

MEDICAL CONTESTED CASE HEARING NO. 13123

**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**

Contested case hearings were held on July 23, 2013 and August 23, 2013 to decide the following disputed issue:

1. Is the preponderance of the evidence contrary to the decision of the IRO that the claimant is not entitled to a right shoulder arthroscopy with bicep tenodesis, possible labral repair and rotator cuff repair for the (Date of Injury) compensable injury?

**PARTIES PRESENT**

Petitioner, Dr. KB, did not appear at the July 23, 2013 hearing. Petitioner, Dr. KB, appeared by telephone on his own behalf at the August 23, 2013 hearing. Claimant appeared and was represented by attorney MC at both hearings. Respondent/Self-Insured Carrier appeared and was represented by attorney PM at both hearings.

**BACKGROUND INFORMATION**

Claimant sustained a right shoulder injury on (Date of Injury) when he was lifting some boxes and putting merchandise on shelves and he felt a pop in his right shoulder. Claimant received physical therapy, medications, and injections for his injury. Claimant eventually underwent shoulder surgery on January 19, 2011 that was performed by Dr. DS. Claimant began treating with Dr. KB on August 20, 2012. Dr. B noted that Claimant was still having pain and his range of motion was limited. Therefore, he recommended additional testing. Claimant underwent two MRIs and continued to receive medications. Eventually, Dr. B recommended surgery in the form of a right shoulder arthroscopy with bicep tenodesis, possible labral repair and rotator cuff repair.

Dr. B's request for surgery was denied by the Self-Insured Carrier's Utilization Review Agents (URAs.). Dr. B appealed the Self-Insured Carrier's decision to an Independent Review Organization (IRO) that upheld the Self-Insured Carrier's decision. The IRO stated that Claimant had no documented complaints of pain with active arc of motion from 90-130 degrees and had a type 1 SLAP lesion. Therefore, the IRO reviewer stated that Claimant did not meet the criteria for the proposed surgery. Dr. B appealed the IRO reviewer's decision to a Medical Contested Case Hearing. Petitioner and Claimant assert that the medical records and the testimony of Dr. B support their position that the proposed surgical procedure is medically necessary.

## 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. 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(s), "A decision issued by an IRO is not considered an agency decision and neither the Department nor the Division is considered a party 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 a diagnostic arthroscopy, the ODG lists the following criteria:

Recommended as indicated below. Criteria for diagnostic arthroscopy (shoulder arthroscopy for diagnostic purposes): Most orthopedic surgeons can generally determine the diagnosis through examination and imaging studies alone. Diagnostic arthroscopy should be limited to cases where imaging is inconclusive and acute pain or functional limitation continues despite conservative care. Shoulder arthroscopy should be performed in the outpatient setting. If a rotator cuff tear is shown to be present following a diagnostic arthroscopy, follow the

guidelines for either a full or partial thickness rotator cuff tear. (Washington, 2002) (de Jager, 2004) (Kaplan, 2004)

For average hospital LOS if criteria are met, see Hospital length of stay (LOS).

With regard to ruptured bicep tendon surgery, the ODG lists the following criteria:

Not recommended except as indicated below. Nonsurgical treatment is usually all that is needed for tears in the proximal biceps tendons (biceps tendon tear at the shoulder). Surgery may be an appropriate treatment option for tears in the distal biceps tendons (biceps tendon tear at the elbow) for patients who need normal arm strength. (Mazzocca, 2008) (Chillemi, 2007) Ruptures of the proximal (long head) of the biceps tendon are usually due to degenerative changes in the tendon. It can almost always be managed conservatively, since there is no accompanying functional disability. Surgery may be desired for cosmetic reasons, especially by young body builders, but is not necessary for function. (Rantanen, 1999) When patients having rotator cuff surgery also have a torn biceps tendon, repairing it with tenodesis takes only 10 minutes longer than tenotomy but yields better outcomes. In tenodesis, the surgeon cuts the normal attachment of the biceps tendon on the shoulder socket and reattaches it to the humerus. This maneuver takes pressure off the cartilage rim of the shoulder socket (the labrum), and a portion of the tendon can be resected. The alternative, a tenotomy, simply involves cutting and suturing the tendon. With tenodesis, patients have a longer recovery, but they're also more likely to have better function and a normal appearing biceps muscle. With tenotomy, there can be arm cramping, weakness, and a biceps tendon abnormality called a "Popeye deformity". Tenodesis is a better approach except for the aged, senile, and less active. (Koh, 2010)

