

MEDICAL CONTESTED CASE HEARING NO. 15045

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 determined that:

The preponderance of the evidence is contrary to the decision of the Independent Review Organization (IRO) that Claimant is not entitled to Oxycontin 80mg #90. The preponderance of the evidence is not contrary to the decision of the IRO that the Claimant is not entitled to MS Contin 100mg #90 or Flexeril 10mg #90.

STATEMENT OF THE CASE

On May 14, 2015, Britt Clark, a Division hearing officer, held a contested case hearing to decide the following disputed issue:

Is the preponderance of the evidence contrary to the decision of the Independent Review Organization (IRO) that the Claimant is not entitled to MS Contin 100mg#90, Flexeril 10mg #90, and Oxycontin 80mg #90?

PARTIES PRESENT

Claimant/Petitioner appeared and was assisted by JF, ombudsman. Carrier/Respondent appeared and was represented by RT, attorney.

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 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."

On the date of this medical contested case hearing, the ODG provides the following with regard to Oxycontin:

Not recommended for first-line use for treatment of acute or chronic non-malignant pain because short-acting opioids are recommended prior to use of long-acting opioids. See Opioids, long-acting. OxyContin® is the brand name of a time-release formula of the analgesic chemical oxycodone, produced by the pharmaceutical company Purdue Pharma. See Opioids for general guidelines, as well as specific Oxycodone controlled release (OxyContin®) listing for more information and references. This drug was recently included in a list of 20 medications identified by the FDA's Adverse Event Reporting System, that are under FDA investigation. (FDA, 2008) On April 2, 2010, the FDA approved a new formulation of Oxycontin designed to discourage abuse, but according to the manufacturer, there is no evidence that the reformulation is less subject to misuse, abuse, diversion, overdose or addiction. (FDA, 2010) Due to issues of abuse and Black Box FDA warnings, Oxycontin is recommended as second line therapy for long acting opioids. Oxycontin ranked #1 in amount billed for WC in 2011. (Coventry, 2012) This study found that introduction of abuse-deterrent formulations (ADF) of OxyContin led to an initial decline in abuse, followed by a plateau, and then significant levels of residual abuse, plus an uptick in heroin use. ADF OxyContin led to a decline in past-month abuse after its introduction (from 45% in January–June 2009 to 26% in July–December 2012), but this decline leveled off, with 25% to 30% of new patients entering treatment reporting past-month abuse from 2012 to 2014. Among individuals who continued to abuse ADF

OxyContin, 43% said they changed their preferred route of administration from injected or inhaled to the oral route, 34% managed to defeat the ADF OxyContin mechanism and continued to inject or inhale the drug, and 23% exclusively swallowed the pill regardless of formulation. (Cicero, 2015).

On the date of this medical contested case hearing, the ODG provides the following with regard to Flexeril:

Recommended as an option, using a short course of therapy. See Medications for subacute & chronic pain for other preferred options. Cyclobenzaprine (Flexeril®) is more effective than placebo in the management of back pain; the effect is modest and comes at the price of greater adverse effects. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. (Browning, 2001) Treatment should be brief; this medication is not recommended for longer than 2-3 weeks. There is also a post-op use. The addition of cyclobenzaprine to other agents is not recommended. (Clinical Pharmacology, 2008) Cyclobenzaprine-treated patients with fibromyalgia were 3 times as likely to report overall improvement and to report moderate reductions in individual symptoms, particularly sleep. (Tofferi, 2004) Note: Cyclobenzaprine is closely related to the tricyclic antidepressants, e.g., amitriptyline. See Antidepressants. Cyclobenzaprine is associated with a number needed to treat of 3 at 2 weeks for symptom improvement in LBP and is associated with drowsiness and dizziness. (Kinkade, 2007) Cyclobenzaprine is a skeletal muscle relaxant and a central nervous system (CNS) depressant that is marketed as Flexeril by Ortho McNeil Pharmaceutical. See also Muscle relaxants (for pain), Cyclobenzaprine listing.

