MEDICAL CONTESTED CASE HEARING NO. 09090
M6-09-15983-01

DECISION AND ORDER

This case is decided pursuant to Chapter 410 of the Texas Workers' Compensation Act and Rules of the Division of Workers' Compensation adopted thereunder.

ISSUE

A benefit contested case hearing was held on December 16, 2008, to decide the following disputed issue:

> Is the preponderance of the evidence contrary to the decision of the Independent Review Organization (IRO) that Claimant is not entitled to supportive care for the compensable injury of _____?

PARTIES PRESENT

Claimant appeared and was assisted by ombudsman, KF. Carrier appeared and was represented by adjuster, NM.

BACKGROUND INFORMATION

It is undisputed that Claimant sustained a compensable injury to his low back while working as a fabrication shop supervisor for the employer herein. As a result of his compensable injury, Claimant has undergone one back surgery and the implantation of a spinal cord stimulator.

Claimant has treated with a chiropractor for complaints of paraspinal discomfort from L3 to L5. On July 16, 2008, Dr. B completed a preauthorization request for "supportive care PRN." In the request, Dr. B explained that supportive care is defined as "care for patients having reached maximum therapeutic benefit in who (sic) periodic trials of therapeutic withdrawal fail to sustaine (sic) previouse (sic) therapeutic gains that would otherwise progressively deteriorate." He requested chiropractic spinal pain management (post surgical) for the diagnoses of discopathy, sciatic neuralgia and myalgia/myositis. The procedure (CPT) code was 97140 (joint mobilization). Under "Treatment Start Date/End Date/Frequency/Duration" Dr. B stated that "supportive care" would only be incorporated on an as needed basis.

The carrier's first utilization review doctor, a chiropractor (Dr. M) characterized the reviewed procedure/treatment as physical therapy. The reviewer denied "PT 'supportive care'" citing the *ODG*. Dr. M noted that he discussed the requested treatment with Dr. B at length. Dr. M stated that the requested treatment consisted of spinal decompression and manipulation (which is supported by Dr. B's treatment notes). Dr. M stated that the low back chapter of the *ODG* recommends up to 18 chiropractic treatments with manipulation only with clear evidence of functional improvement. In the instant case, Dr. M noted that the recommended number of manipulative treatments had been far exceeded. Dr. M also noted that the *ODG* does not recommend spinal decompression. Dr. M further opined that the positive Minor's sign and nondescript paraspinal palpation findings

referenced in Dr. B's treatment notes had no evidence of reliability or validity and did not constitute measures of functional improvement. Dr. M stated that the *ODG* does not refer the reader to the *Mercy Guidelines* in cases in which *ODG* does not apply, rather the preface to the *ODG* states that recommendations in the *ODG* regarding chiropractic care are based primarily on the scientific literature and, as an additional source, the *Mercy Guidelines*. Dr. M noted that the *ODG* does not have a provision for the use of manipulation for "supportive care" because there is no evidence of the benefit of such care. Dr. M stated that while the *Mercy Guidelines* do have a provision for supportive care where there is a clear pattern of attempts at therapeutic withdrawal with clear evidence of functional deterioration as a result of those attempts; clear evidence of functional improvement as a result of the treatments that cannot be realized through self-care; and, clear evidence of the patient being on a home exercise program with documented compliance with the program. Dr. M concluded that there was no documentation of such a process taking place in Claimant's case.

Dr. B requested reconsideration and disagreed with Dr. M's assessment. He stated that the care he requested was "supportive" not "acute/corrective" care and referenced the *ODG* citation to the *Mercy Guidelines*. He stated that the *ODG* recommends chiropractic; decompression; traction on page 217 under the low back chapter. He disagreed with Dr. M's assessment of the Minor's test and its reliability. He disagreed with the assessment that the *ODG* does not recommend manipulation and decompression for supportive care and referenced the *Mercy Guidelines* cited by the *ODG*.

The utilization review doctor, also a chiropractor Dr. G, who reviewed the request on reconsideration also denied the requested treatment. He also cited the *ODG* and stated the documentation and peer to peer consultation did not show objective functional loss requiring "Physical Medicine Therapy (cpt 97140)" on a supportive basis. He further opined that there had not been an adequate assessment of objective improvement after the supportive care had been provided. Dr. G cited the manual therapy and manipulation sections of the Pain chapter of the *ODG* and upheld the preauthorization denial.