#### **ODG Indications for Surgery -- Ruptured biceps tendon surgery:**

**Criteria for tenodesis of long head of biceps** (Consideration of tenodesis should include the following: Patient should be a young adult; not recommended as an independent stand alone procedure. There must be evidence of an incomplete tear.) with diagnosis of *incomplete tear or fraying of the proximal biceps tendon* (The diagnosis of fraying is usually identified at the time of acromioplasty or rotator cuff repair so may require retrospective review.):

1. **Subjective Clinical Findings:** Complaint of more than "normal" amount of pain that does not resolve with attempt to use arm. Pain and function fails to follow normal course of recovery. PLUS
2. **Objective Clinical Findings:** Partial thickness tears do not have classical appearance of ruptured muscle. PLUS

3. **Imaging Clinical Findings:** Same as that required to rule out full thickness rotator cuff tear: Conventional x-rays, AP and true lateral or axillary view. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of deficit in rotator cuff.

Criteria for tenodesis of long head of biceps with diagnosis of complete tear of the proximal biceps tendon: Surgery almost never considered in full thickness ruptures. Also required:

1. **Subjective Clinical Findings:** Pain, weakness, and deformity. PLUS
2. **Objective Clinical Findings:** Classical appearance of ruptured muscle.

Criteria for reinsertion of ruptured biceps tendon with diagnosis of distal rupture of the biceps tendon: All should be repaired within 2 to 3 weeks of injury or diagnosis. A diagnosis is made when the physician cannot palpate the insertion of the tendon at the patient's antecubital fossa. Surgery is not indicated if 3 or more months have elapsed. (Washington, 2002)

With regard to surgery for a SLAP tear, the ODG lists the following classifications and criteria:

#### **SLAP lesion diagnosis:**

Recommend criteria below, and the use of shoulder arthroscopy. When the glenoid labrum becomes injured or torn, it is described as a labral tear. These tears may be classified by the position of the tear in relation to the glenoid (which is often called the "shoulder socket"). A SLAP tear is a tear in the labrum that covers the top part of the shoulder socket from front to back (Superior Labral tear from Anterior to Posterior). A SLAP tear occurs at the point where the long head of biceps tendon attaches. This type of tear occurs most commonly during falls on an outstretched arm. SLAP lesions have proven difficult to diagnose clinically. This study concluded that SLAP-specific physical examination results cannot be used as the sole basis of a diagnosis of a SLAP lesion. (Jones, 2007) Pathology of the SLAP lesion poses a significant challenge to the rehabilitation specialist due to the complex nature and wide variety of etiological factors associated with these lesions. (Wilk, 2005) SLAP lesions are becoming a more recognized cause of shoulder pain and disability. The diagnosis of these lesions is difficult due to vague symptoms and a high degree of overlap with other shoulder disorders, and this requires a high index of suspicion. Advances in MR arthrography may lead to advances in preoperative diagnosis of labral tears, but definitive diagnosis, classification, and management is greatly facilitated with the use of the shoulder arthroscopy. (Maurer, 2003) In a systematic review of studies evaluating 15 clinical tests for labral pathology against MRI or surgery, six accurate tests were identified from high quality studies: Biceps Load I, Biceps Load II, Internal Rotation Resistance (IRRT), Crank, Kim, and Jerk tests. (Munro, 2009) This

systematic review concluded that there are no good physical examination tests for effectively diagnosing superior labrum anterior posterior (SLAP) shoulder tears, and special tests for SLAP tears are clinically limited and invalid. (Calvert, 2009) See also Surgery for SLAP lesions. 1

### **Criteria for Classification of SLAP lesions:**

- *Type I:* Fraying and degeneration of the superior labrum, normal biceps (no detachment); Most common type of SLAP tear (75% of SLAP tears); Often associated with rotator cuff tears; These may be treated with debridement.
- *Type II:* Detachment of superior labrum and biceps insertion from the supraglenoid tubercle; When traction is applied to the biceps, the labrum arches away from the glenoid; Typically the superior and middle glenohumeral ligaments are unstable; May resemble a normal variant (Buford complex); Three subtypes: based on detachment of labrum involved anterior aspect of labrum alone, the posterior aspect alone, or both aspects; Posterior labrum tears may be caused by impingement of the cuff against the labrum with the arm in the abducted and externally rotated position; Type-II lesions in patients older than 40 years of age are associated with a supraspinatus tear whereas in patients younger than 40 years are associated with participation in overhead sports and a Bankart lesion; Treatment involves anatomic arthroscopic repair.
- *Type III:* Bucket handle type tear; Biceps anchor is intact.
- *Type IV:* Vertical tear (bucket-handle tear) of the superior labrum, which extends into biceps (intrasubstance tear); May be treated with biceps tenodesis if more than 50% of the tendon is involved. (Wheless, 2007)

