MEDICAL CONTESTED CASE HEARING NO. 13104

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 medical contested case hearing was held on June 6, 2013, to decide the following disputed issues:

1. Is the preponderance of the evidence contrary to the decision of the Independent Review Organization (hereinafter "IRO") that Petitioner / Claimant is not entitled to Naprosyn EC 375mg, Parafon DSC and Tylenol ES for the compensable injury of (Date of Injury)?

2. Did the Petitioner / Claimant timely appeal the IRO decision?

PARTIES PRESENT

Petitioner / Claimant appeared and was assisted by EA, ombudsman. Respondent / Carrier appeared and was represented by PG, attorney.

BACKGROUND INFORMATION

On (Date of Injury), Petitioner / Claimant worked for the employer, (Employer), and sustained an injury to her lower back. She received medical treatment for her injury and was seen by HT, MD, on several occasions including for surgery that was performed on March 28, 2000. Eventually, a request for Naprosyn EC 375mg, Parafon DSC and Tylenol ES was proposed. Such requested medications underwent utilization review and were denied on January 8, 2013 by SP, D.O. Reconsideration was requested and such reconsideration was denied on January 22, 2013 by EG, M.D. Petitioner / Claimant then appealed the denials to an IRO and the IRO reviewer upheld the previous adverse determinations. Consequently, Petitioner / Claimant appealed the IRO decision and this is the reason for the present discussion and decision.

DISCUSSION

Timeliness of Appeal

Rule 133.308(s)(1)(A) states, to wit:

The written appeal must be filed with the division's Chief Clerk of Proceedings no later than the later of the 20th day after the effective date of this section ***or*** 20 days after the date the IRO

decision is sent to the appealing party and must be filed in the form and manner required by the division. Requests that are timely submitted to a division location other than the division's Chief Clerk of Proceedings, such as a local field office of the division, will be considered timely filed and forwarded to the Chief Clerk of Proceedings for processing; however, this may result in a delay in the processing of the request.

Id (emphasis added). Essentially, the Rule actually provides for two separate deadlines for the filing of an appeal of the IRO decision with the later in time applying.

In this particular case, the IRO decision was issued and sent to the parties on February 19, 2013. Therefore, the applicable deadline for the filing of the appeal of the IRO decision in this case was 20 days from the date the IRO decision was sent to the parties which was March 11, 2013. Petitioner / Claimant filed her appeal of the IRO decision with the Division on March 15, 2013. There are no other applicable provisions and/or Division Rules providing for extensions of and/or good cause exceptions to the 20-day deadline for appealing the IRO decisions. Since the Petitioner / Claimant did not comply with the 20-day deadline contained in the applicable Division Rules, the appeal of the IRO decision was untimely.

Medical Necessity

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. TEX. LAB. CODE § 408.021. "Health care reasonably required" is defined 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. TEX. LAB. CODE § 401.011 (22a). Health care under the Texas Workers' Compensation system must be consistent with evidence-based medicine if that evidence is available. "Evidence-based medicine" means 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. TEX. LAB. CODE § 401.011 (18a). 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. TEX. LAB. CODE § 413.011(e). Medical services consistent with the medical policies and fee guidelines adopted by the commissioner are presumed reasonable in accordance with the Texas Labor Code. TEX. LAB. CODE § 413.017(1).

In accordance with the above statutory guidance, the Division has adopted treatment guidelines by rule. 28 Tex. Admin. Code § 137.100 (Division Rule 137.100). This Rule directs health care providers to provide treatment in accordance with the current edition of the *Official Disability Guidelines* (hereinafter "ODG") and that 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.

