

**DECISION AND ORDER**

This case is decided pursuant to Chapter 410 of the Texas Workers' Compensation Act and the Rules of the Texas Department of Insurance, Division of Workers' Compensation. For the reasons discussed herein, the Hearing Officer determines that the preponderance of the evidence is not contrary to the decision of the Independent Review Organization that Claimant is not entitled to revision anterior cervical discectomy and fusion C6-C7, total C5-C6 disk replacement with 1 day Inpatient Stay for the compensable injury of (Date of Injury).

**STATEMENT OF THE CASE**

On March 31, 2015, Jacqueline Harrison, a Division hearing officer, held a contested case hearing to decide the following disputed issue:

1. Is the preponderance of the evidence contrary to the decision of the Independent Review Organization (IRO) that the Claimant is not entitled to revision anterior cervical discectomy and fusion C6-C7, total C5-C6 disk replacement with 1 day for the compensable injury of (Date of Injury)?

**PARTIES PRESENT**

Petitioner/Provider appeared via telephone and represented himself. Claimant appeared and was assisted by VS, ombudsman. Respondent/Carrier appeared and was represented by JRT, attorney.

**DISCUSSION**

Evidence presented in the contested case hearing revealed that Claimant sustained a compensable injury on (Date of Injury). Claimant, a 58 year old male, was standing on a chair when he fell forward, striking his head on a ladder in front of him. Claimant subsequently underwent medical treatment which included, but was not limited to, medications, physical therapy, epidural steroid injection and subsequently post anterior cervical discectomy and fusion on February 15, 2011, and a right shoulder arthroscopy in March, 2013. Claimant recently presented to his treating physician with complaints of cervical pain radiating into his right arm.

Dr. KB, the Petitioner, testified that a hybrid procedure which consisted of revision anterior cervical discectomy and fusion C6-C7, total C5-C6 disk replacement with 1 day for the compensable injury of (Date of Injury), was recommended to relieve Claimant's current pain. Dr. B pointed out that the requested procedures were necessary due to the previous fusion and that a 2 level fusion was inferior and more costly.

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 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."

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

#### Discectomy-laminectomy-laminoplasty

Recommended as an option if there is a radiographically demonstrated abnormality to support clinical findings consistent with one of the following: (1) Progression of myelopathy or focal motor deficit; (2) Intractable radicular pain in the presence of documented clinical and radiographic findings; or (3) Presence of spinal instability when performed in conjunction with stabilization. (See Fusion, anterior cervical.) Surgery is not recommended for disc herniation in a patient with non-specific symptoms and no physical signs. In addition, although surgery for spondylosis and radiculopathy may offer some short term benefit, non-operative treatment with PT

can provide similar improvement in pain and function at 12-16 months for patients without progressive neurologic deficits or instability. (Persson, 1997) The American Academy of Orthopaedic Surgeons has recommended that an anterior approach is appropriate when there is evidence of radiculopathy, and/or when there is evidence of central location and there is any degree of segmental kyphosis. A posterior approach has been suggested by the same group when there is evidence of lateral soft disc herniations with predominate arm pain and for caudal lesions in large, short-necked individuals. (Albert, 1999) The overall goals of cervical surgery should be decompression, restoration of alignment, and stability. (Jacobs-Cochrane, 2004) (Dowd, 1999) (Colorado, 2001) In terms of posterior procedures, there does not appear to be sufficient evidence to support the use of laminoplasty versus laminectomy based on outcomes or post-operative morbidity. Research has indicated that as many as 60% of patients who received laminoplasty had posterior neck and shoulder girdle pain post-operatively (versus 25% in the laminectomy group). (Hosono, 1996) (Heller, 2001) Some authors continue to prefer laminoplasty to anterior spinal decompression and fusion (for myelopathy due to disc herniation) as they feel the risk of chronic neck pain is less troublesome than the risk of bone graft complications and/or adjacent spondylosis that can be found with the fusion procedure. (Sakaura, 2005) It is not clear from the evidence that long-term outcomes are improved with the surgical treatment of cervical radiculopathy compared with nonoperative measures. However, relatively rapid and substantial relief of pain and impairment in the short term (6-12 weeks after surgery) after surgical treatment appears to have been reliably achieved. (Haldeman, 2008)

