With regard to Cervical Traction Equipment, Dr. Agrawal states that conservative care is a slow healing process whereas durable medical devices help in reducing the pain on an immediate basis, thereby increasing the movement of patient and helping him/her to undergo conservative care with an ease. Patients with moderate to severe musculoskeletal pain may experience suboptimal relief despite the use of an oral medication. Also, a patient cannot take oral medicines any time within 8 hours however, DME can be used at any time as and when required at home. As far as the prescribed physical therapy is concerned; the ultimate goal of physical therapy care is to correctly align spine for long-term health and wellness. Physical therapy care is a process which can take several weeks to restore proper posture, resolve injury and re-condition the spine's supporting soft tissues. The use of DME can provide pain relief on an immediate basis. Thus, they have the capability to act as a catalyst for making the recovery period faster which will help the patient to get back to his/her normal life as early as possible.

Further, clinically, traction is usually prescribed for the following conditions: discogenic pain from bulges, protrusions, and herniation; degenerative disc or joint disease; radiculopathy; facet joint syndrome; joint hypo-mobility; muscle spasms; foraminal stenosis; post-laminectomy syndromes.

Cervical traction is used for a number of cervical spine injuries including cervical herniated nucleus pulposus, radiculopathy, strains, zygapophyseal joint syndromes and myofascial pain. The main reason for its use is relief of pain.

Cervical traction and a good home exercise program have been shown to reduce cervical disc herniation and its subsequent symptoms.

In this case, Assignor sustained sprain/strain injury and had positive findings of disc herniation in the MRI report. Thus, CTE was an appropriate solution.

With regards to the LSO, it is used in primary care to reduce pain and improve mobility. 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. These devices assume the role that otherwise is played by the patient's own musculature.

With regards to LSO and lumbar cushion, orthotic devices are different from total immobilization as they allow a sufficient amount of movement and when used properly, provide proper support to better enable the patient to perform activities of daily living. Lumbo-sacral orthosis, a type of orthotic device, is designed to support, (not immobilize completely) and treat muscles, joints, and skeletal problems. Its main function is to immobilize only injured areas and assist in recovery, stabilize areas of weakness immediately after injury, help lessen strain and pressure on the spine while heavy lifting, improves posture and elongate the spine, make transitional movements such as sitting to standing, more comfortable and alleviate back pain. The brace helps to support the spine until muscle strength can do the job.

Contrary, to the opinion of the peer reviewer, Assignor is an ideal candidate for an LSO brace. The LSO brace prescribed to the patient would provide additional support to weakened spinal structure, including the muscles, reduce pressure to relieve the muscle tension, promote healing while preventing painful movements that patient experienced while performing activities, and reduction of micro-motion to limit pain from muscle

tension and irritated joints or nerve roots. In the article Using a Back Brace for Lower Back Pain Relief ,a back brace is designed to achieve the following goals:

Provide additional spinal support- A back brace can add stability when the low back unstable due to injured or weakened spinal structures. By holding the torso in a safe, supportive measure, a back brace can help provide a health healing environment for the current injury and prevent additional injuries.

Reduce pressure on the spinal structures- A back brace can help unload some of the weight normally placed on the lower back, in the process reducing pressure on the spine's joints, discs, and muscles. By reducing spinal pressure, a back brace may lessen painful muscle tension that is a common protective reaction following an injury.

Reduce range of motion during healing- A back brace is used to prevent or restrict painful movements, such as twisting the spine or bending forward, backward, or to the side. Limiting painful movements and postures can also help improve awareness of the body's positioning (proprioception), which allows the wearer to consciously adjust posture for improved back health.

Reduce micro-motion between vertebral segments- braces also limit excess micro-movements at a particular spinal segment or vertebral fracture, thereby limiting pain from muscle tension and irritated joints or nerve roots.

Adding a back brace to a treatment regimen has been shown in studies to improve mobility and pain scores better than only physical therapy and pain indication. It is generally agreed that back braces can help in providing pain relief.

Assignor was prescribed with an LSO brace to limit the movement of the spine which caused him pain during the recovery process. His symptomology indicates that an LSO brace was in fact required to prevent the patient from further experiencing pain, preventing further injury and allowing him to return to activities of daily living in the most expedient way.

In general, lumbar supports are used in clinical settings for conservative management of low back pain. Generally, patients feel safer, stable and comfortable when performing activities of daily of daily living while wearing LSO. A randomized clinical study showed lumbar supports significantly improved functional status, back pain level and minimize drug use. The study indicated the interest of lumbar support as a complementary and nonpharmacologic treatment besides the classic medication use in low back pain.

As far as lumbar cushion is concerned, it can help by providing proper support.A traumatic injury can injure the tendons, ligaments or muscles resulting in low back pain. This can be instigated from a car accident, playing sports or a fall, causing the spine to become compressed. This compression can induce the disc to herniate or rupture, putting pressure on any of the nerve roots in the spinal cord. When this happens, bac pain and sciatica can result. Spinal stenosis is the narrowing of the spaces of the spine.