Some of the pertinent provisions of the ODG applicable to this case are as follows, to wit:

> **Medications for subacute & chronic pain:**
>
> Recommended as indicated below. Relief of pain with the use of medications is generally temporary, and measures of the lasting benefit from this modality should include evaluating the effect of pain relief in relationship to improvements in function and increased activity. Before prescribing any medication for pain the following should occur:
>
> (1) determine the aim of use of the medication;
> (2) determine the potential benefits and adverse effects;
> (3) determine the patient's preference.
>
> Only one medication should be given at a time, and interventions that are active and passive should remain unchanged at the time of the medication change. A trial should be given for each individual medication. Analgesic medications should show effects within 1 to 3 days, and the analgesic effect of antidepressants should occur within 1 week. A record of pain and function with the medication should be recorded. (Mens, 2005) The recent AHRQ review of comparative effectiveness and safety of analgesics for osteoarthritis concluded that each of the analgesics was associated with a unique set of benefits and risks, and no currently available analgesic was identified as offering a clear overall advantage compared with the others. (Chou, 2006) There are multiple medication choices listed separately (not all recommended). See Anticonvulsants for chronic pain; Antidepressants for chronic pain; Antidepressants for neuropathic pain; Antidepressants for non-neuropathic pain; Antiemetics (for opioid nausea); Anxiety medications in chronic pain; Anti-epilepsy drugs (AEDs); Anti-Inflammatories; Benzodiazepines; Boswellia Serrata Resin (Frankincense); Buprenorphine; Cannabinoids; Capsaicin; Cod liver oil; Compound drugs; Curcumin (Turmeric); Cyclobenzaprine (Flexeril®); Duloxetine (Cymbalta®); Gabapentin (Neurontin®); Glucosamine (and Chondroitin Sulfate); Green tea; Herbal medicines; Implantable drug-delivery systems (IDDSs); Injection with anaesthetics and/or steroids; Insomnia treatment; Intrathecal drug delivery systems, medications; Intravenous regional sympathetic blocks (for RSD, nerve blocks); Ketamine; Medical food; Methadone; Milnacipran (Ixel®); Muscle relaxants; Nonprescription medications; NSAIDs (non-steroidal anti-inflammatory drugs); NSAIDs, GI symptoms & cardiovascular risk; Opioids (with links to multiple topics on opioids); Proton pump inhibitors (PPIs); Pycnogenol (maritime pine bark); Salicylate topicals; Tapentadol; Topical

analgesics; Uncaria Tomentosa (Cat's Claw); Venlafaxine (Effexor®); White willow bark; & Ziconotide (Prialt®).

Naproxen (Naprosyn®, EC-Naprosyn®, Anaprox®, Anaprox DS®, Aleve® [otc], Naprelan®):

Recommended as an option. Naproxen is a nonsteroidal anti-inflammatory drug (NSAID) for the relief of the signs and symptoms of osteoarthritis. See NSAIDs (non-steroidal anti-inflammatory drugs); NSAIDs, GI symptoms & cardiovascular risk; NSAIDs, hypertension and renal function; & NSAIDs, specific drug list & adverse effects for general guidelines, as well as specific Naproxen (Naprosyn®, EC-Naprosyn®, Anaprox®, Anaprox DS®, Aleve® [otc], Naprelan®) listing for more information and references. See also Anti-inflammatory medications.

Muscle relaxants (for pain):

Recommend non-sedating muscle relaxants with caution as a second-line option for short-term (less than two weeks) treatment of acute LBP and for short-term treatment of acute exacerbations in patients with chronic LBP. (Chou, 2007) (Mens, 2005) (Van Tulder, 1998) (van Tulder, 2003) (van Tulder, 2006) (Schnitzer, 2004) (See, 2008) See the Low Back Chapter. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. (Schnitzer, 2004) (Van Tulder, 2004) (Airaksinen, 2006) Sedation is the most commonly reported adverse effect of muscle relaxant medications. These drugs should be used with caution in patients driving motor vehicles or operating heavy machinery. Drugs with the most limited published evidence in terms of clinical effectiveness include chlorzoxazone, methocarbamol, dantrolene and baclofen. (Chou, 2004) According to a recent review in *American Family Physician,* skeletal muscle relaxants are the most widely prescribed drug class for musculoskeletal conditions (18.5% of prescriptions), and the most commonly prescribed antispasmodic agents are carisoprodol, cyclobenzaprine, metaxalone, and methocarbamol, but despite their popularity, skeletal muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. (See2, 2008)

Classifications: Muscle relaxants are a broad range of medications that are generally divided into antispasmodics, antispasticity drugs, and drugs with both actions. (See, 2008) (van Tulder, 2006)

ANTISPASTICITY DRUGS: Used to decrease spasticity in conditions such as cerebral palsy, MS, and spinal cord injuries (upper motor neuron syndromes).

