MEDICAL CONTESTED CASE HEARING NO 12045
M6-11-35919-01

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.

ISSUES

A contested case hearing was held on November 10, 2011 to decide the following disputed issue:

Is the preponderance of the evidence contrary to the decision of the Independent Review Organization (IRO) that therapeutic activities, manual therapy, ultrasound therapy and electrical stimulation is not healthcare reasonably required for the compensable injury of (Date of Injury)?

PARTIES PRESENT

Claimant appeared and was assisted by MM, ombudsman. Carrier appeared and was represented by EL, adjuster.

EVIDENCE PRESENTED

The following witnesses testified:

For Claimant: Claimant.

For Carrier: None

The following exhibits were admitted into evidence:

Hearing Officer's Exhibits HO-1 and HO-2.

Claimant's Exhibits C-1 through C-11

Carrier's Exhibits CR-A through CR-E

BACKGROUND INFORMATION

Claimant is a 60-year-old substitute teacher who was injured on (Date of Injury) when she sat in a broken chair at work and it collapsed, causing her to fall to the floor. She said that she injured the entire left side of her body. Claimant has had 12 sessions of physical therapy and injections. After that, she was given a home therapy program. She continues to have neck, left shoulder, lumbar spine, bilateral hand, left hip, left knee and left groin pain. Her treating physician Dr. S, M.D., has requested the disputed additional treatment consisting of therapeutic activities, manual

therapy, ultrasound therapy, and electrical stimulation of the left hip and lumbar spine. This additional treatment was denied by Carrier's utilization reviewers and the denial was upheld by the IRO, from which Decision Claimant has requested this contested case hearing.

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. Health care reasonably required is further defined in Texas Labor Code Section 401.011 (22a) 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 evidence based medicine or, if evidence based medicine is not available, then generally accepted standards of medical practice recognized in the medical community. Health care under the Texas Workers' Compensation system must be consistent with evidence based medicine if that evidence is available. Evidence based medicine is further defined in Texas Labor Code Section 401.011 (18a) to be 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. The Commissioner of the Division of Workers' Compensation is required to adopt treatment guidelines that are evidence-based, scientifically valid, outcome-focused and designed to reduce excessive or inappropriate medical care while safeguarding necessary medical care. Texas Labor Code Section 413.011(e). Medical services consistent with the medical policies and fee guidelines adopted by the commissioner are presumed reasonable in accordance with Texas Labor Code Section 413.017(1).

In accordance with the above statutory guidance, the Division of Workers' Compensation has adopted treatment guidelines by Division Rule 137.100. This rule directs health care providers to provide treatment in accordance with the current edition of the Official Disability Guidelines (ODG), and such treatment is presumed to be health care reasonably required as defined in the Texas Labor Code. Thus, the focus of any health care dispute starts with the health care set out in the ODG. Also, in accordance with Division Rule 133.308 (t), "A decision issued by an IRO is not considered an agency decision and neither the Department nor the Division are considered parties to an appeal. In a Contested Case Hearing (CCH), the party appealing the IRO decision has the burden of overcoming the decision issued by an IRO by a preponderance of evidence-based medical evidence."

With regard to the requested therapy, the ODG provides as follows:

> PHYSICAL THERAPY (PT)
> Recommended. There is strong evidence that physical methods, including exercise and return to normal activities, have the best long-term outcome in employees with low back pain. See also Exercise. Direction from physical and occupational therapy providers can play a role in this, with the evidence supporting active therapy and not extensive use of passive modalities. The most