### **Surgery for SLAP lesions:**

Recommended for Type II lesions, and for Type IV lesions if more than 50% of the tendon is involved. See SLAP lesion diagnosis. The advent of shoulder arthroscopy, as well as our improved understanding of shoulder anatomy and biomechanics, has led to the identification of previously undiagnosed lesions involving the superior labrum and biceps tendon anchor. Although the history and physical examinations as well as improved imaging modalities (arthro-MRI, arthro-CT) are extremely important in understanding the pathology, the definitive diagnosis of superior labrum anterior to posterior (SLAP) lesions is accomplished through diagnostic arthroscopy. Treatment of these lesions is directed according to the type of SLAP lesion. Generally, type I and type III lesions did not need any treatment or are debrided, whereas type II and many type IV lesions are repaired. (Nam, 2003) (Pujol, 2006) (Wheless, 2007) Shoulder surgery for SLAP tears

may not be successful for many patients. For example, of pitchers who failed physical rehabilitation and then went on to surgery just 7% were able to play as well as they had before, but for pitchers who just underwent physical rehabilitation, 22% were able to play as well as they previously had. (Fedoriw, 2012)

With regard to rotator cuff repairs, the ODG lists the following criteria:

Recommended as indicated below. Repair of the rotator cuff is indicated for significant tears that impair activities by causing weakness of arm elevation or rotation, particularly acutely in younger workers. However, rotator cuff tears are frequently partial-thickness or smaller full-thickness tears. For partial-thickness rotator cuff tears and small full-thickness tears presenting primarily as impingement, surgery is reserved for cases failing conservative therapy for three months. The preferred procedure is usually arthroscopic decompression, but the outcomes from open repair are as good or better. Surgery is not indicated for patients with mild symptoms or those who have no limitations of activities. (Ejnisman-Cochrane, 2004) (Grant, 2004) Lesions of the rotator cuff are best thought of as a continuum, from mild inflammation and degeneration to full avulsions. Studies of normal subjects document the universal presence of degenerative changes and conditions, including full avulsions without symptoms. Conservative treatment has results similar to surgical treatment but without surgical risks. Studies evaluating results of conservative treatment of full-thickness rotator cuff tears have shown an 82-86% success rate for patients presenting within three months of injury. The efficacy of arthroscopic decompression for full-thickness tears depends on the size of the tear; one study reported satisfactory results in 90% of patients with small tears. A prior study by the same group reported satisfactory results in 86% of patients who underwent open repair for larger tears. Surgical outcomes are much better in younger patients with a rotator cuff tear, than in older patients, who may be suffering from degenerative changes in the rotator cuff. Referral for surgical consultation may be indicated for patients who have: Activity limitation for more than three months, plus existence of a surgical lesion; Failure of exercise programs to increase range of motion and strength of the musculature around the shoulder, plus existence of a surgical lesion; Clear clinical and imaging evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical repair; Red flag conditions (e.g., acute rotator cuff tear in a young worker, glenohumeral joint dislocation, etc.). Suspected acute tears of the rotator cuff in young workers may be surgically repaired acutely to restore function; in older workers, these tears are typically treated conservatively at first. Partial-thickness tears are treated the same as impingement syndrome regardless of MRI findings. Outpatient rotator cuff

repair is a well accepted and cost effective procedure. (Cordasco, 2000)  
Difference between surgery & exercise was not significant. (Brox, 1999) There is significant variation in surgical decision-making and a lack of clinical agreement among orthopaedic surgeons about rotator cuff surgery. (Dunn, 2005) For rotator cuff pain with an intact tendon, a trial of 3 to 6 months of conservative therapy is reasonable before orthopaedic referral. Patients with small tears of the rotator cuff may be referred to an orthopaedist after 6 to 12 weeks of conservative treatment. (Burbank2, 2008) Patients with workers' compensation claims have worse outcomes after rotator cuff repair. (Henn, 2008)f

*Revision rotator cuff repair:* The results of revision rotator cuff repair are inferior to those of primary repair. While pain relief may be achieved in most patients, selection criteria should include patients with an intact deltoid origin, good-quality rotator cuff tissue, preoperative elevation above the horizontal, and only one prior procedure. (Djurasovic, 2001)