Associated symptoms include exaggerated reflexes, autonomic hyperreflexia, dystonia, contractures, paresis, lack of dexterity and fatigability. (Chou, 2004)

Baclofen (Lioresal®, generic available): The mechanism of action is blockade of the pre- and post-synaptic $GABA_B$ receptors. It is recommended orally for the treatment of spasticity and muscle spasm related to multiple sclerosis and spinal cord injuries. Baclofen has been noted to have benefits for treating lancinating, paroxysmal neuropathic pain (trigeminal neuralgia, non-FDA approved). (ICSI, 2007)

Side Effects: Sedation, dizziness, weakness, hypotension, nausea, respiratory depression and constipation. This drug should not be discontinued abruptly (withdrawal includes the risk of hallucinations and seizures). Use with caution in patients with renal and liver impairment.

Dosing: Oral: 5 mg three times a day. Upward titration can be made every 3 days up to a maximum dose of 80 mg a day. (See, 2008)

Dantrolene (Dantrium®, generic available): Not recommended. The mechanism of action is a direct inhibition of muscle contraction by decreasing the release of calcium from the sarcoplasmic reticulum.

Side Effects: A black-box warning has been issued about symptomatic fatal or nonfatal hepatitis.

Dosing: 25 mg a day for 7 days, 25 mg three times a day for 7 days, 50 mg three times a day for 7 days and then 100 mg three times a day. (See, 2008)

ANTISPASMODICS: Used to decrease muscle spasm in conditions such as LBP although it appears that these medications are often used for the treatment of musculoskeletal conditions whether spasm is present or not. The mechanism of action for most of these agents is not known. (Chou, 2004)

Cyclobenzaprine (Flexeril®, Fexmid™, generic available, ER as Amrix®): Recommended for a short course of therapy. Immediate release (eg, Flexeril, generic) recommended over extended release (Amrix) due to recommended short course of therapy (also note substantial increase in cost for extended release without corresponding benefit for short course of therapy). Limited, mixed-evidence does not allow for a recommendation for chronic use. Cyclobenzaprine is a skeletal muscle relaxant and a central nervous system depressant with similar effects to tricyclic antidepressants (e.g. amitriptyline). Cyclobenzaprine is more effective than placebo in the management of back pain, although the effect is modest and comes at the price of adverse effects. It has a central mechanism of action, but it is not effective in treating spasticity from cerebral palsy or spinal cord disease. Cyclobenzaprine is associated with a number needed to treat of 3 at

2 weeks for symptom improvement. The greatest effect appears to be in the first 4 days of treatment. (Browning, 2001) (Kinkade, 2007) (Toth, 2004) See Cyclobenzaprine. Cyclobenzaprine has been shown to produce a modest benefit in treatment of fibromyalgia. Cyclobenzaprine-treated patients with fibromyalgia were 3 times more likely to report overall improvement and to report moderate reductions in individual symptoms (particularly sleep). A meta-analysis concluded that the number needed to treat for patients with fibromyalgia was 4.8. (ICSI, 2007) (Tofferi, 2004) A recent RCT found that time to relief was better with immediate release compared to extended release cyclobenzaprine. (Landy, 2011)

Side Effects: Include anticholinergic effects (drowsiness, urinary retention and dry mouth). Sedative effects may limit use. Headache has been noted. This medication should be avoided in patients with arrhythmias, heart block, heart failure and recent myocardial infarction. Side effects limit use in the elderly. (See, 2008) (Toth, 2004)

Dosing: 5 mg three times a day. Can be increased to 10 mg three times a day. This medication is not recommended to be used for longer than 2-3 weeks. (See, 2008)

Methocarbamol (Robaxin®, Relaxin™, generic available): The mechanism of action is unknown, but appears to be related to central nervous system depressant effects with related sedative properties. This drug was approved by the FDA in 1957.