effective strategy may be delivering individually designed exercise programs in a supervised format (for example, home exercises with regular therapist follow-up), encouraging adherence to achieve high dosage, and stretching and muscle-strengthening exercises seem to be the most effective types of exercises for treating chronic low back pain. (Hayden, 2005) Studies also suggest benefit from early use of aggressive physical therapy ("sports medicine model"), training in exercises for home use, and a functional restoration program, including intensive physical training, occupational therapy, and psychological support. (Zigenfus, 2000) (Linz, 2002) (Cherkin-NEJM, 1998) (Rainville, 2002) Successful outcomes depend on a functional restoration program, including intensive physical training, versus extensive use of passive modalities. (Mannion, 2001) (Jousset, 2004) (Rainville, 2004) (Airaksinen, 2006) One clinical trial found both effective, but chiropractic was slightly more favorable for acute back pain and physical therapy for chronic cases. (Skargren, 1998) A spinal stabilization program is more effective than standard physical therapy sessions, in which no exercises are prescribed. With regard to manual therapy, this approach may be the most common physical therapy modality for chronic low back disorder, and it may be appropriate as a pain reducing modality, but it should not be used as an isolated modality because it does not concomitantly reduce disability, handicap, or improve quality of life. (Goldby-*Spine*, 2006) Better symptom relief is achieved with directional preference exercise. (Long, 2004) As compared with no therapy, physical therapy (up to 20 sessions over 12 weeks) following disc herniation surgery was effective. Because of the limited benefits of physical therapy relative to "sham" therapy (massage), it is open to question whether this treatment acts primarily physiologically, but psychological factors may contribute substantially to the benefits observed. (Erdogmus, 2007) In this RCT, exercise and stretching, regardless of whether it is achieved via yoga classes or conventional PT supervision, helps improve low back pain. (Sherman, 2011) See also specific physical therapy modalities, as well as Exercise; Work conditioning; Lumbar extension exercise equipment; McKenzie method; Stretching; & Aquatic therapy. [Physical therapy is the treatment of a disease or injury by the use of therapeutic exercise and other interventions that focus on improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, activities of daily living and alleviating pain. (BlueCross BlueShield, 2005) As for visits with any medical provider, physical therapy treatment does not preclude an employee from being at work when not visiting the medical provider, although time off may be required for the visit.]

Active Treatment versus Passive Modalities: The use of active treatment modalities instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with acute low back pain

treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz, 2007) The most commonly used active treatment modality is Therapeutic exercises (97110), but other active therapies may be recommended as well, including Neuromuscular reeducation (97112), Manual therapy (97140), and Therapeutic activities/exercises (97530). A recent RCT comparing active spinal stabilization exercises (using the GDS or Godelive Denys-Struyf method) with passive electrotherapy using TENS plus microwave treatment (considered conventional physical therapy in Spanish primary care), concluded that treatment of nonspecific LBP using the GDS method provides greater improvements in the midterm (6 months) in terms of pain, functional ability, and quality of life. (Arribas, 2009)

Patient Selection Criteria: Multiple studies have shown that patients with a high level of fear-avoidance do much better in a supervised physical therapy exercise program, and patients with low fear-avoidance do better following a self-directed exercise program. When using the Fear-Avoidance Beliefs Questionnaire (FABQ), scores greater than 34 predicted success with PT supervised care. (Fritz, 2001) (Fritz, 2002) (George, 2003) (Klaber, 2004) (Riipinen, 2005) (Hicks, 2005) Without proper patient selection, routine physical therapy may be no more effective than one session of assessment and advice from a physical therapist. (Frost, 2004) Patients exhibiting the centralization phenomenon during lumbar range of motion testing should be treated with the specific exercises (flexion or extension) that promote centralization of symptoms. When findings from the patient's history or physical examination are associated with clinical instability, they should be treated with a trunk strengthening and stabilization exercise program. (Fritz-*Spine*, 2003) Practitioners must be cautious when implementing the wait-and-see approach for LBP, and once medical clearance has been obtained, patients should be advised to keep as active as possible. Patients presenting with high fear avoidance characteristics should have these concerns addressed aggressively to prevent long-term disability, and they should be encouraged to promote the resumption of physical activity. (Hanney, 2009)