This puts pressure on the spinal cord and nerves, causing pain or numbness with walking. Over time, this condition can lead to leg weakness and loss of feeling. Lumbar cushions help support the lower back quickly and conveniently, helping to ease low back pain by promoting proper spine alignment.

Lumbar cushions are also commonly used in the treatment of sprain and strain injuries following a motor vehicle accident. These cushions are designed to support the lower back and promote proper spinal alignment, reducing pain and promoting healing.

A study published in the Journal of Physical Therapy Science looked at the use of a lumbar cushion in patients with lumbar disc herniation, a common injury sustained in motor vehicle accidents. The study found that the use of a lumbar cushion was associated with significant improvements in pain, disability, and quality of life

Overall, the study suggests that lumbar cushions can be an effective treatment option for individuals with sprain and strain injuries following a motor vehicle accident.

With regard to Bed Board and Mattress, they are not only recommended for bed ridden patients and its after effects like decubitus ulcers or bed sores. They also provide numerous other benefits in musculoskeletal pains such as: pressure point relief, support back/spine alignment, relieve and prevent pain during different sleeping positions, etc. They are used for relieving current pain as well as preventing further pain. It helps reduce pain especially in the back, hips and shoulders.

A combination of foam mattress and bed board helps to relieve pressure points and thereby help people suffering from muscle pain. Since blood circulation and weight are distributed fairly, the body reacts positively by sleeping.

One study, published in the journal Spine in 1995, found that bed boards were effective in reducing pain and improving function in people with acute low back pain. The study involved 100 people who were randomly assigned to either a bed board group or a control group. The bed board group used a bed board for 12 weeks, while the control group did not use a bed board. After 12 weeks, the bed board group had significantly less pain and improved function than the control group

Another study, published in the journal Physical Therapy in 2003, found that bed boards were effective in reducing pain and improving sleep quality in people with acute low back pain. The study involved 60 people who were randomly assigned to either a bed board group or a control group. The bed board group used a bed board for 6 weeks, while the control group did not use a bed board. After 6 weeks, the bed board group had significantly less pain and improved sleep quality than the control group.

With regards to cervical collar the goal of using cervical collar was not for complete immobilization but rather to serve as a gentle reminder to avoid excessive motion and may help to encourage proper body mechanics, including good posture. Moreover, the cervical collar was not prescribed to be worn for a longer period of time. The cervical collar was medically necessary because Assignor had a neck injury with pain due to the whiplash and trauma from the vehicular impact. The use of a cervical collar is a common treatment in this type of injury to assist in short term recovery.

A cervical collar is typically used if the patient suffers from the following conditions after an MVA:

Whiplash and Trauma- If you've been in a car accident or sustained some other kind of injury, like a fall, a cervical collar may protect your neck and prevent further injury  
General neck pain or stiffness- A cervical collar may help to take some strain off your neck muscles.

Assignor was prescribed a cervical collar to support his/her neck and to limit the movement of the neck and head. Whiplash is one of the most common side-effects of an MVA. Whiplash symptoms are typical of a sprain and strain when cervical ligaments and muscles are stretched or torn and includes: neck pain, stiffness and muscular spasm, which may radiate into the head and/or upper back. In addition, some people with whiplash experience headaches referred from the cervical spine. The doctor may recommend a cervical collar as part of your treatment regimen.

Neck support pillows are widely used in patients with neck pain to reduce pain and get better quality of sleep. Research suggests that not just sleep position, but sleep itself, can play a role in musculoskeletal pain, including neck and shoulder pain. This is because sleep disturbances disrupt the muscle relaxation and healing that normally occur during sleep. Additionally, it is well established that pain can disrupt sleep, contributing to a vicious cycle of pain disrupting sleep, and sleep problems contributing to pain. Thus, patients suffering from neck pain are recommended to use a cervical pillow in order to minimize the risk of further increasing the pain.

One study, published in the journal Spine in 2006, found that cervical pillows were effective in reducing pain and improving sleep quality in people with acute neck pain. The study involved 60 people who were randomly assigned to either a cervical pillow group or a control group. The cervical pillow group used a cervical pillow for 6 weeks, while the control group did not use a cervical pillow. After 6 weeks, the cervical pillow group had significantly less pain and improved sleep quality than the control group.

Another study, published in the journal Physical Therapy in 2009, found that cervical pillows were effective in reducing pain and improving function in people with acute

neck pain. The study involved 40 people who were randomly assigned to either a cervical pillow group or a control group. The cervical pillow group used a cervical pillow for 12 weeks, while the control group did not use a cervical pillow. After 12 weeks, the cervical pillow group had significantly less pain and improved function than the control group.