Side Effects: Drowsiness, dizziness and lightheadedness.

Dosing: 1500 mg four times a day for the first 2-3 days, then decreased to 750 mg four times a day. (See, 2008)

Metaxalone (Skelaxin®, generic available) is reported to be a relatively non-sedating muscle relaxant. The exact mechanism of action is unknown, but the effect is presumed to be due to general depression of the central nervous system. Metaxalone was approved by the FDA in 1964 and data to support approval were published in the mid-1960s. (Toth, 2004)

Side Effects: Dizziness and drowsiness, although less than that compared to other skeletal muscle relaxants. Other side effects include headache, nervousness, nausea, vomiting, and GI upset. A hypersensitivity reaction (rash) has been reported. Use with caution in patients with renal and/or hepatic failure.

Dosing: 800 mg three to four times a day (See, 2008)

Chlorzoxazone (Parafon Forte®, Paraflex®, Relax™DS, Remular S™, generic available): this drug works primarily in the spinal cord and the subcortical areas of the brain. The mechanism of action is unknown but the effect is thought to be

due to general depression of the central nervous system. Advantages over other muscle relaxants include reduced sedation and less evidence for abuse. (See, 2008)

Side Effects: Drowsiness and dizziness. Urine discoloration may occur. Avoid use in patients with hepatic impairment.

Dosing: 250-750 mg three times a day to four times a day.

Carisoprodol (Soma®, Soprodal 350™, Vanadom®, generic available): Not recommended in ODG. Suggested by the manufacturer for use as an adjunct to rest, physical therapy, analgesics, and other measures for the relief of discomfort associated with acute, painful musculoskeletal conditions. (AHFS, 2008) A 250 mg formulation was FDA approved in 9/07 for treatment of acute, painful musculoskeletal conditions such as backache. Neither of these formulations is recommended for longer than a 2 to 3 week period. Carisoprodol is metabolized to meprobamate an anixolytic that is a schedule IV controlled substance. Carisoprodol is classified as a schedule IV drug in several states but not on a federal level. It is suggested that its main effect is due to generalized sedation as well as treatment of anxiety. This drug was approved for marketing before the FDA required clinical studies to prove safety and efficacy. Withdrawal symptoms may occur with abrupt discontinuation. (See, 2008) (Reeves, 2003) For more details, see Carisoprodol, where it is "Not recommended." See also Weaning of medications.

Side Effects: drowsiness, psychological and physical dependence, & withdrawal with acute discontinuation.

Dosing: 250 mg-350 mg four times a day. (See, 2008)

Orphenadrine (Norflex®, Banflex®, Antiflex™, Mio-Rel™, Orphenate™, generic available): This drug is similar to diphenhydramine, but has greater anticholinergic effects. The mode of action is not clearly understood. Effects are thought to be secondary to analgesic and anticholinergic properties. This drug was approved by the FDA in 1959.

Side Effects: Anticholinergic effects (drowsiness, urinary retention, dry mouth). Side effects may limit use in the elderly. This medication has been reported in case studies to be abused for euphoria and to have mood elevating effects. (Shariatmadari, 1975)

Dosing: 100 mg twice a day; combination products are given three to four times a day. (See, 2008)

ANTISPASTICITY/ANTISPASMODIC DRUGS:

Tizanidine (Zanaflex®, generic available) is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. (Malanga, 2008) Eight studies have demonstrated efficacy for low back pain. (Chou, 2007) One study (conducted only in females) demonstrated a significant decrease in pain associated with subacute and chronic myofascial pain syndrome and the authors recommended its use as a first line option to treat myofascial pain. (Malanga, 2002) May also provide benefit as an adjunct treatment for fibromyalgia. (ICSI, 2007)

Side effects: somnolence, dizziness, dry mouth, hypotension, weakness, hepatotoxicity (LFTs should be monitored baseline, 1, 3, and 6 months). (See, 2008)