Post Epidural Steroid Injections: ESIs are currently recommended as a possible option for short-term treatment of radicular pain (sciatica), defined as pain in dermatomal distribution with corroborative findings of radiculopathy. The general goal of physical therapy during the acute/subacute phase of injury is to decrease guarding, maintain motion, and decrease pain and inflammation. Progression of rehabilitation to a more advanced program of stabilization occurs in the maintenance phase once pain is controlled. There is little evidence-based research

that addresses the use of physical therapy post ESIs, but it appears that most randomized controlled trials have utilized an ongoing, home directed program post injection. Based on current literature, the only need for further physical therapy treatment post ESI would be to emphasize the home exercise program, and this requirement would generally be included in the currently suggested maximum visits for the underlying condition, or at least not require more than 2 additional visits to reinforce the home exercise program. ESIs have been found to have limited effectiveness for treatment of chronic pain. The claimant should continue to follow a home exercise program post injection. (Luijesterburg, 2007) (Luijsterburg2, 2007) (Price, 2005) (Vad, 2002) (Smeal, 2004)

Post-surgical (discectomy) rehab: A recent Cochrane review concluded that exercise programs starting 4-6 weeks post-surgery seem to lead to a faster decrease in pain and disability than no treatment; high intensity exercise programs seem to lead to a faster decrease in pain and disability than low intensity programs; home exercises are as good as supervised exercises; and active programs do not increase the re-operation rate. Although it is not harmful to return to activity after lumbar disc surgery, it is still unclear what exact components should be included in rehabilitation programs. High intensity programs seem to be more effective but they could also be more expensive. Another question is whether all patients should be treated post-surgery or is a minimal intervention with the message return to an active lifestyle sufficient, with only patients that still have symptoms 4 to 6 weeks post-surgery requiring rehabilitation programs. (Ostelo, 2009)

ODG Physical Therapy Guidelines –
Allow for fading of treatment frequency (from up to 3 or more visits per week to 1 or less), plus active self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface, including assessment after a "six-visit clinical trial".
Lumbar sprains and strains (ICD9 847.2):
10 visits over 8 weeks
Sprains and strains of unspecified parts of back (ICD9 847):
10 visits over 5 weeks
Sprains and strains of sacroiliac region (ICD9 846):
Medical treatment: 10 visits over 8 weeks
Lumbago; Backache, unspecified (ICD9 724.2; 724.5):
9 visits over 8 weeks
Intervertebral disc disorders without myelopathy (ICD9 722.1; 722.2; 722.5; 722.6; 722.8):
Medical treatment: 10 visits over 8 weeks
Post-injection treatment: 1-2 visits over 1 week

Post-surgical treatment (discectomy/laminectomy): 16 visits over 8 weeks
Post-surgical treatment (arthroplasty): 26 visits over 16 weeks
Post-surgical treatment (fusion, after graft maturity): 34 visits over 16 weeks
Intervertebral disc disorder with myelopathy (ICD9 722.7)
Medical treatment: 10 visits over 8 weeks
Post-surgical treatment: 48 visits over 18 weeks
Spinal stenosis (ICD9 724.0):
10 visits over 8 weeks
See 722.1 for post-surgical visits
Sciatica; Thoracic/lumbosacral neuritis/radiculitis, unspecified (ICD9 724.3; 724.4):
10-12 visits over 8 weeks
See 722.1 for post-surgical visits
Curvature of spine (ICD9 737)
12 visits over 10 weeks
See 722.1 for post-surgical visits
Fracture of vertebral column without spinal cord injury (ICD9 805):
Medical treatment: 8 visits over 10 weeks
Post-surgical treatment: 34 visits over 16 weeks
Fracture of vertebral column with spinal cord injury (ICD9 806):
Medical treatment: 8 visits over 10 weeks
Post-surgical treatment: 48 visits over 18 weeks
Work conditioning (See also Procedure Summary entry):
10 visits over 8 weeks

With regard to the requested ultrasound therapy, the ODG provides as follows:

