MEDICAL CONTESTED CASE HEARING NO 12041
M5-11-35295-01
M5-11-35294-01
M5-11-35296-01

DECISION AND ORDER

This case is decided pursuant to Chapter 410 of the Texas Workers' Compensation Act and Rules of the Division of Workers' Compensation adopted thereunder.

ISSUES

A contested case hearing was held on November 01, 2011, to decide the following disputed issues:

Regarding Docket No 03275125-06:

1. Is the preponderance of the evidence contrary to the decision of the IRO that the claimant is not entitled to office visits coded 99213 for September 16, 2010 and January 27, 2011, for the compensable injury of (Date of Injury)?

Regarding Docket No 03275125-07:

2. Is the preponderance of the evidence contrary to the decision of the IRO that the claimant is not entitled to office visits for October 25, 2010, and November 08, 2010, for the compensable injury of (Date of Injury)?

Regarding Docket No 03275125-08:

3. Is the preponderance of the evidence contrary to the decision of the IRO that claimant is not entitled to DOS September 01, 2010 and October 13, 2010, the use of pantoprazole sodium; DOS September 07, 2010, the use of hydrocodone; DOS September 07, 2010, the use of ketorolac tromethamine; DOS October 13, 2010, the use of cyclobenzaprine; and DOS October 13, 2010, the use of Oxycontin or oxycodone for the compensable injury of (Date of Injury)?

PARTIES PRESENT

Petitioner/Claimant appeared and was assisted by NW, ombudsman. Respondent/Carrier appeared and was represented by KM, attorney.

BACKGROUND INFORMATION

On (Date of Injury), Claimant sustained an injury to his lumbar spine from repetitive work. He ultimately has had two lumbar surgeries and extensive conservative care including medications, injections, therapies and the PRIDE program. He is currently seeing a pain management doctor and has regular visits to control his pain and keep his medications followed.

Each of the three IRO reports disagree with the requested office visits and medications, except the IRO doctor under Docket No 03275125-08 agrees with the use of Baclofen for muscle spasms caused by Claimant's multiple surgeries. Claimant contends all of the requested office visits and medications were medically necessary given his condition and to control his pain.

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. 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. (Division Rule 133.308 (t).)

Under the Official Disability Guidelines in reference to office visits under the pain section, the following recommendation is made:

> Recommended as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. The ODG Codes for Automated Approval (CAA), designed to automate claims management decision-making, indicates the number of E&M office visits (codes 99201-99285) reflecting the typical number of E&M encounters for a diagnosis, but this is not intended to limit or cap the number of E&M encounters that are medically necessary for a particular patient. Office visits that exceed the number of office visits listed in the CAA may serve as a "flag" to payors for possible evaluation, however, payors should not automatically deny payment for these if preauthorization has not been obtained. *Note:* The high quality medical studies required for treatment guidelines such as ODG provides guidance about specific treatments and diagnostic procedures, but not about the recommended number of E&M office visits. Studies have and are being conducted as to the value of "virtual visits" compared with inpatient visits; however the value of patient/doctor interventions has not been questioned. (Dixon, 2008) (Wallace, 2004) Further, ODG does provide guidance for therapeutic office visits not included among the E&M codes, for example Chiropractic manipulation and Physical/Occupational therapy.

The IRO doctor notes there is no documentation in the Official Disability Guidelines for the use of pantoprazole sodium for the use of chronic pain or depression or opiate dependency. It is used for hyper acidity and reflux.

The Official Disability Guidelines places hydrocodone and Oxycontin under "opioids" and defines them as:

"Hydrocodone/Acetaminophen (Anexsia®, Co-Gesic®, Hycet™; Lorcet®, Lortab®; Margesic-H®, Maxidone™; Norco®, Stagesic®, Vicodin®, Xodol®, Zydone®; generics available): Indicated for moderate to moderately severe pain. Note: there are no FDA-approved hydrocodone products for pain unless formulated as a combination. Side Effects: See opioid adverse effects. Analgesic dose: The usual dose of 5/500mg is 1 or 2 tablets PO every four to six hours as needed for pain (Max 8 tablets/day). For higher doses of hydrocodone (>5mg/tab) and acetaminophen (>500mg/tab) the recommended dose is usually 1 tablet every four to six hours as needed for pain. Hydrocodone has a recommended maximum dose of 60mg/24 hours. The dose is limited by the dosage of acetaminophen, which should not exceed 4g/24 hours.