**Late deterioration:** Has been found with both anterior and posterior approaches. (Rao, 2006) With the anterior approach, recurrent symptoms have been found secondary to deterioration of the adjacent segment, inadequate decompression at the time of the initial surgery, pseudoarthrosis, graft or implant failure, and/or continued growth of osteophytes. With the posterior approach, recurrent symptoms have been found secondary to development of kyphosis, instability, spread of ossification of the posterior longitudinal ligament, and development of stenosis at new levels. In a study based on 932,009 hospital discharges associated with cervical spine surgery, anterior fusions were shown to have a much lower rate of complications compared to posterior fusions, with the overall percent of cases with complications being 2.40% for anterior decompression, 3.44% for anterior fusion, and 10.49% for posterior fusion. (Wang, 2007)

*Pre-operative evaluation:*

**MRI:** This is a very sensitive test for radicular disorders but has a lower negative predictive value. Disc bulges have been found in one study in 52% of subjects and

protrusions in 27% without back pain. At age 60 years, 93% of subjects in one study had disc degeneration/bulges on MRI. (Boden, 1990)

EMG: Optional for cervical surgery. See Electromyography.

*Surgery versus nonoperative care:* Cervical radiculopathy will likely improve with surgery or nonoperative care, but surgery can lead to a greater degree of improvement faster, at the cost of increased risks and the recovery period. Patients with cervical radiculopathy, related to disc herniation or spinal stenosis, improved with or without neck surgery, according to this RCT. The patients who underwent surgery recovered more rapidly and had a modest advantage at 12 months in the percent who rated their condition as better/much better, 87% in the surgical group compared with 62% in the nonsurgical group. The surgical group also had an advantage in neck pain scores at 12 months, but the differences declined by the two-year follow-up. According to the authors, structured physical therapy should be tried before surgery is chosen. (Engquist, 2013)

***ODG Indications for Surgery-- Discectomy/laminectomy (excluding fractures):***

Washington State has published guidelines for cervical surgery for the entrapment of a single nerve root and/or multiple nerve roots. (Washington, 2004) Their recommendations require the presence of all of the following criteria prior to surgery for each nerve root that has been planned for intervention (but ODG does not agree with the EMG requirement):

- A. There must be evidence of radicular pain and sensory symptoms in a cervical distribution that correlate with the involved cervical level or presence of a positive Spurling test.
- B. There should be evidence of motor deficit or reflex changes or positive EMG findings that correlate with the cervical level. *Note:* Despite what the Washington State guidelines say, ODG recommends that EMG is optional if there is other evidence of motor deficit or reflex changes. EMG is useful in cases where clinical findings are unclear, there is a discrepancy in imaging, or to identify other etiologies of symptoms such as metabolic (diabetes/thyroid) or peripheral pathology (such as carpal tunnel). For more information, see EMG.
- C. An abnormal imaging (CT/myelogram and/or MRI) study must show positive findings that correlate with nerve root involvement that is found with the previous objective physical and/or diagnostic findings. If there is no evidence of sensory, motor, reflex or EMG changes, confirmatory selective nerve root blocks may be substituted if these blocks correlate with the imaging study. The block should produce pain in the abnormal nerve root and provide at least 75% pain relief for the duration of the local anesthetic.
- D. Etiologies of pain such as metabolic sources (diabetes/thyroid disease) non-structural radiculopathies (inflammatory, malignant or motor neuron disease),

and/or peripheral sources (carpal tunnel syndrome) should be addressed prior to cervical surgical procedures.

- E. There must be evidence that the patient has received and failed at least a 6-8 week trial of conservative care.

For hospital LOS after admission criteria are met, see Hospital length of stay (LOS).

#### Fusion, anterior cervical

Recommended as an option in combination with anterior cervical discectomy for approved indications, although current evidence is conflicting about the benefit of fusion in general. (See Discectomy/laminectomy/laminoplasty.) Evidence is also conflicting as to whether autograft or allograft is preferable and/or what specific benefits are provided with fixation devices. Many patients have been found to have excellent outcomes while undergoing simple discectomy alone (for one- to two-level procedures), and have also been found to go on to develop spontaneous fusion after an anterior discectomy. (Bertalanffy, 1988) (Savolainen, 1998) (Donaldson, 2002) (Rosenorn, 1983) Cervical fusion for degenerative disease resulting in axial neck pain and no radiculopathy remains controversial and conservative therapy remains the choice if there is no evidence of instability. (Bambakidis, 2005) Conservative anterior cervical fusion techniques appear to be equally effective compared to techniques using allografts, plates or cages. (Savolainen, 1998) (Dowd, 1999) (Colorado, 2001) (Fouyas-Cochrane, 2002) (Goffin, 2003) Cervical fusion may demonstrate good results in appropriately chosen patients with cervical spondylosis and axial neck pain. (Wieser, 2007) One meta-analysis found the differences in benefits and harms between the various surgical techniques are small. The surgeon, patient, and health care provider can therefore make the choice of any surgical technique based on experience, preferences, or costs. According to another systematic review, evidence suggests that surgery with or without fusion can be similarly effective, so surgeons should consider each case individually and take into account their own familiarity and expertise with each procedure. (Verhagen, 2013) (Yoon, 2013) This evidence was substantiated in a recent Cochrane review that stated that hard evidence for the need for a fusion procedure after discectomy was lacking, as outlined below:

- (1) Anterior cervical discectomy compared to anterior cervical discectomy with interbody fusion with a bone graft or substitute: Three of the six randomized controlled studies discussed in the 2004 Cochrane review found no difference between the two techniques and/or that fusion was not necessary. The Cochrane review felt there was conflicting evidence of the relative effectiveness of either procedure. Overall it was noted that patients with discectomy only had shorter hospital stays, and shorter length of operation. There was moderate evidence that pain relief after five to six weeks was higher for the patients who had discectomy

with fusion. Return to work was higher early on (five weeks) in the patients with discectomy with fusion, but there was no significant difference at ten weeks. (Jacobs-Cochrane, 2004) (Abd-Alrahman, 1999) (Dowd, 1999) (Martins, 1976) (van den Bent, 1996) (Savolainen, 1998) One disadvantage of fusion appears to be abnormal kinematic strain on adjacent spinal levels. (Ragab, 2006) (Eck, 2002) (Matsunaga, 1999) (Katsuura, 2001) The advantage of fusion appears to be a decreased rate of kyphosis in the operated segments. (Yamamoto, 1991) (Abd-Alrahman, 1999)

- (2) Fusion with autograft versus allograft: The Cochrane review found limited evidence that the use of autograft provided better pain reduction than animal allograft. It also found that there was no difference between biocompatible osteoconductive polymer or autograft (limited evidence). (Jacobs-Cochrane, 2004) (McConnell, 2003) A problem with autograft is morbidity as related to the donor site including infection, prolonged drainage, hematomas, persistent pain and sensory loss. (Younger, 1989) (Sawin, 1998) (Sasso, 2005) Autograft is thought to increase fusion rates with less graft collapse. (Deutsch, 2007). See Decompression, myelopathy.
- (3) Fusion with autograft with plate fixation versus allograft with plate fixation, Single level: A recent retrospective review of patients who received allograft with plate fixation versus autograft with plate fixation at a single level found fusion rates in 100% versus 90.3% respectively. This was not statistically significant. Satisfactory outcomes were noted in all non-union patients. (Samartzis, 2005)
- (4) Fusion with different types of autograft: The Cochrane review did not find evidence that a vertebral body graft was superior to an iliac crest graft. (McGuire, 1994)
- (5) Fusion with autograft versus fusion with autograft and additional instrumentation:

Plate Fixation: In single-level surgery there is limited evidence that there is any difference between the use of plates and fusion with autograft in terms of union rates. For two-level surgery, there was moderate evidence that there was more improvement in arm pain for patients treated with a plate than for those without a plate. Fusion rate is improved with plating in multi-level surgery. (Wright, 2007) See Plate fixation, cervical spine surgery.

Cage: Donor site pain may be decreased with the use of a cage rather than a plate, but donor site pain was not presented in a standardized manner. At two years pseudoarthrosis rate has been found to be lower in the fusion group (15%) versus the cage group (44%). A six-year follow-up of the same study group revealed no

significant difference in outcome variables between the two treatment groups (both groups had pain relief). In the subgroup of patients with the cage who attained fusion, the overall outcome was better than with fusion alone. Patients treated with cage instrumentation have less segmental kyphosis and better-preserved disc height. This only appears to affect outcome in a positive way in cage patients that achieve fusion (versus cage patients with pseudoarthrosis). (Poelsson, 2007) (Varuch, 2002) (Hacker 2000) See also Adjacent segment disease/degeneration (fusion).

(6) Fusion with allograft alone versus with allograft and additional instrumentation:

Plate Fixation: Retrospective studies indicate high levels of pseudoarthrosis rates (as high as 20% for one-level and 50% for two-level procedures) using allograft alone. In a recent comparative retrospective study examining fusion rate with plating, successful fusion was achieved in 96% of single-level cases and 91% of two-level procedures. This could be compared to a previous retrospective study by the same authors of non-plated cases that achieved successful fusion in 90% of single-level procedures and 72% of two-level procedures. (Kaiser, 2002) (Martin, 1999) See Plate fixation, cervical spine surgery.