ULTRASOUND, THERAPEUTIC
Not recommended based on the medical evidence, which shows that there is no proven efficacy in the treatment of acute low back symptoms. However, therapeutic ultrasound has few adverse effects, is not invasive, and is moderately costly, so where deep heating is desirable, providers and payors might agree in advance on a limited trial of ultrasound for treatment of acute LBP, but only if used as an adjunct to a program of evidence-based conservative care including exercise (but it is still not recommended by ODG). Therapeutic ultrasound is one of the most widely and frequently used electrophysical agents. Despite over 60 years of clinical use, the effectiveness of ultrasound for treating people with pain, musculoskeletal injuries, and soft tissue lesions remains questionable. There is little evidence that active therapeutic ultrasound is more effective than placebo ultrasound for treating people with pain or a range of musculoskeletal injuries or for promoting soft tissue healing. (van Tulder, 1997) (Philadelphia Panel, 2001)

(Robertson, 2001) In a small study, extension and lateral flexion range of motion significantly increased in the ultrasound (US) group, compared to sham-US. (Ansari, 2006) See also Heat therapy.

With regard to Massage Therapy, the ODG states:

MASSAGE:
Recommended as an option in conjunction with recommended exercise programs. Manual massage administered by professional providers has shown some proven efficacy in the treatment of acute low back symptoms, based on quality studies. Mechanical massage devices are not recommended. (Furlan-*Cochrane,* 2002) (Werners, 1999) (Cherkin, 2001) (Cherkin-Annals, 2003) (Sherman, 2004) A recent meta-analysis concluded that massage might be beneficial for patients with subacute and chronic non-specific low-back pain, especially when combined with exercises and education. When massage was compared to an inert therapy (sham treatment), massage was superior for pain and function on both short and long-term follow-ups. When massage was compared to other active treatments, massage was similar to exercises, and massage was superior to joint mobilization, relaxation therapy, physical therapy, acupuncture and self-care education. Reflexology on the feet had no effect on pain and functioning. The beneficial effects of massage in patients with chronic low-back pain lasted at least one year after the end of the treatment. In comparing different techniques of massage, acupuncture massage produced better results than classic (Swedish) massage and Thai massage produced similar results to classic (Swedish) massage. (Furlan-*Cochrane,* 2008)

Recent research: Massage therapy may effectively reduce or relieve chronic back pain for 6 months or more, according to a high quality RCT that also compared relaxation massage with structural massage, which focuses on correcting soft-tissue abnormalities. The study found that patients receiving any massage compared to usual care were twice as likely to report significant improvements in both pain and function, and, after 10 weeks, about two-thirds of those receiving massage improved substantially, versus only about one-third in the usual care group, but no clinically meaningful difference between relaxation and structural massage was observed in terms of relieving disability or symptoms. (Cherkin, 2011)

ODG's recommended frequency and duration of treatment for massage therapy are the same as Manipulation: Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks.

With regard to Electrical Muscle Stimulation, the ODG provides as follows:

> TENS, chronic pain (transcutaneous electrical nerve stimulation)
>
> Not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, including reductions in medication use, for the conditions described below. While TENS may reflect the long-standing accepted standard of care within many medical communities, the results of studies are inconclusive; the published trials do not provide information on the stimulation parameters which are most likely to provide optimum pain relief, nor do they answer questions about long-term effectiveness. (Carroll-*Cochrane,* 2001) Several published evidence-based assessments of transcutaneous electrical nerve stimulation (TENS) have found that evidence is lacking concerning effectiveness. One problem with current studies is that many only evaluated single-dose treatment, which may not reflect the use of this modality in a clinical setting. Other problems include statistical methodology, small sample size, influence of placebo effect, and difficulty comparing the different outcomes that were measured.
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> ***Recommendations by types of pain:*** A home-based treatment trial of one month may be appropriate for neuropathic pain and CRPS II (conditions that have limited published evidence for the use of TENS as noted below), and for CRPS I (with basically no literature to support use).
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> *Neuropathic pain:* Some evidence (Chong, 2003), including diabetic neuropathy (Spruce, 2002) and post-herpetic neuralgia. (Niv, 2005)
>
> *Phantom limb pain and CRPS II:* Some evidence to support use. (Finsen, 1988) (Lundeberg, 1985)
>
> *Spasticity:* TENS may be a supplement to medical treatment in the management of spasticity in spinal cord injury. (Aydin, 2005)
>
> *Multiple sclerosis (MS):* While TENS does not appear to be effective in reducing spasticity in MS patients it may be useful in treating MS patients with pain and muscle spasm. (Miller, 2007)
>
> ***Recommendations for specific body parts*** (See specific body-part chapters below):
> **Low back:** Not recommended as an isolated intervention
> **Knee:** Recommended as an option for osteoarthritis as adjunct treatment to a therapeutic exercise program