The ODG reflects to consult the general guidelines for long-acting Opioids for Oxycontin. The ODG provides the following general instructions with regard to Opioids:

CRITERIA FOR USE OF OPIOIDS

Therapeutic Trial of Opioids

- (1) Establish a Treatment Plan. The use of opioids should be part of a treatment plan that is tailored to the patient. Questions to ask prior to starting therapy:
 - (a) Are there reasonable alternatives to treatment, and have these been tried?
 - (b) Is the patient likely to improve? Examples: Was there improvement on opioid treatment in the acute and subacute phases? Were there trials of other treatment, including non-opioid medications?

- (c) Has the patient received a screen for the risk of addiction? Is there likelihood of abuse or an adverse outcome? Specific questions about current use of alcohol, illegal drugs, other prescription drugs, and over-the-counter drugs should be asked. Obtaining a history of personal and/or family substance abuse issues is important. See Substance abuse (tolerance, dependence, addiction). See Opioids, screening for risk of addiction. (Webster, 2008) (Ballyantyne, 2007)
 - (d) Ask about Red Flags indicating that opioids may not be helpful in the chronic phase: (1) Little or no relief with opioid therapy in the acute and subacute phases. (2) The patient has been given a diagnosis in one of the particular diagnostic categories that have not been shown to have good success with opioid therapy: conversion disorder; somatization disorder; pain disorder associated with psychological factors (such as anxiety or depression, or a previous history of substance abuse). Patients may misuse opioids prescribed for pain to obtain relief from depressed feelings, anxiety, insomnia, or discomforting memories. There are better treatments for this type of pathology. (Sullivan, 2006) (Sullivan, 2005) (Wilsey, 2008) (Savage, 2008)
 - (e) When the patient is requesting opioid medications for their pain and inconsistencies are identified in the history, presentation, behaviors or physical findings, physicians and surgeons who make a clinical decision to withhold opioid medications should document the basis for their decision.
- (2) Steps to Take Before a Therapeutic Trial of Opioids:
- (a) Attempt to determine if the pain is nociceptive or neuropathic. Also attempt to determine if there are underlying contributing psychological issues. Neuropathic pain may require higher doses of opioids, and opioids are not generally recommended as a first-line therapy for some neuropathic pain.
 - (b) A therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics.
 - (c) Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals.
 - (d) Baseline pain and functional assessments should be made. Function should include social, physical, psychological, daily and work activities, and should be performed using a validated instrument or numerical rating scale. See Function Measures.
 - (e) Pain related assessment should include history of pain treatment and effect of pain and function.

- (f) Assess the likelihood that the patient could be weaned from opioids if there is no improvement in pain and function.
 - (g) The patient should have at least one physical and psychosocial assessment by the treating doctor (and a possible second opinion by a specialist) to assess whether a trial of opioids should occur. When subjective complaints do not correlate with imaging studies and/or physical findings and/or when psychosocial issue concerns exist, a second opinion with a pain specialist and a psychological assessment should be obtained. (Sullivan, 2006) (Sullivan, 2005) (Wilsey, 2008) (Savage, 2008) (Ballyantyne, 2007)
 - (h) The physician and surgeon should discuss the risks and benefits of the use of controlled substances and other treatment modalities with the patient, caregiver or guardian.
 - (i) A written consent or pain agreement for chronic use is not required but may make it easier for the physician and surgeon to document patient education, the treatment plan, and the informed consent. Patient, guardian, and caregiver attitudes about medicines may influence the patient's use of medications for relief from pain. See Guidelines for Pain Treatment Agreement. This should include the consequences of non-adherence.
 - (j) Consider the use of a urine drug screen to assess for the use or the presence of illegal drugs.
- (3) Initiating Therapy
- (a) Intermittent pain: Start with a short-acting opioid trying one medication at a time.
 - (b) Continuous pain: extended-release opioids are recommended. Patients on this modality may require a dose of “rescue” opioids. The need for extra opioid can be a guide to determine the sustained release dose required.
 - (c) Only change 1 drug at a time.
 - (d) Prophylactic treatment of constipation should be initiated.
 - (e) If partial analgesia is not obtained, opioids should be discontinued.
- (4) On-Going Management. Actions Should Include:
- (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy.
 - (b) The lowest possible dose should be prescribed to improve pain and function.
 - (c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period

since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. (Passik, 2000)