Dr. B disagreed with Dr. G's assessment also. He again made the distinction between acute/corrective care and supportive care and cited the *ODG* reference to the *Mercy Guidelines*.

An IRO reviewer and licensed chiropractor reviewed the records and upheld the adverse determinations of the utilization review doctors. The IRO reviewer listed "physical therapy" as the "description of the service or services in dispute." In the Clinical History portion of the report, the reviewer noted that Dr. B had requested preauthorization for chiropractic spinal pain management. The reviewer noted that Claimant had undergone continuous chiropractic treatment with no long term or significant benefit. The reviewer stated that Dr. B was requesting supportive care once a month, which the reviewer characterized as maintenance care rather than supportive care. Citing the *ODG*, the reviewer stated that the Pain chapter does not recommend manual therapy and manipulation for maintenance; and, stated that evidence-based medicine guidelines indicate supportive care until a patient has reached MMI and maintenance treatments have been determined. The reviewer stated that the *ODG* pain chapter stated that manual therapy and manipulation is recommended as an option for the low back if there is a recurrence or flare-up, but there needs to be a real evaluation of the treatment's success, which is clearly documented in the records. Because Dr. B's records failed to provide the necessary documentation of the success of the requested treatment the preauthorization denial for the requested service was upheld by the IRO.

Dr. B testified that the requested chiropractic services were supported by the *ODG* and other evidence-based medicine, specifically the *Mercy Guidelines*. He testified that based on actual results in his patients chronic or residual symptoms respond well to supportive chiropractic care. He concluded that Claimant needs supportive care on a permanent basis.

DISCUSSION

Texas Labor Code Section 408.021 provides that an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. **Section 401.011(22-a)** defines health care reasonably required as "health care that is clinically appropriate and considered effective for the injured employee's injury and provided in accordance with best practices consistent with: (A) evidence based medicine; or (B) if that evidence is not available, generally accepted standards of medical practice recognized in the medical community."

"Evidence based medicine" is further defined, by **Section 401.011(18-a)** as the use of the current best quality scientific and medical evidence formulated from credible scientific studies, including peer-reviewed medical literature and other current scientifically based texts, and treatment and practice guidelines in making decisions about the care of individual patients.

The Division of Workers' Compensation has adopted treatment guidelines under Division **Rule 137.100**. That rule requires that health care providers provide treatment in accordance with the current edition of the *Official Disability Guidelines (ODG)*, and treatment provided pursuant to those guidelines is presumed to be health care reasonably required as mandated by the above-referenced sections of the **Texas Labor Code**.

ODG

The initial inquiry, therefore, in any dispute regarding medical necessity, is whether the proposed care is consistent with the *ODG*. As the utilization review and IRO doctors in the instant case have stated, the *ODG* allows for chiropractic treatment for low back injuries and sets out the circumstances under which such treatment is recommended as reasonable and necessary.

The *ODG* Treatment Guidelines for chiropractic treatment of the low back refer the reader to "manipulation," which the *ODG* discuss as follows:

> Recommended as an option. Medical evidence shows good outcomes from the use of manipulation in acute low back pain without radiculopathy (but also not necessarily any better than outcomes from other recommended treatments). If manipulation has not resulted in functional improvement in the first one or two weeks, it should be stopped and the patient reevaluated. For patients with chronic low back pain, manipulation may be safe and outcomes may be good, but the studies are not quite as convincing. While not proven by multiple high quality studies, a trial of manipulation for patients with radiculopathy may also be an option, when radiculopathy is not progressive, and studies support its safety. As with any conservative intervention in the absence of definitive high quality evidence, careful attention to patient response to treatment is critical. Many passive and palliative interventions can provide relief in the short term but may risk