*Recent research:* Evidence on the pros and cons of various operative and nonoperative treatments for rotator cuff tears is limited and inconclusive, an AHRQ comparative effectiveness review concluded. While the data are sparse, patients improved substantially with all interventions; there were few clinically important differences between approaches, and complications were rare. Most patients try to resolve their pain and disability with a course of physical therapy before attempting surgery, but the study found very little good quality research to guide the choice of nonoperative treatment, the timing of treatment, and who would most benefit from various forms of treatment. Four out of five studies comparing surgical and nonsurgical management favored operative repair, but the evidence was too limited to make conclusions regarding comparative effectiveness. 113 studies comparing various operations found no differences in functional outcomes between open vs mini-open repair, mini-open vs arthroscopic repair, arthroscopic repairs with vs without acromioplasty, and single-row vs double-row fixation. Patients who had mini-open repair returned to work about a month earlier than patients who had open repair. On the other hand, functional improvement was better after open repair compared with arthroscopic debridement. With regard to adding continuous passive motion to postoperative physical therapy, 11 trials yielded moderate evidence for no difference in function or pain. One study found no difference in range of motion or strength, while another suggested that adding continuous passive motion shortened the time until return to work and the time to 90 degrees abduction. For other postoperative rehabilitation strategies, one study showed that progressive loading reduced pain compared to traditional loading. In general, though, most studies found no difference in health-related quality of life, function, pain, range of motion, and

strength with one approach versus another (e.g., with or without aquatics, individualized vs at home alone, videotape vs therapist-based, etc.). In the 72 studies that assessed prognostic factors, older age, increasing tear size, and greater preoperative symptoms were consistently associated with recurrent tears, whereas gender, workers' compensation status, and duration of symptoms usually did not predict poorer outcomes. (Seida, 2010) "Rotator cuff surgery is a viable option for many patients, but, as with any surgery, it is not for everybody," said AHRQ Director Carolyn M. Clancy, M.D. "This report has good news: most interventions work, and each patient should talk to his or her doctor about which to option to pursue." Most older patients who suffer a rotator cuff tear are first treated with up to 3 months of nonsurgical treatment such as pain and anti-inflammatory medications, exercise, and rest. If treatments other than surgery do not work, the rotator cuff may be repaired surgically, using a variety of methods ranging from minimally invasive techniques to an open operation. Patients can then undergo rehabilitation to restore their range of motion, muscle strength, and function following surgery. Rotator cuff tears also can occur in younger adults, usually as a result of traumatic injury. In such cases they are almost always treated with surgery. Some doctors have maintained that earlier surgery results in less pain and better use of the shoulder, leading to an earlier return to work and decreased costs; so, patients often face the difficult decision of opting for surgery rather than waiting for nonoperative treatments to work. However, researchers found little evidence that earlier surgery benefits patients. Comparative Effectiveness of Nonoperative and Operative Treatments for Rotator Cuff Tears is the newest comparative effectiveness report from the AHRQ's Effective Health Care Program. The Effective Health Care Program represents the leading federal effort to compare alternative treatments for health conditions and make the findings public, to help doctors, nurses, pharmacists and others work together with patients to choose the most effective treatments. (Clancy, 2010) This prospective cohort study concluded that PT is effective for most patients with atraumatic full-thickness rotator cuff tears and shoulder pain, without the need for surgery. At six weeks fewer than 10% of patients had decided to undergo surgery, and after 2 years, only 2% of the rest had opted for surgery. Patients did most of their physical therapy at home and usually made only 1 weekly visit to the physical therapist. (Kuhn, 2011) One-third of rotator cuff repairs fail, and 74% of the failures occur within three months of surgery. Healed tendons, or recurrent tears, at six months can predict outcomes at seven years. (Kluger, 2011) Not surprisingly, larger tears are harder to repair, and the retear rate based on rotator cuff tear size is: 10% for  $\leq 2$  cm<sup>2</sup>; 16% for 2–4 cm<sup>2</sup>; 31% for 4–6 cm<sup>2</sup>; 50% for 6–8 cm<sup>2</sup>; & 57% for  $>8$  cm<sup>2</sup>. (Murrell, 2012) There is insufficient evidence to

suggest efficacy in operative or nonoperative treatment of rotator cuff tears in in patients aged older than 60 years. (Downie, 2012)

**ODG Indications for Surgery -- Rotator cuff repair:**

**Criteria for rotator cuff repair with diagnosis of full thickness rotator cuff tear AND Cervical pathology and frozen shoulder syndrome have been ruled out:**

1. **Subjective Clinical Findings:** Shoulder pain and inability to elevate the arm; tenderness over the greater tuberosity is common in acute cases. PLUS
2. **Objective Clinical Findings:** Patient may have weakness with abduction testing. May also demonstrate atrophy of shoulder musculature. Usually has full passive range of motion. PLUS
3. **Imaging Clinical Findings:** Conventional x-rays, AP, and true lateral or axillary views. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of deficit in rotator cuff.