Oxycodone immediate release (OxyIR® capsule; Roxicodne® tablets; generic available), Oxycodone controlled release (OxyContin®): [Boxed Warning]: Oxycontin® Tablets are a controlled release formulation of oxycodone hydrochloride indicated for the management of moderate to severe pain when a continuous, around-the-clock analgesic is needed for an extended period of time. Oyxcontin tablets are NOT intended for use as a prn analgesic. Side Effects: See opioid adverse effects. Analgesic dose: (Immediate release tablets) 5mg every 6 hours as needed. Controlled release: In opioid naive patients the starting dose is 10mg every 12 hours. Doses should be tailored for each individual patient, factoring in medical condition, the patient's prior opioid exposure, and other analgesics the patient may be taking. See full prescribing information to calculate conversions from other opioids. Note: See manufacturer's special instructions for prescribing doses of over 80mg and 160mg. Dietary caution: patients taking 160mg tablets should be advised to avoid high fat meals due to an increase in peak plasma concentration. (Product information, Purdue Pharma)"

Both of these medications refer the reader to "Opioids" in the Official Disability Guidelines. Below are applicable sections from the ODG for 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? 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. (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 dairy 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.

7) When to Continue Opioids
(a) If the patient has returned to work
(b) If the patient has improved functioning and pain

Under the Official Disability Guidelines in reference to ketorolac tromethamine, the following recommendation is made under the NSAIDs section:

> *Ketorolac (Toradol®, generic available):* 10 mg. [Boxed Warning]: The oral form is only recommended for short-term (up to 5 days) in management of moderately severe acute pain that requires analgesia at the opioid level and only as continuation following IV or IM dosing, if necessary. This medication is not indicated for minor or chronic painful conditions. Increasing doses beyond a daily maximum dose of 40 mg will not provide better efficacy, and will increase the risk of serious side effects. The FDA boxed warning would relegate this drug to second-line use unless there were no safer alternatives. *Dosing: Acute pain (transition from IV or IM) for adults < 65 years of age:* 20mg PO followed by 10mg PO every 4 to 6 hours (max 40 mg/day). An oral formulation should not be given as an initial dose. (Toradol® Package Insert) The FDA has approved a nasal formulation of ketorolac (Sprix) for short-term pain management. (FDA, 2010)

Under the Official Disability Guidelines in reference to cyclobenzaprine, the following recommendation is made under the muscle relaxants section:

> Recommend non-sedating muscle relaxants with caution as a second-line option for short-term 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)

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)

As for the individual office visits, Claimant testified why he went to each visit. Primarily, the visits were done in the process of changing pain management doctors to a doctor closer to his

home. Claimant failed to show by a preponderance of evidence-based medicinal evidence that the requested office visits are health care reasonably required for the compensable injury.

As for the medications other than cyclobenzaprine, Claimant failed to present an evidence-based medical opinion from a competent source to overcome the IRO's decision. Claimant's records, without sufficient reference to the Official Disability Guidelines or other evidence-based medicine justifying departure from the Official Disability Guidelines, do not meet the requisite evidentiary standard required to overcome the IRO. The preponderance of the evidence is not contrary to the IRO decision and the requested medications do not meet the criteria set out in the Official Disability Guidelines.

As for cyclobenzaprine (an anti-spasmodic), the IRO doctor stated it was not medically necessary as the Baclofen (also an anti-spasmodic) -- which he agreed was consistent with the Official Disability Guidelines -- was sufficient for the muscle spasms and that it was not appropriate or necessary when taken in combination with the Baclofen. The IRO doctor stated the use of Baclofen was reasonable in keeping with Claimant's multiple back surgeries and spasms. However, the medications were not taken together. The Baclofen was stopped because it did not agree with Claimant. The doctor switched Claimant to cyclobenzaprine. The Official Disability Guidelines and evidence-based medicine support the use of the cyclobenzaprine.

Even though all the evidence presented was not discussed, it was considered. The Findings of Fact and Conclusions of Law are based on all of the evidence presented.

FINDINGS OF FACT

1. The parties stipulated to the following facts:

   A. Venue is proper in the (City)Field Office of the Texas Department of Insurance, Division of Workers' Compensation.

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

   C. On (Date of Injury), Employer provided workers' compensation insurance with North American Specialty Insurance Company, Carrier.