treatment dependence without meaningful long-term benefit. Such interventions should be utilized to the extent they are aimed at facilitating return to normal functional activities, particularly work. Potential cautions or contraindications include coagulopathy, fracture, and progressive neurologic deficit. (Andersson-NEJM, 1999) (Cherkin-NEJM, 1998) (Mohseni, 1998) (Aure, 2003) (Pengel, 2002) (Assendelft-Annals, 2003) (Assendelft-Cochrane, 2003) (Cherkin-Annals, 2003) (Licciardone, 2003) (Giles, 2003) (Ferreira, 2003) (Assendelft-Cochrane, 2004) (Grunnesjo, 2004) (Bronfort, 2004) (Hoiriis, 2004) (Oliphant, 2004) (Koes, 2004) (Legorreta, 2004) (UK BEAM, 2004) (Ianuzzi, 2005) (Muller, 2005) (Licciardone, 2005) (Airaksinen, 2006) (Ernst, 2006) (Hurwitz, 2006) (Santilli, 2006) One high-quality clinical trial comparing chiropractic and physical therapy found both effective, but chiropractic was slightly more favorable for acute back pain and PT for chronic cases. (Skargren, 1998) An economic evaluation of four treatments for low-back pain (excluding pharmaceuticals) concluded that mean costs per treatment group were $369 for medical care only, $560 for chiropractic care only, $579 for chiropractic care with physical modalities, and $760 for medical care with physical therapy. This study did not compare outcome success. (Kominski, 2005) Physician consultation is more cost-effective alone than when combined with manipulative treatment; outcomes show significant improvement in both groups, but the combination group had slightly more reduction in pain and clearly higher patient satisfaction. (Niemisto, 2005) Various techniques of manipulation are done by different providers. Manipulation, as used in the above studies, is defined as a process of physiological movement which goes beyond the passive range of motion into the paraphysiological zone, which may involve high velocity with or without recoil. This form of manipulation ("diversified") is the most commonly used by chiropractors; there is another form ("flexion-distraction"), but there are limited studies. The efficacy of distraction manipulation is not well established. (Gay, 2005) Spinal manipulation has been reviewed in 4 good-quality systematic reviews, and short-term, but not long-term, improvements have been reported. (Kinkade, 2007) Patients with acute low back pain receiving recommended first-line care did not recover more quickly with the addition of diclofenac or spinal manipulative therapy, according to the results of a randomized controlled trial in the November 8 issue of *The Lancet*. (Hancock, 2007) In this study of workers' comp patients, less chiropractic care visits was significantly associated with a lower likelihood of disability recurrence and 8.6% shorter disability duration. (Wasiak, 2007) A recent RCT found pain reductions were similar in both the experimental and control groups. Outcomes were assessed daily on days 1 to 14 by patient diary and at 6 months by mailed questionnaire. Limitations of the study included inability to closely monitor patient diaries, low recruitment rate, inability to blind clinicians and patients to treatment, and use of equivalence doses as the primary outcome measure. (Jüni, 2008)
Number of Vists: Several studies of manipulation have looked at duration of treatment, and they generally showed measured improvement within the first few weeks or 3-6 visits of chiropractic treatment, although improvement tapered off after the initial sessions. If chiropractic treatment is going to be effective, there should be some outward sign of subjective or objective improvement within the first 6 visits. These findings question the need for extended treatment, or at least encourage the need for reassessment after a few weeks of treatment. (Burton, 2000) (Hurwitz, 2002) (MD Consult, 2003) (Stig, 2001) (Niemsto, 2003) (Haas, 2004) (Haas2, 2004) (Descarreaux, 2004) One specific study showed a success rate of 88% by six weeks with an average total of 8.2

visits, and 3.8 more if recurrence. (Triano, 1992) Another clinical trial found that only 4 sessions of manipulation and stabilizing exercises resulted in less pain and disability than physician consultation alone. (Niemsto, 2003)

Patient Selection Criteria: The results of a recent study demonstrate that two factors - symptom duration of less than 16 days, and no symptoms extending distal to the knee - were associated with a very good outcome from early referral for spinal manipulation. After only 1-2 sessions of spinal manipulation treatment and a range of motion exercise, the success rate when both criteria were present was 85%, and when both criteria absent was only 28%. (Fritz, 2005) Other studies support using patient selection criteria, including: (1) Duration of current LBP less than 16 days; (2) Not having symptoms below the knee; (3) FABQ score less than 19 points; (4) At least one hypomobile segment in the lumbar spine; & (5) Hip internal rotation range of motion >35 degrees. (Flynn, 2002) (Niemisto, 2004) (Fritz, 2004) (Childs, 2004) (Riipinen, 2005) Patients with signs and symptoms that suggest movement restrictions of the lumbar region should be treated with joint mobilization–manipulation techniques and range of motion exercises. (Fritz-*Spine*, 2003)

Active Treatment versus Passive Modalities: Manipulation is a passive treatment, but many chiropractors also perform active treatments, and these recommendations are covered under Physical therapy (PT), as well as Education and Exercise. The use of active treatment modalities instead of passive treatments is associated with substantially better clinical outcomes. (Fritz, 2007) Active treatments also allow for fading of treatment frequency along with active self-directed home PT, so that less visits would be required in uncomplicated cases.