Complications:

Collapse of the grafted bone and loss of cervical lordosis: collapse of grafted bone has been found to be less likely in plated groups for patients with multiple-level fusion. Plating has been found to maintain cervical lordosis in both multi-level and one-level procedures. (Trojanovich, 2002) (Herrmann, 2004) (Katsuura, 1996) The significance on outcome of kyphosis or loss of cervical lordosis in terms of prediction of clinical outcome remains under investigation. (Poelsson, 2004) (Haden, 2005) (Poelsson, 2007) (Hwang, 2007) See also Laryngoscopy (screening for recurrent laryngeal nerve injury prior to revision ACDF).

Pseudoarthrosis: This is recognized as an etiology of continued cervical pain and unsatisfactory outcome. Treatment options include a revision anterior approach vs. a posterior approach. Regardless of approach, there is a high rate of continued moderate to severe pain even after solid fusion is achieved. (Kuhns, 2005) (Mummaneni, 2004) (Coric, 1997)

Anterior versus posterior fusion: In a study based on 932,009 hospital discharges associated with cervical spine surgery, anterior fusions were shown to have a much lower rate of complications compared to posterior fusions, with the overall percent of cases with complications being 2.40% for anterior decompression, 3.44% for anterior fusion, and 10.49% for posterior fusion. (Wang, 2007)

Predictors of outcome of ACDF: Predictors of good outcome include non-smoking, a pre-operative lower pain level, soft disc disease, disease in one level, greater segmental kyphosis pre-operatively, radicular pain without additional neck or lumbar

pain, short duration of symptoms, younger age, no use of analgesics, gainful employment, higher preoperative NDI and normal ratings on biopsychosocial tests such as the Distress and Risk Assessment Method (DRAM). Predictors of poor outcomes include non-specific neck pain, psychological distress, psychosomatic problems and poor general health, litigation and workers' compensation. (Anderson, 2009) (Peolsson, 2006) (Peolsson, 2003) Patients who smoke have compromised fusion outcomes. (Peolsson, 2008)

See Plate fixation, cervical spine surgery. See also Adjacent segment disease/degeneration (fusion) & Iliac crest donor-site pain treatment.

*Use of Bone-morphogenetic protein (BMP):* FDA informed healthcare professionals of reports of life-threatening complications associated with recombinant human Bone Morphogenetic Protein (rhBMP) when used in the cervical spine for spinal fusion. The safety and effectiveness of rhBMP in the cervical spine have not been demonstrated, and these products are not approved for this use. These complications were associated with swelling of neck and throat tissue, which resulted in compression of the airway and/or neurological structures in the neck. (FDA MedWatch, 2008) Bone-morphogenetic protein was used in approximately 25% of all spinal fusions nationally in 2006, with use associated with more frequent complications for anterior cervical fusions. No differences were seen for lumbar, thoracic, or posterior cervical procedures, but the use of BMP in anterior cervical fusion procedures was associated with a higher rate of complication occurrence (7.09% with BMP vs. 4.68% without BMP) with the primary increases seen in wound-related complications (1.22% with vs. 0.65% without) and dysphagia or hoarseness (4.35% with vs. 2.45% without). (Cahill-JAMA, 2009)

For hospital LOS after admission criteria are met, see Hospital length of stay (LOS).

Criteria for Cervical Fusion – Recommended Indications:

- (1) Acute traumatic spinal injury (fracture or dislocation) resulting in cervical spinal instability.
- (2) Osteomyelitis (bone infection) resulting in vertebral body destruction.
- (3) Primary or metastatic bone tumor resulting in fracture instability or spinal cord compression.
- (4) Cervical nerve root compression verified by diagnostic imaging (i.e., MRI or CT myelogram) and resulting in severe pain OR profound weakness of the extremities.
- (5) Spondylotic myelopathy based on clinical signs and/or symptoms (Clumsiness of hands, urinary urgency, new-onset bowel or bladder incontinence, frequent falls, hyperreflexia, Hoffmann sign, increased tone or spasticity, loss of thenar or

hypothenar eminence, gait abnormality or pathologic Babinski sign) and Diagnostic imaging (i.e., MRI or CT myelogram) demonstrating spinal cord compression.