- (d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management.
 - (e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. (Webster, 2008)
 - (f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion).
 - (g) Continuing review of overall situation with regard to nonopioid means of pain control.
 - (h) Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse. (Sullivan, 2006) (Sullivan, 2005) (Wilsey, 2008) (Savage, 2008) (Ballyantyne, 2007)
- (5) Recommended Frequency of Visits While in the Trial Phase (first 6 months):
- (a) Every 2 weeks for the first 2 to 4 months
 - (b) Then at approximate 1 ½ to 2-month intervals

Note: According to the California Medical Board Guidelines for Prescribing Controlled Substances for Pain, patients with pain who are

managed with controlled substances should be seen monthly, quarterly, or semiannually as required by the standard of care. (California, 1994)

- (6) When to Discontinue Opioids: See Opioid hyperalgesia. Also see Weaning of Medications. Prior to discontinuing, it should be determined that the patient has not had treatment failure due to causes that can be corrected such as under-dosing or inappropriate dosing schedule. Weaning should occur under direct ongoing medical supervision as a slow taper except for the below mentioned possible indications for immediate discontinuation. The patient should not be abandoned.
 - (a) If there is no overall improvement in function, unless there are extenuating circumstances
 - (b) Continuing pain with the evidence of intolerable adverse effects; lack of significant benefit (persistent pain and lack of improved function despite high doses of opiates- e.g. > 120 mg/day morphine equivalents)
 - (c) Decrease in functioning
 - (d) Resolution of pain
 - (e) If serious non-adherence is occurring
 - (f) The patient requests discontinuing
 - (g) Immediate discontinuation has been suggested for: evidence of illegal activity including diversion, prescription forgery, or stealing; the patient is involved in a motor vehicle accident and/or arrest related to opioids, illicit drugs and/or alcohol; intentional suicide attempt; aggressive or threatening behavior in the clinic. It is suggested that a patient be given a 30-day supply of medications (to facilitate finding other treatment) or be started on a slow weaning schedule if a decision is made by the physician to terminate prescribing of opioids/controlled substances.
 - (h) Many physicians will allow one “slip” from a medication contract without immediate termination of opioids/controlled substances, with the consequences being a re-discussion of the clinic policy on controlled substances, including the consequences of repeat violations.
 - (i) If there are repeated violations from the medication contract or any other evidence of abuse, addiction, or possible diversion it has been suggested that a patient show evidence of a consult with a physician that is trained in addiction to assess the ongoing situation and recommend possible detoxification. (Weaver, 2002)
 - (j) When the patient is requesting opioid medications for their pain and inconsistencies are identified in the history, presentation, behaviors or physical findings, physicians and surgeons who make a clinical

decision to withhold opioid medications should document the basis for their decision.

- (k) Routine long-term opioid therapy is not recommended, and ODG recommends consideration of a one-month limit on opioids for new chronic non-malignant pain patients in most cases, as there is little research to support use. The research available does not support overall general effectiveness and indicates numerous adverse effects with long-term use. The latter includes the risk of ongoing psychological dependence with difficulty weaning. See Opioids for chronic pain.
 - (7) When to Continue Opioids
 - (a) If the patient has returned to work
 - (b) If the patient has improved functioning and pain
- (Washington, 2002) (Colorado, 2002) (Ontario, 2000) (VA/DoD, 2003) (Maddox-AAPM/APS, 1997) (Wisconsin, 2004) (Warfield, 2004)

The ODG section on OxyContin references the “long-acting” portion of the opiates of the ODG, which is the following:

Not recommended for first-line use for treatment of acute or chronic non-malignant pain. Short-acting opioids are recommended prior to use of long-acting opioids for treatment of chronic pain if all other criteria for use have been met. See Opioids, criteria for use. Use of long-acting opioids is only recommended if there is evidence of improvement in function with use of short-acting opioids. This class of drugs is not recommended for acute pain in opioid-naïve patients or for as-needed pain relief. When specific long-acting opioids are compared it appears that the primary difference between drugs in this class is cost. (Chou, 2003) Also see Opioids for chronic pain, where opioids in general are not recommended as a first-line treatment for chronic non-malignant pain, while immediate-release opioids may be appropriate for short-term use for severe acute pain, not to exceed 2 weeks.