Neck: Not recommended as a primary treatment modality for use in whiplash-associated disorders, acute mechanical neck disease or chronic neck disorders with radicular findings
Ankle and foot: Not recommended
Elbow: Not recommended
Forearm, Wrist and Hand: Not recommended
Shoulder: Recommended for post-stroke rehabilitation

How it works: TENS consists of an electrical pulse generator connected to skin-surface electrodes that apply stimulation to peripheral nerves at well-tolerated frequencies. Electrodes can either be placed at the site of pain or other locations, using a trial and error methodology. A TENS unit can be varied by amplitude, pulse width (duration) and pulse rate (frequency). The most common applications include (1) high frequency or conventional TENS (40-150 Hz, with a short duration of up to 50 microseconds) and (2) low frequency or acupuncture-like TENS (1-4 Hz at a high stimulus intensity). Other modes of TENS include: (1) brief-intense TENS (>80 Hz); (2) burst TENS (bursts at less than 10 Hz) at high frequency; and (3) modulation TENS. The difference between clinical effectiveness of the modalities has not been well defined. (Koke, 2004) TENS should be differentiated from other types of electrical stimulators. See Electrical stimulators (E-stim) for a list of alternatives.

Recent studies: There has been a recent meta-analysis published that came to a conclusion that there was a significant decrease in pain when electrical nerve stimulation (ENS) of most types was applied to any anatomic location of chronic musculoskeletal pain (back, knee, hip, neck) for any length of treatment. Of the 38 studies used in the analysis, 35 favored ENS over placebo. All locations of pain were included based on the rationale that “mechanism, rather than anatomic location of pain, is likely to be a critical factor for therapy.” The overall design of this study used questionable methodology and the results require further evaluation before application to specific clinical practice. (Johnson, 2007) (Novak, 2007) (Furlan, 2007) Although electrotherapeutic modalities are frequently used in the management of CLBP, few studies were found to support their use. Most studies on TENS can be considered of relatively poor methodological quality. TENS does not appear to have an impact on perceived disability or long-term pain. Highfrequency TENS appears to be more effective on pain intensity when compared with low frequency, but this has to be confirmed in future comparative trials. It is also not known if adding TENS to an evidence-based intervention, such as exercise, improves even more outcomes, but studies assessing the interactions between exercise and TENS found no cumulative impact. (Poitras, 2008) A recent meta-analysis concluded that the evidence from the small number of placebo-controlled trials does not support the use of TENS in

the routine management of chronic LBP. There was conflicting evidence about whether TENS was beneficial in reducing back pain intensity and consistent evidence that it did not improve back-specific functional status. There was moderate evidence that work status and the use of medical services did not change with treatment. Patients treated with acupuncture-like TENS responded similarly to those treated with conventional TENS. (Khadilkar-*Cochrane*, 2008) A new evidence-based review from the American Academy of Neurology concludes that TENS is not recommended for use in treating chronic low-back pain (level A, 2 class 1 studies) but adds that TENS should be considered to treat diabetic neuropathy (level B, 2 class 2 studies). In the highest-quality studies of chronic low back pain, there was no benefit of TENS compared to sham or placebo TENS. In diabetic polyneuropathy, some studies showed slight benefit. Acute low back pain not normally seen in neurologic conditions was not considered in this review. The authors also point out that absence of evidence is not evidence of absence, and that TENS has had a long-standing role in pain management, is easy to handle, has a favorable benefit-to-risk ratio, and can be discontinued easily if it is not efficacious. (Dubinsky, 2010)