**Criteria for rotator cuff repair OR anterior acromioplasty with diagnosis of partial thickness rotator cuff repair OR acromial impingement syndrome (80% of these patients will get better without surgery.)**

1. **Conservative Care:** Recommend 3 to 6 months: Three months is adequate if treatment has been continuous, six months if treatment has been intermittent. Treatment must be directed toward gaining full ROM, which requires both stretching and strengthening to balance the musculature. PLUS
2. **Subjective Clinical Findings:** Pain with active arc motion 90 to 130 degrees. AND Pain at night (Tenderness over the greater tuberosity is common in acute cases.) PLUS
3. **Objective Clinical Findings:** Weak or absent abduction; may also demonstrate atrophy. AND Tenderness over rotator cuff or anterior acromial area. AND Positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test). PLUS
4. **Imaging Clinical Findings:** Conventional x-rays, AP, and true lateral or axillary view. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of deficit in rotator cuff. (Washington, 2002)

For average hospital LOS if criteria are met, see Hospital length of stay (LOS).

Dr. B, a board certified orthopedic surgeon, testified that Claimant meets the ODG criteria for surgery based upon his physical examination findings and Claimant's lack of improvement with conservative care. Dr. B states in his medical records that Claimant has continued to remain symptomatic despite having received physical therapy, medications, and undergoing a prior right

shoulder surgery. Dr. B's records indicate that Claimant complained of a popping sensation in his right shoulder and that Claimant has limited range of motion in his right shoulder.

Dr. B testified that Claimant has clinical findings and objective testing to support the medical necessity of an arthroscopic surgery with bicep tenodesis. Dr. B relied on a MRI report dated November 2, 2010 that revealed evidence of a tear of the biceps tendon to support the medical necessity of the bicep tendon surgery. Dr. B testified that he is not planning to do surgery to repair a SLAP tear and that the main procedure he is requesting is the shoulder arthroscopy with bicep tenodesis. Dr. B stated that if the arthroscopic procedure revealed a rotator cuff tear that he would repair it also.

Claimant previously underwent surgery on January 19, 2011 and the operative report from Dr. DS indicates that he repaired the SLAP tear and the labral tear that were identified on the November 2, 2010 MRI report. Dr. S also noted in his operative report that there was no evidence of a rotator cuff tear. Post-surgery, Claimant underwent two MRIs on May 14, 2012 and August 13, 2012 respectively. The MRI that was performed on May 14, 2012 indicates that there is evidence of arthritis, distal supraspinatus tendinosis, but the rotator cuff tendons are intact, the labrum is intact, and the long bicep tendon is intact. The MRI that was performed on August 13, 2012 reveals the same findings. Dr. B did not address the prior surgery in his testimony nor did he discuss the findings of the later MRIs.

Review of the medical evidence supports Petitioner's and Claimant's position that he meets the criteria for a diagnostic arthroscopic procedure. However, all of the ODG requirements for a bicep tenodesis, possible labral repair, and rotator cuff repair are not met in this case. Since all of the ODG requirements for the requested procedures have not been met and since no other evidence-based medicine was put forth in support of the necessity of the proposed procedures, Claimant and Petitioner have failed to prove that the preponderance of the evidence based medical evidence is contrary to the IRO decision.

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 (Self-Insured), Employer.
  - C. Claimant sustained a compensable injury on (Date of Injury).

2. Self-Insured Carrier delivered to Claimant and Provider a single document stating the true corporate name of Self-Insured 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. A right shoulder arthroscopy with bicep tenodesis, possible labral repair and rotator cuff repair 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. The preponderance of the evidence is not contrary to the decision of the IRO that a right shoulder arthroscopy with bicep tenodesis, possible labral repair and rotator cuff repair is not health care reasonably required for the compensable injury of (Date of Injury).

### **DECISION**

Claimant is not entitled to a right shoulder arthroscopy with bicep tenodesis, possible labral repair and rotator cuff repair for the compensable injury of (Date of Injury).

### **ORDER**

Self-Insured 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 §408.021.

The true corporate name of the insurance carrier is **(SELF-INSURED)** and the name and address of its registered agent for service of process is:

**(SELF-INSURED)**  
**(STREET ADDRESS)**  
**(CITY), TX (ZIP CODE)**

Signed this 28th day of August, 2013.

Jacquelyn Coleman  
Hearing Officer