Dosing: 4 mg initial dose; titrate gradually by 2 – 4 mg every 6 – 8 hours until therapeutic effect with tolerable side-effects; maximum 36 mg per day. (See, 2008) Use with caution in renal impairment; should be avoided in hepatic impairment. Tizanidine use has been associated with hepatic aminotransaminase elevations that are usually asymptomatic and reversible with discontinuation. This medication is related to clonidine and should not be discontinued abruptly. Weaning should occur gradually, particularly in patients that have had prolonged use. (Zanaflex-FDA, 2008)

Benzodiazepines: Not recommended due to rapid development of tolerance and dependence. There appears to be little benefit for the use of this class of drugs over nonbenzodiazepines for the treatment of spasm. (See, 2008) See Benzodiazepines.

Nonprescription medications:

Recommended. Acetaminophen (safest); NSAIDs (aspirin, ibuprofen). (Bigos, 1999) A 2008 Cochrane review found that NSAIDs are not more effective than acetaminophen for acute low-back pain, but acetaminophen had fewer side effects, which support recommending NSAIDs as a treatment option after acetaminophen. (Roelofs-Cochrane, 2008) There should be caution about daily doses of acetaminophen and liver disease if over 3 g/day or in combination with other NSAIDs. (Watkins, 2006) See also NSAIDs (non-steroidal anti-inflammatory drugs).

NSAIDs (non-steroidal anti-inflammatory drugs):

Specific recommendations:

Osteoarthritis (including knee and hip): Recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be

considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence to recommend one drug in this class over another based on efficacy. In particular, there appears to be no difference between traditional NSAIDs and COX-2 NSAIDs in terms of pain relief. The main concern of selection is based on adverse effects. COX-2 NSAIDs have fewer GI side effects at the risk of increased cardiovascular side effects, although the FDA has concluded that long-term clinical trials are best interpreted to suggest that cardiovascular risk occurs with all NSAIDs and is a class effect (with naproxyn being the safest drug). There is no evidence of long-term effectiveness for pain or function. (Chen, 2008) (Laine, 2008)

Back Pain - Acute low back pain & acute exacerbations of chronic pain: Recommended as a second-line treatment after acetaminophen. In general, there is conflicting to negative evidence that NSAIDs are more effective than acetaminophen for acute LBP. (van Tulder, 2006) (Hancock, 2007) For patients with acute low back pain with sciatica a recent Cochrane review (including three heterogeneous randomized controlled trials) found no differences in treatment with NSAIDs vs. placebo. In patients with axial low back pain this same review found that NSAIDs were not more effective than acetaminophen for acute low-back pain, and that acetaminophen had fewer side effects. (Roelofs-Cochrane, 2008) The addition of NSAIDs or spinal manipulative therapy does not appear to increase recovery in patients with acute low back pain over that received with acetaminophen treatment and advice from their physician. (Hancock, 2007)

Back Pain - Chronic low back pain: Recommended as an option for short-term symptomatic relief. A Cochrane review of the literature on drug relief for low back pain (LBP) suggested that NSAIDs were no more effective than other drugs such as acetaminophen, narcotic analgesics, and muscle relaxants. The review also found that NSAIDs had more adverse effects than placebo and acetaminophen but fewer effects than muscle relaxants and narcotic analgesics. In addition, evidence from the review suggested that no one NSAID, including COX-2 inhibitors, was clearly more effective than another. (Roelofs-Cochrane, 2008) See also Anti-inflammatory medications.

Neuropathic pain: There is inconsistent evidence for the use of these medications to treat long-term neuropathic pain, but they may be useful to treat breakthrough pain and mixed pain conditions such as osteoarthritis (and other nociceptive pain) in patients with neuropathic pain. (Namaka, 2004) (Gore, 2006)

See NSAIDs, GI symptoms & cardiovascular risk; NSAIDs, hypertension and renal function; & Medications for acute pain (analgesics). Besides the above well-