Current Treatment Coverage Guidelines:

- *BlueCross BlueShield:* TENS is considered investigational for treatment of chronic back pain, chronic pain and post-surgical pain, but is covered for certain members based on CMS rules. (BlueCross BlueShield, 2007)
- *CMS:* The use of TENS for the relief of acute post-operative pain is covered for 30 days or less (as an adjunct and/or alternative to pharmaceutical treatment). TENS is also covered as treatment for chronic intractable pain. Medicare requires a month-long trial period in order to determine if there is a significant therapeutic effect. (Medicare, 2006)
- *Aetna & Humana:* consistent with the CMS Guidelines (Aetna, 2005) (Humana, 2004)
- *VA:* TENS is considered equivocal when compared to other modalities. (US Dept VA, 2001)
- *European Federation of Neurological Societies (EFNS):* TENS may be better than placebo (level C) although worse than electro-acupuncture (level B); TENS is non-invasive and suitable as a preliminary or add-on therapy. (Cruccu, 2007)

Criteria for the use of TENS:

Chronic intractable pain (for the conditions noted above):

- Documentation of pain of at least three months duration
- There is evidence that other appropriate pain modalities have been tried (including medication) and failed
- A one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with

documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial
- Other ongoing pain treatment should also be documented during the trial period including medication usage
- A treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted
- A 2-lead unit is generally recommended; if a 4-lead unit is recommended, there must be documentation of why this is necessary

Form-fitting TENS device: This is only considered medically necessary when there is documentation that there is such a large area that requires stimulation that a conventional system cannot accommodate the treatment, that the patient has medical conditions (such as skin pathology) that prevents the use of the traditional system, or the TENS unit is to be used under a cast (as in treatment for disuse atrophy).

The IRO reviewer is a board certified orthopedic surgeon and practicing neurosurgeon who noted that there was no documentation in Claimant's treatment records that Claimant made improvement in the 12 sessions of physical therapy which she had undergone. The requested treatment exceeded the evidence based recommendations for treatment of Claimant's conditions. The ultrasound therapy and electrical stimulation requested is not treatment supported by the ODG. There is insufficient peer reviewed literature to establish efficacy of ultrasound therapy and electrical stimulation therapy either for chronic or acute low back pain. Although Claimant testified at the hearing that she felt that the additional treatment would help her, she provided no evidence based medicine to support the medical necessity of the requested treatment.

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 (Date of Injury), Claimant was the employee of (Employer).

   C. On (Date of Injury), Employer provided workers' compensation insurance through Hartford Accident & Indemnity Company.

   D. Claimant sustained a compensable injury on (Date of Injury).

E. The IRO determined that therapeutic activities, manual therapy, ultrasound therapy and electrical stimulation is not healthcare reasonably necessary for the compensable injury of (Date of Injury).

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

3. Therapeutic activities, manual therapy, ultrasound therapy and electrical stimulation is not healthcare reasonably required for the compensable injury of (Date of Injury).

CONCLUSIONS OF LAW

1. The Texas Department of Insurance, Division of Workers' Compensation, has jurisdiction to hear this case.
2. Venue is proper in the (City) Field Office.
3. The preponderance of the evidence is not contrary to the decision of the IRO that therapeutic activities, manual therapy, ultrasound therapy and electrical stimulation is not healthcare reasonably necessary for the compensable injury of (Date of Injury).

DECISION

Claimant is not entitled therapeutic activities, manual therapy, ultrasound therapy and electrical stimulation for the compensable injury of (Date of Injury).

ORDER

Carrier is not liable for the benefits at issue in this hearing, and it is so ordered. Claimant remains entitled to medical benefits for the compensable injury in accordance with §408.021.

The true corporate name of the insurance carrier is **HARTFORD ACCIDENT & INDEMNITY COMPANY** and the name and address of its registered agent for service of process is:

CORPORATION SERVICE COMPANY
211 EAST 7TH STREET #620
AUSTIN, TX 78701

Signed this 18th day of November, 2011.

Warren E. Hancock
Hearing Officer