- (6) Spondylotic radiculopathy or nontraumatic instability with All of the following criteria:
- (a) Significant symptoms that correlate with physical exam findings AND radiologist-interpreted imaging reports.
  - (b) Persistent or progressive radicular pain or weakness secondary to nerve root compression or moderate to severe neck pain, despite 8 weeks conservative therapy with at least 2 of the following:
    - Active pain management with pharmacotherapy that addresses neuropathic pain and other pain sources (e.g., an NSAID, muscle relaxant or tricyclic antidepressant);
    - Medical management with oral steroids, facet or epidural injections;
    - Physical therapy, documented participation in a formal, active physical therapy program as directed by a physiatrist or physical therapist, may include a home exercise program and activity modification, as appropriate.
  - (c) Clinically significant function limitation, resulting in inability or significantly decreased ability to perform normal, daily activities of work or at-home duties.
  - (d) Diagnostic imaging (i.e., MRI or CT myelogram) demonstrates cervical nerve root compression, or Diagnostic imaging by x-ray demonstrates Instability by flexion and extension x-rays; Sagittal plane translation >3mm; OR Sagittal plane translation >20% of vertebral body width; OR Relative sagittal plane angulation >11 degrees.
  - (e) Not recommend repeat surgery at the same level.
  - (f) Tobacco cessation: Because of the high risk of pseudoarthrosis, a smoker anticipating a spinal fusion should adhere to a tobacco-cessation program that results in abstinence from tobacco for at least six weeks prior to surgery.
  - (g) Number of levels: When requesting authorization for cervical fusion of multiple levels, each level is subject to the criteria above. Fewer levels are preferred to limit strain on the unfused segments. If there is multi-level degeneration, prefer limiting to no more than three levels. With one level, there is approximately a 80% chance of benefit, for a two-level fusion it drops to around 60%, and for a three-level fusion to around 50%. But not

fusing additional levels meeting the criteria, risks having to do future operations.

- (h) The decision on technique (e.g., autograft versus allograft, instrumentation) should be left to the surgeon.

The case was reviewed by an Injury Management Organization [IMO] Physician Advisor, MVH, M.D., an orthopedic surgeon who is licensed by the State of Texas. Dr. VH denied the requested procedures explaining that the proposed surgery would not appear medically necessary. Dr. VH explained that the Claimant had a myelogram that showed decreased fill of the C5 and C6 nerve root sleeves on the post myelogram CT scan. Dr. VH noted that the C5-C6 had unciniate hypertrophy and there were facet changes at C3-C4 and C4-C5. However, he indicated that the pathology at C5-C6 appeared to be foraminal and not central.

Upon reconsideration, IMO Physician Advisor, AD, M.D., also licensed in Texas, upheld Dr. VH's adverse determination for the revision anterior cervical discectomy and fusion C6-C7, total C5-C6 disk replacement with 1 day for the compensable injury of (Date of Injury). Dr. D explained that he would recommend the Claimant's treating physician get the Claimant set up with a pain management specialist to better control the symptoms. Dr. D noted that the Claimant had neurologic deficits and pathology at 2 levels. Dr. D reported that there had been a prior cervical fusion and that the Claimant would benefit from surgery to decompress and fuse the 2 levels of pathology, known as a revision. However, Dr. D opined that the request for disc replacement does not meet evidence based guidelines. Dr. D went further to explain that there was insufficient peer review long term studies to show the safety or efficacy of this surgical procedure with arthroplasty with a revision fusion surgery below the prosthesis.

Upon questioning, Dr. B admitted in his testimony that he did not provide for the reviewers any documentation regarding the safety and efficacy of the use of the hybrid procedure. However, he noted that his use of the MOBI-C for the total disk replacement prosthesis, was the only disk replacement that is FDA approved for two-level discectomies.

Review of the medical evidence supports Petitioner's and Claimant's position that he meets the criteria for a revision anterior cervical discectomy and fusion C6-C7. However, all of the ODG requirements for a C5-C6 disk replacement 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.

The Hearing Officer considered all of the evidence admitted. The Findings of Fact and Conclusions of Law are based on an assessment of all of the evidence whether or not the evidence is specifically discussed in this Decision and Order.

## **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 the (Employer), Employer.
  - C. On (Date of Injury), Employer provided workers' compensation insurance with State Office of Risk Management, as a self-insurer.
  - D. On (Date of Injury), Claimant sustained a compensable injury.
2. Carrier delivered to Petitioner/Provider and 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. A revision anterior cervical discectomy and fusion C6-C7, total C5-C6 disk replacement with 1 day, is not health care reasonably required for treatment 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 revision anterior cervical discectomy and fusion C6-C7, total C5-C6 disk replacement with 1 day inpatient hospital stay, is not health care reasonably required for the compensable injury of (Date of Injury).

## **DECISION**

Claimant is not entitled to a revision anterior cervical discectomy and fusion C6-C7, total C5-C6 disk replacement with 1 day inpatient hospital stay, for the compensable injury of (Date of Injury).

## **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 §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:

For service in person:

**SSV  
ADDRESS  
CITY, STATE, ZIP**

For service by mail, the address is:

**SSV  
ADDRESS  
CITY, STATE, ZIP**

Signed this 16th day of April, 2015.

Jacqueline Harrison  
Hearing Officer