Long-acting opioids: Also known as “controlled-release”, “extended-release” or “sustained-release” these drugs are a highly potent form of opiate analgesic. The proposed advantage of long-acting opioids is that they stabilize medication levels, stabilize pain control, improve sleep, lessen end-of-dose breakthrough pain, lessen risk of addiction, provide around-the-clock analgesia, and improve quality of life.

Long-acting versus short-acting formulations: Pederson, et al. 2014, in a recent qualitative systematic review that identified six randomized controlled trials and evaluated multiple randomized open trials which compared long-acting and short-acting formulations of opioids in populations with osteoarthritis or low-back pain,

the following was found: (1) No study found a significantly different pain score when comparing the long-acting and short-acting groups; (2) No study found a significant difference in the consumption of rescue analgesics; (3) A preliminary non-randomized trial found that pain intensity and duration of breakthrough pain was reduced when patients on short-acting formulations were stabilized on long-acting opioids, but the number of pain episodes remained the same; (4) No study found a difference in global assessment of efficacy between the two groups; (5) No difference in sleep quality was noted between two studies and in a third trial, the group taking the long-acting formulation reported a better quality of sleep at baseline and this was maintained through the trial; (6) Two trials found less nausea in the long-acting group; (7) One study found less depression and confusion in the normal release group; (8) The time until maximum “drug liking” in patients with a history of recreational drug use was longer for the long-acting formulations compared to short-acting, but the same drug-liking effect could be reached if the dosage of the long-acting opioid was increased; (9) All studies found similar effects of short-acting tablets when compared to crushed long-acting formulations. The authors of this review found no evidence to support the recommendation for use of long-acting/controlled-release over short-acting formulations. Numerous limitations were noted, including the paucity of studies with few patients included and moderate-to-low quality of methodology. All trials were of short duration (less than 8 weeks). No trials compared the risk of addiction between long-acting and short-acting agents. These results were similar to 2003 findings that provided evidence that both formulations were equally effective for pain control. No studies have been conducted in patients with neuropathic pain, fibromyalgia, or other unclear painful conditions comparing long-acting to short-acting opioids. (Pederson, 2014) (Chou, 2003) In this study, long-acting opioids are associated with a greater than 2-fold risk for unintentional overdose compared with short-acting formulations, and the risk is more than 5-fold greater in the first 2 weeks of using a long-acting opioid. Only short-acting agents should be used whenever possible, especially during the first 2 weeks of therapy. The best solution is to avoid prescribing opioids entirely for chronic pain because there is no high-quality evidence that they are effective for this indication, and the risk of adverse effects, including death from unintentional overdose, is great. (Miller, 2015)

Drug class review: A drug class review was published in 2011 by the Oregon Health & Science University. These authors found there was no evidence to suggest superior efficacy of long-acting opioids as a class over short-acting opioids. There were three fairly homogenous trials comparing oxycodone long-acting to short-acting and both appeared equally effective for pain control. There was no convincing evidence to suggest lower adverse event rates for long-acting

opioids compared to short-acting. There are no studies comparing rates of addiction or abuse between the two groups. (Carson, 2011)

Long-acting versus long-acting formulations: There is currently insufficient evidence to prove any one long-acting opioid has superior efficacy or safety profile when compared to another drug of this class. (Pederson, 2014) (Chou, 2003) (Carson, 2011) It has been suggested that the major difference between the different long-acting drugs when compared is cost. (Chou, 2003)

Guidelines: The American Society of Interventional Pain Physicians stated in 2012 that there was fair evidence for lack of significant difference in effectiveness of adverse effects between long-acting and short-acting opioids. (Manchikanti, 2012) The American Pain Society-American Academy of Pain Medicine Opioid Guidelines state that there is insufficient evidence to recommend short-acting versus long-acting opioids. They go as far as to say that there is also insufficient evidence to recommend as-needed versus around-the-clock dosing of opioids. (Chou, 2009)

FDA labeling changes: In September 2013 the FDA announced labeling changes to reflect that extended-release and long-acting opioids are no longer indicated for merely moderate pain. Previously, the labels for extended-release/ long-acting (ER/LA) opioid analgesics stated that they were indicated for moderate to severe pain in patients requiring continuous, around-the-clock opioid treatment for an extended period of time. The labels now will state that the drugs are indicated for the management of pain severe enough to require daily, around-the-clock opioid treatment and for which alternative treatments are inadequate. This class of drug is not indicated for as-needed pain relief. The FDA will now require manufacturers to perform more studies and clinical trials to further assess the known risks of misuse, abuse, hyperalgesia, addiction, overdose, and death, as related to the use of this class of drug. The FDA did not take action on dose and duration limits, as had been suggested by stakeholders. (FDA, 2013)