Current research: A recent comprehensive meta-analysis of all clinical trials of manipulation has concluded that there was good evidence for its use in acute, sub-acute, and chronic low back pain, while the evidence for use in radiculopathy was not as strong, but still positive. (Lawrence, 2008) A Delphi consensus study based on this meta-analysis has made some recommendations regarding chiropractic treatment frequency and duration. They recommend an initial trial of 6-12 visits over a 2-4 week period, and, at the midway point as well as at the end of the trial, there should be a formal assessment whether the treatment is continuing to produce satisfactory clinical gains. If the criteria to support continuing chiropractic care (substantive, measurable functional gains with remaining functional deficits) have been achieved, a follow-up course of treatment may be indicated consisting of another 4-12 visits over a 2-4 week period. According to the study, "One of the goals of any treatment plan should be to reduce the frequency of treatments to the point where maximum therapeutic benefit continues to be achieved while encouraging more active self-therapy, such as independent strengthening and range of motion exercises, and rehabilitative exercises. Patients also need to be encouraged to return to usual activity levels despite residual pain, as well as to avoid catastrophizing and overdependence on physicians, including doctors of chiropractic." (Globe, 2008) These recommendations are consistent with the recommendations in ODG, which suggest a trial of 6 visits, and then 12 more visits (for a total of 18) based on the results of the trial, except that the Delphi recommendations in effect incorporate two trials, with a total of up to 12 trial visits with a re-evaluation in the middle, before also continuing up to 12 more visits (for a total of up to 24). Payors may want to consider this option for patients showing continuing improvement, based on documentation at two points during the course of therapy, allowing 24 visits in total, especially if the documentation of improvement has shown that the patient has achieved or

maintained RTW.

ODG Chiropractic Guidelines:
Therapeutic care –
Mild: up to 6 visits over 2 weeks
Severe:* Trial of 6 visits over 2 weeks
Severe: With evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks, if acute, avoid chronicity
Elective/maintenance care – Not medically necessary
Recurrences/flare-ups – Need to re-evaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months when there is evidence of significant functional limitations on exam that are likely to respond to repeat chiropractic care
* Severe may include severe sprains/strains (Grade II-III[1]) and/or non-progressive radiculopathy (the ODG Chiropractic Guidelines are the same for sprains and disc disorders)

The chiropractic treatment section of the Pain Chapter of the *ODG*, refers the reader to manual therapy and manipulation and discusses that treatment as follows:

> Recommended for chronic pain if caused by musculoskeletal conditions, and manipulation is specifically recommended as an option in the Low Back Chapter and the Neck Chapter. (For more information and references, see those chapters.) Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. See also specific body-part chapters below:
> **Low back:** Recommended as an option. *Therapeutic care* – Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. *Elective/maintenance care* – Not medically necessary. *Recurrences/flare-ups* – Need to re-evaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months.
> **Treatment Parameters from state guidelines**:
> a. Time to produce effect: 4 to 6 treatments.
> b. Frequency: 1 to 2 times per week for the first 2 weeks as indicated by the severity of the condition. Treatment may continue at 1 treatment per week for the next 6 weeks.
> c. Maximum duration: 8 weeks. At week 8, patients should be reevaluated. Care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation is helpful in improving function, decreasing pain and improving quality of life. In these cases, treatment may be continued at 1 treatment every other week until the patient has reached MMI and maintenance treatments have been determined. Extended durations of care beyond what is considered “maximum” may be necessary in cases of re-injury, interrupted continuity of care, exacerbation of symptoms, and in those patients with comorbidities. Such care should be re-evaluated and documented on a monthly basis. Treatment beyond 4-6 visits should be documented with objective improvement in function. Palliative care should be reevaluated and documented at each treatment session. (Colorado, 2006) Injured workers with complicating factors may need more treatment, if documented by the treating physician.