Further, there are no specific guidelines/articles delineating the absolute structured path for treatment to be universally prescribed to all patients. Accordingly, great deference should be given to the treating provider charged with the responsibility to examine, diagnose and treat a patient who presents with symptoms and positive clinical findings. It is well settled that it is up to the clinician to decide, based on the circumstances of the injury and the individual patient's exam findings, whether the referral of the DME is appropriate. A guideline/article is just not absolute. It is intended to help the clinician make decisions regarding care based on all of the information presented to her/him for each patient. In fact, the guidelines and articles cited by the peer review doctor are not the accepted standard of care for treatment of No-Fault patients like Assignor. Of note, the peer reviewer cites to these articles and guidelines, which are not a peer-reviewed authority in No Fault claims. These guidelines and articles should not be considered as authority to support the denial of the services at issue.

The peer review lacks sufficient factual support for its conclusions. The peer reviewer does not appropriately cite to competent medical authority to set forth the factual basis and medical rationale to justify the position that the durable medical equipment was not medically necessary. Moreover, to the extent any citations are made, they are speculative, conclusory and not correlated to the treatment and services provided to this patient and by no means act as an absolute standard in the medical community, because no such authority exists.

After careful consideration of the documents submitted and the parties' oral arguments at the hearing, I find that Applicant has submitted sufficient credible evidence to rebut the peer review reports of Dr. Patel and Dr. Tawfellos with regard to the Cervical Traction Equipment, Custom-Fitted Lumbosacral Orthosis, and Cervical Collar. The rebuttal of Dr. Agrawal meaningfully refers to and rebuts the assertions of Dr. Patel and Dr. Tawfellos and presents a cogent medical rationale in opposition to the peer review reports with respect to these items. I am persuaded by the opinion and rationale of Dr. Agrawal and find that Applicant has established that these items were medically necessary. However, with regard to the Off the Shelf Lumbosacral Orthosis, Lumbar Cushion, Mattress, Bed Board, and Cervical Pillow, I find that Applicant has failed to submit sufficient credible evidence to rebut the peer review reports of Dr. Patel and Dr. Tawfellos; therefore, reimbursement for these items is denied. It is noted that Assignor was prescribed an Off the Shelf Lumbosacral Orthosis by Dr. Rahman on June 29, 2023 and was later prescribed a Custom-Fitted Lumbosacral Orthosis on August 9, 2023. It is unclear why a second LSO was prescribed and why the first LSO was insufficient to treat Assignor's injuries.

Based on the foregoing, Applicant is awarded \$1,885.63.

5. Optional imposition of administrative costs on Applicant.  
Applicable for arbitration requests filed on and after March 1, 2002.

I do NOT impose the administrative costs of arbitration to the applicant, in the amount established for the current calendar year by the Designated Organization.

6. **I find as follows with regard to the policy issues before me:**
- The policy was not in force on the date of the accident
  - The applicant was excluded under policy conditions or exclusions
  - The applicant violated policy conditions, resulting in exclusion from coverage
  - The applicant was not an "eligible injured person"
  - The conditions for MVAIC eligibility were not met
  - The injured person was not a "qualified person" (under the MVAIC)
  - The applicant's injuries didn't arise out of the "use or operation" of a motor vehicle
  - The respondent is not subject to the jurisdiction of the New York No-Fault arbitration forum

Accordingly, the applicant is AWARDED the following:

A.

Medical		From/To	Claim Amount	Status
	<b>Bakhra Supply Inc</b>	<b>08/15/23 - 08/15/23</b>	<b>\$1,652.63</b>	<b>Awarded: \$1,652.63</b>
	<b>Bakhra Supply Inc</b>	<b>09/19/23 - 09/19/23</b>	<b>\$1,536.40</b>	<b>Awarded: \$233.00</b>
<b>Total</b>			<b>\$3,189.03</b>	<b>Awarded: \$1,885.63</b>

- B. The insurer shall also compute and pay the applicant interest set forth below. 01/08/2024 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

In accordance with 11 NYCRR 65-3.9(c), interest shall be paid on the claim awarded in the amount of \$1,885.63 from January 8, 2024, the date the arbitration was requested.

C. Attorney's Fees

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

In accordance with 11 NYCRR 65-4.6(d) the insurer shall pay Applicant an attorney's fee on the claim awarded in the amount of \$1,885.63.

- D. The respondent shall also pay the applicant forty dollars (\$40) to reimburse the applicant for the fee paid to the Designated Organization, unless the fee was previously returned pursuant to an earlier award.

This award is in full settlement of all no-fault benefit claims submitted to this arbitrator.

State of NY  
SS :  
County of Nassau

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

07/30/2024  
(Dated)

Debbie Thomas

**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:**  
e8f346c5f7ef82f78a6091039de49162

**Electronically Signed**

Your name: Debbie Thomas  
Signed on: 07/30/2024