After consideration of the above portions of the ODG, Claimant met his burden of proof on the medication of Oxycontin. Claimant relied on the medical documentation from Dr. DE, his treating doctor. Dr. E's request for this medication was very thorough, and he explained the medical necessity of this medication by explaining the benefits Claimant derived from the medication, the functional benefits maintained on the Oxycontin, the unsuccessful efforts of trying other medications as a substitute and other concerns raised by the ODG. His request was particularized to Claimant's case and supported by his medical records. The IRO doctor stated that the documentation did not show a functional benefit and quantifiable pain relief for Oxycontin. He also stated there was a lack of documentation to know whether diversion was

taking place. However, Claimant's medical records clearly show there was routine drug testing to ensure no diversion was taking place. The records further showed significant improvement while Claimant was taking Oxycontin, and a significant increase in low back pain and deficits in activities of daily living when Dr. E attempted to wean him off the medication. The ODG suggests that Opioids, such as Oxycontin, should be continued if the patient has improved functioning and lessened pain, which was shown throughout Dr. E's records. Dr. E's records showed that the request for Oxycontin was in accordance with the ODG. The preponderance of the evidence is contrary to the opinion of the IRO reviewer regarding the request for Oxycontin 80mg #90.

Concerning the medication on Flexeril, Claimant did not meet his burden. The ODG clearly states this medication is recommended only for a short course of therapy and that the effect of this medication is modest and comes at the price of greater adverse effects. The ODG reflects that treatment should be brief with this medication, and is not recommended for longer than 2-3 weeks. Dr. E's analysis focused on the benefits of Oxycontin, and his analysis regarding Flexeril amounts to a statement that it controls Claimant's back spasms and that it is inexpensive. He did not provide a sufficient justification, based on evidence-based medicine, to justify continuing Flexeril. Dr. E's analysis that this medication controls Claimant's back spasms did not constitute sufficient evidence, based on evidence-based medicine, to overcome the IRO's determination that Claimant is not entitled to this medication, especially given the guidance of the ODG.

At the hearing, the Claimant/Petitioner conceded that he was no longer perusing MS Contin per the letter of Dr. E. Dr. E reflected he was no longer attempting to authorize this medication and there was insufficient evidence to support the medical necessity of it. Therefore, the preponderance of the evidence is not contrary to the decision of the IRO that Claimant/Petitioner is not entitled to MS Contin.

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 (Employer), Employer.
 - C. On (Date of Injury), Employer provided workers' compensation insurance through Protective Insurance Company, Carrier.

- D. On (Date of Injury), Claimant sustained a compensable injury.
2. Carrier/Respondent delivered to Claimant/Petitioner a single document stating the true corporate name of Carrier/Respondent, and the name and street address of Carrier/Respondent's registered agent, which document was admitted into evidence as Hearing Officer's Exhibit Number 2.
 3. Oxycontin 80mg #90 is health care reasonably required for the compensable injury of (Date of Injury).
 4. MS Contin 100mg #90 and Flexeril 10mg #90 are 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 contrary to the decision of the IRO that Claimant is not entitled to Oxycontin 80mg #90.
4. The preponderance of the evidence is not contrary to the decision of the Independent Review Organization (IRO) that the Claimant is not entitled to MS Contin 100mg #90 or Flexeril 10mg #90.

DECISION

Claimant is entitled to Oxycontin 80mg #90. Claimant is not entitled to MS Contin 100mg #90 or Flexeril 10mg #90.

ORDER

Carrier/Respondent is ordered to pay benefits in accordance with this decision, the Texas Workers' Compensation Act, and the Commissioner's Rules.

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

**CT CORPORATION SYSTEM
1999 BRYAN STREET, SUITE 900
DALLAS, TEXAS 75201-3136**

Signed this 21st day of May, 2015.

BRITT CLARK
Hearing Officer