More information from the Low Back Chapter (see that chapter for more references):
Number of Vists: Several studies of manipulation have looked at duration of treatment, and they generally showed measured improvement within the first few weeks or 3-6 visits of chiropractic treatment, although improvement tapered off after the initial sessions. If chiropractic treatment is going to be effective, there should be some outward sign of subjective or objective improvement within the first 6 visits.
Active Treatment versus Passive Modalities: Manipulation is a passive treatment, but many chiropractors also perform active treatments, and these recommendations are covered under Physical therapy (PT), as well as Education and Exercise. The use of active treatment modalities instead of passive treatments is associated with substantially better clinical outcomes. (Fritz, 2007) Active treatments also allow for fading of treatment frequency along with active self-directed home PT, so that less visits would be required in uncomplicated cases.
Current Research: A recent comprehensive meta-analysis of all clinical trials of manipulation for low back conditions has concluded that there was good evidence for its use in acute, sub-acute, and chronic low back pain, while the evidence for use in radiculopathy was not as strong, but still positive. (Lawrence, 2008) A Delphi consensus study based on this meta-analysis has made some recommendations regarding chiropractic treatment frequency and duration for low back conditions. They recommend an initial trial of 6-12 visits over a 2-4 week period, and, at the midway point as well as at the end of the trial, there should be a formal assessment whether the treatment is continuing to produce satisfactory clinical gains. If the criteria to support continuing chiropractic care (substantive, measurable functional gains with remaining functional deficits) have been achieved, a follow-up course of treatment may be indicated consisting of another 4-12 visits over a 2-4 week period. According to the study, "One of the goals of any treatment plan should be to reduce the frequency of treatments to the point where maximum therapeutic benefit continues to be achieved while encouraging more active self-therapy, such as independent strengthening and range of motion exercises, and rehabilitative exercises. Patients also need to be encouraged to return to usual activity levels despite residual pain, as well as to avoid catastrophizing and overdependence on physicians, including doctors of chiropractic." (Globe, 2008) These recommendations are consistent with the recommendations in ODG, which suggest a trial of 6 visits, and then 12 more visits (for a total of 18) based on the results of the trial, except that the Delphi recommendations in effect incorporate two trials, with a total of up to 12 trial visits with a re-evaluation in the middle, before also continuing up to 12 more visits (for a total of up to 24). Payors may want to consider this option for patients showing continuing improvement, based on documentation at two points during the course of therapy, allowing 24 visits in total, especially if the documentation of improvement has shown that the patient has achieved or maintained RTW.

As noted previously herein, "health care reasonably required" means health care that is clinically appropriate and considered effective for the injured employee's injury and provided in accordance with best practices consistent with evidence-based medicine or if that evidence is not available, generally accepted standards of medical practice recognized in the medical community. Treatment provided pursuant to the *ODG* is presumed to be health care reasonably required.

All of the doctors who reviewed the requested chiropractic treatment/supportive care and the IRO

doctor denied the requested supportive care citing the relevant provisions of the *ODG*, specifically the fact Claimant had already well exceeded the recommended chiropractic treatment, had gained no significant benefit from the treatment, and there was insufficient medical documentation that warranted a departure from the *ODG* standard of care. It is incumbent on the Claimant, therefore, to provide evidence-based medicine sufficient to overcome the *ODG* and the opinions of the doctors correctly applying the *ODG*.

Other Evidence Based Medicine

When weighing medical evidence, the hearing officer must first determine whether the doctor giving the expert opinion is qualified to offer it, but also, the hearing officer must determine whether the opinion is relevant to the issues in the case and whether the opinion is based upon a reliable foundation. An expert's bald assurance of validity is not enough. *See* ***Black v. Food Lion, Inc.***, 171 F.3rd 308 (5th Cir. 1999); ***E.I. Du Pont De Nemours and Company, Inc. v. Robinson***, 923 S.W.2d 549 (Tex. 1995). When determining reliability, the hearing officer must consider the evidence in terms of (1) general acceptance of the theory and technique by the relevant scientific community; (2) the expert's qualifications; (3) the existence of literature supporting or rejecting the theory; (4) the technique's potential rate of error; (5) the availability of other experts to test and evaluate the technique; (6) the clarity with which the theory or technique can be explained to the trial court; and (7) the experience and skill of the person who applied the technique on the occasion in question. ***Kelly v. State***, 792 S.W.2d 579 (Tex. App.-Fort Worth 1990).