> documented side effects of NSAIDs, there are other less well-known effects of NSAIDs, and the use of NSAIDs has been shown to possibly delay and hamper healing in all the soft tissues, including muscles, ligaments, tendons, and cartilage. (Maroon, 2006) Revised AGS practice guidelines on the management of persistent pain (including noncancer-related pain) in the elderly recommend that patients avoid NSAIDs and consider the use of low-dose opioid therapy instead, because the risks of NSAIDs in older patients, which include increased cardiovascular risk and gastrointestinal toxicity, usually outweigh the benefits. (AGS, 2009)

In the instant case, the utilization review doctors denied the requested treatment and the IRO reviewer upheld the denial of the requested treatment. The IRO reviewer who is neurosurgeon reviewed Petitioner / Claimant's records and opined that the proposed medications were not indicated as medically necessary based on the clinical data provided. Thereafter, the IRO reviewer cited medical judgment, clinical experience and expertise in accordance with accepted medical standards, the ODG, and other evidence based, scientifically valid, outcome focused guidelines in upholding the denials of the requested treatment.

When weighing expert testimony, the hearing officer must first determine whether the doctor rendering an expert opinion is qualified to offer such. In addition, the hearing officer must determine whether the opinion is relevant to the issues at bar and whether it is based upon a reliable foundation. An expert's bald assurance of validity is not enough. *See Black v. Food Lion, Inc.*, 171 F.3d 308 (5th Cir. 1999); *E.I. Du Pont De Nemours and Company, Inc. v. Robinson*, 923 S.W.2d 549 (Tex. 1995). A medical doctor is not automatically qualified as an expert on every medical question and an unsupported opinion has little, if any, weight. *See Black*, 171 F.3d 308. In determining reliability of the evidence, 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) *aff'd*, 824 S.W.2d 568 (Tex. Crim. App. 1992).

Additionally, "[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." *See* Division Rule 133.308 (s). "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." *Id.*

Accordingly, Petitioner / Claimant, as the party appealing the IRO decision, had the burden of overcoming the IRO decision by a preponderance of evidence-based medical evidence. Although Petitioner / Claimant presented documentary and testimonial evidence including her medical records, there was insufficient explanation through the use of evidence-based medical evidence as to how Petitioner / Claimant met the requirements of ODG for the requested medications. Petitioner / Claimant also did not establish the necessity of the requested medications at issue through other evidence-based medical evidence. As such, insufficient evidence-based medical evidence existed to explain that the requested medications were medically reasonable and necessary. Therefore, the preponderance of the evidence is not contrary to the decision of the IRO that Petitioner / Claimant is not entitled to Naprosyn EC 375mg, Parafon DSC and Tylenol ES for the compensable injury of (Date of Injury).

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), Petitioner / Claimant was an employee of (Employer), the Employer.

   C. On (Date of Injury), Employer provided workers' compensation with Pacific Employers Insurance Company.

   D. On (Date of Injury), Petitioner / Claimant sustained a compensable injury.

   E. The IRO determined that Petitioner / Claimant is not entitled to Naprosyn EC 375mg, Parafon DSC and Tylenol ES for the compensable injury of (Date of Injury).

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

3. Petitioner / Claimant's appeal of the IRO decision was not filed within the 20-day deadline contained in Division Rule 133.308(s)(1)(A).

4. Naprosyn EC 375mg, Parafon DSC and Tylenol ES is not health care 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. Petitioner / Claimant's appeal of the IRO decision was untimely.

4. The preponderance of the evidence is not contrary to the decision of the IRO that Petitioner / Claimant is not entitled to Naprosyn EC 375mg, Parafon DSC and Tylenol ES for the compensable injury of (Date of Injury).

DECISION

Petitioner / Claimant's appeal of the IRO decision was untimely. Petitioner / Claimant is not entitled to Naprosyn EC 375mg, Parafon DSC and Tylenol ES for the compensable injury of (Date of Injury).

ORDER

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

The true corporate name of the insurance carrier is **PACIFIC EMPLOYERS INSURANCE COMPANY** and the name and address of its registered agent for service of process is

CT CORPORATION SYSTEM
350 NORTH ST PAUL STREET
DALLAS, TX 75201

Signed this 14th day of June 2013.

Julio Gomez, Jr.
Hearing Officer