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

   E. For Docket No 03275125-06, the Independent Review Organization board certified anesthesiology/pain medication M.D. determined Claimant should not have office visits coded 99213 for September 16, 2010, and January 27, 2011.

F. For Docket No 03275125-07, the Independent Review Organization board certified anesthesiologist specializing in pain management determined Claimant should not have office visits for October 25, 2010, and November 08, 2010.

G. For Docket No 03275125-08, the Independent Review Organization board certified psychiatrist and neurology physician determined Claimant should not have DOS September 01, 2010 and October 13, 2010, the use of pantoprazole sodium; DOS September 07, 2010, the use of hydrocodone; DOS September 07, 2010, the use of ketorolac tremethamine; DOS October 13, 2010, cyclobenzaprine; and DOS October 13, 2010, the use of Oxycontin or oxycodone.

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

3. Office visits coded 99213 for September 16, 2010 and January 27, 2011 are not health care reasonably required for the compensable injury of (Date of Injury).

4. Office visits for October 25, 2010, and November 08, 2010, are not health care reasonably required for the compensable injury of (Date of Injury).

5. DOS September 01, 2010 and October 13, 2010, the use of pantoprazole sodium; DOS September 07, 2010, the use of hydrocodone; DOS September 07, 2010, the use of ketorolac tremethamine; and DOS October 13, 2010, the use of Oxycontin or oxycodone are not health care reasonably required for the compensable injury of (Date of Injury).

6. DOS October 13, 2010, cyclobenzaprine is health care reasonably required for the compensable injury of (Date of Injury).

7. The IRO doctor in Docket No. 03275125-08 found that DOS September 13, 2010, the use of Baclofen is 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.

In Docket No. 03275125-06:

3. The preponderance of the evidence is not contrary to the decision of the IRO that office visits coded 99213 for September 16, 2010 and January 27, 2011, are not health care reasonably required for the compensable injury of (Date of Injury).

In Docket No. 03275125-07:

4. The preponderance of the evidence is not contrary to the decision of the IRO that office visits for October 25, 2010, and November 08, 2010, are not health care reasonably required for the compensable injury of (Date of Injury).

In Docket No. 03275125-08:

5. The preponderance of the evidence is not contrary to the decision of the IRO that DOS September 01, 2010 and October 13, 2010, the use of pantoprazole sodium; DOS September 07, 2010, the use of hydrocodone; DOS September 07, 2010, the use of ketorolac tremethamine; and DOS October 13, 2010, the use of Oxycontin or oxycodone are not health care reasonably required for the compensable injury of (Date of Injury).

6. The preponderance of the evidence is contrary to the decision of the IRO that DOS October 13, 2010, cyclobenzaprine is not health care reasonably required for the compensable injury of (Date of Injury).

7. The preponderance of the evidence is not contrary to the decision of the IRO that DOS September 13, 2010, the use of Baclofen is health care reasonably required for the compensable injury of (Date of Injury).

DECISION

In Docket No. 03275125-06:

Claimant is not entitled to office visits coded 99213 for September 16, 2010 and January 27, 2011,

In Docket No. 03275125-07:

Claimant is not entitled to office visits office visits for October 25, 2010, and November 08, 2010,

In Docket No. 03275125-08:

Claimant is not entitled to DOS September 01, 2010 and October 13, 2010, the use of pantoprazole sodium; DOS September 07, 2010, the use of hydrocodone; DOS September 07, 2010, the use of ketorolac tremethamine; and DOS October 13, 2010, the use of Oxycontin or oxycodone for the compensable injury of (Date of Injury).

Claimant is entitled to DOS September 13, 2010, the use of Baclofen, and DOS October 13, 2010, cyclobenzaprine for the compensable injury of (Date of Injury).

ORDER

Carrier is not liable for the benefits at issue in this hearing with the exception Carrier is liable for the Baclofen and cyclobenzaprine 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 **NORTH AMERICAN SPECIALTY INSURANCE COMPANY** and the name and address of its registered agent for service of process is

CT CORPORATION SYSTEM
350 N. ST. PAUL
DALLAS, TX 75201.

Signed this 2nd day of November, 2011.

KEN WROBEL
Hearing Officer