Claimant failed to present an evidence-based medical opinion from a competent source to overcome the IRO's decision. Dr. B is a licensed chiropractor and may well be qualified to render an opinion regarding conservative neck treatment. The treatment proposed by Dr. B, however, is a departure from the *ODG*. Dr. B's citations to the *ODG* and *Mercy Guidelines* are not persuasive. His testimony that chronic or residual symptoms respond well to supportive care does not amount to evidence-based medicine. Mere citation to the *ODG* does not carry the day. When both parties cite the *ODG* in support of their position, that position must be supported by sufficient evidence to justify application of the *ODG*. In the instant case, the opinions of the URA reviewers and the IRO point specifically to the relevant provisions of the *ODG* and explain that Claimant has far exceeded the number of chiropractic treatments recommended for a low back injury. Without clinical documentation of functional improvement achieved as the result of the continued "supportive care," the evidence-based medicine does not support the requested treatment. Dr. B's records do not provide sufficient documentation of functional improvement justifying the requested supportive care. Dr. B does not address the frequency/duration criteria set out in the *ODG*, rather, he recommends the chiropractic treatment on a permanent basis. Chiropractic treatment of a permanent nature is not recommended by the *ODG* under any circumstances. Dr. B's records and conclusory statements, without evidence-based medicine justifying departure from the *ODG*, do not meet the requisite evidentiary standard required to overcome the *ODG*. The preponderance of the evidence is not contrary to the IRO decision and the requested supportive care does not meet the criteria set out in the *ODG*.

Even though all the evidence presented was not discussed, it was considered. The Findings of Fact and Conclusions of Law are based on all of the evidence presented.

FINDINGS OF FACT

1. The parties stipulated to the following facts:

   A. Venue is proper in the (City) Field Office of the Texas Department of Insurance, Division of Workers' Compensation.

   B. On _____, Claimant was the employee of (Employer), when he sustained a compensable injury.

   C. The IRO determined that the requested services were not reasonable and necessary health care services for the compensable injury of _____.

2. Carrier delivered to Claimant a single document stating the true corporate name of Carrier, and name and street address of Carrier's registered agent which was admitted into evidence as Hearing Officer's Exhibit Number 2.

3. Claimant's treating doctor recommended permanent supportive chiropractic care as needed for treatment of Claimant's low back injury.

4. For treatment of the low back, the *ODG* sets out the circumstances under which chiropractic manual therapy and manipulation is recommended for treatment of low back injuries in both the Low Back and Pain Chapters.

5. Claimant has undergone significant chiropractic manual therapy, decompression and manipulation for treatment of his low back injury without documented evidence of functional improvement.

6. The IRO decision upheld the Carrier's denial of the requested supportive care for treatment of the low back injury because the requested supportive care did not meet the criteria set out in the *ODG* and other evidence-based medicine guidelines.

7. The requested service is not consistent with the *ODG* criteria for chiropractic treatment/supportive care for the low back.

8. The requested supportive care is not health care reasonably required for the compensable injury of _____.

CONCLUSIONS OF LAW

1. The Texas Department of Insurance, Division of Workers' Compensation, has jurisdiction to hear this case.

2. Venue was proper in the (City) Field Office.

3. The preponderance of the evidence is not contrary to the decision of IRO supportive care is not health care reasonably required for the compensable injury of _____.

DECISION

Claimant is not entitled to supportive care for the compensable injury of _____.

ORDER

Carrier is not liable for the benefits at issue in this hearing. Claimant remains entitled to medical benefits for the compensable injury in accordance with Section 408.021.

The true corporate name of the insurance carrier is **INSURANCE COMPANY OF THE STATE OF PENNSYLVANIA** and the name and address of its registered agent for service of process is

CORPORATION SERVICE COMPANY
750 BRAZOS STREET, SUITE 1050
AUSTIN, TEXAS 78701-3232

Signed this 22nd day of January, 2009.

Erika Copeland
Hearing Officer