APPEAL NO. 92389

A contested case hearing was convened in (city), Texas on May 19, 1992. On that date the hearing officer, (hearing officer), noted that the respondent (claimant below) had failed to appear. The hearing officer delayed the start of the hearing and attempted unsuccessfully to telephone respondent. An April 2, 1992 certified letter and accompanying green card notifying respondent of the hearing were made part of the record. The hearing was recessed to allow the hearing officer to give respondent additional notice of the hearing, which was continued until June 30, 1992. On June 30th the hearing officer announced he had tried to telephone respondent but was told by the manager of (Apartments) and (Inn) that respondent no longer lived there and that she had no knowledge of his whereabouts. A copy of the May 19th hearing notification letter, along with the actual letter to respondent which had been returned unclaimed, were made part of the record. The hearing officer made the finding that respondent had been given proper notice, and proceeded with the hearing.

The issue from the benefit review conference was whether respondent "had abandoned medical treatment thereby entitling carrier [appellant herein] to terminate Temporary Income Benefits" (TIBs). The respondent did not appear at the benefit review conference. The benefit review officer on March 26, 1992 entered an interlocutory order authorizing "termination of TIBs at this time" and sending the issue forward to a contested case hearing. The hearing officer held that appellant did not comply with the conditions and procedures required by Texas Workers' Compensation Commission (Commission) rule, Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE §130.4, and thus is not entitled to invoke a presumption of maximum medical improvement (MMI). Appellant argues in its request for review that Finding of Fact No. 7 is irrelevant and Conclusion of Law No. 3 is erroneous, and that respondent should be presumed to have reached MMI. No response to the request for review was filed.

DECISION

We reverse the decision of the hearing officer on suspension of temporary income benefits.

Appellant had not contested the compensability of the workers' compensation claim arising out of respondent's (date of injury) injury. Admitted into evidence at the hearing were a number of medical reports from (hospital). An emergency room note dated (date) diagnosed acute back strain, prescribed medication and bed rest and said respondent was asked to follow up and make an appointment with the hospital's Physical Medicine Department for possibility of a work hardening program. Respondent was again seen in the emergency room on December 5th for symptoms stemming from taking more medications than prescribed. On December 10th he was seen by a (Dr. W) in the hospital's Department of Community and Internal Medicine. Neurologic examination was found to be within normal limits and it was felt respondent probably had chronic low back strain. A December 12th examination report signed by (Dr. VW) indicated chronic, recurrent low back

pain, likely on a musculoskeletal or myofascial basis, and said "[a] trial of a more aggressive, conservative therapy program appears appropriate." Dr. VW recommended continuing with anti-inflammatory medications, referral to physical and occupational therapy with later advancement to work hardening, and a recheck in two weeks. Notes from occupational therapy and physical therapy sessions from December 19th and 20th, respectively, were included. The physical therapy report said, "[w]ill discuss progress in the pain conference on a weekly basis." In an Initial Medical Report (TWCC-61) dated January 23, 1992, Dr. VW stated in response to "Prognosis:" "[u]nknown. Patient did not show for scheduled appointments." Outpatient notes signed by Dr. VW stated as follows: "PT: came for initial eval, but did not return for scheduled appointments. OT: as above. Summary-No show for scheduled appointments."

Also made part of the record was appellant's undated request to set a benefit review conference which was on a Commission form. In describing the disputed issues requiring a benefit review conference, the appellant said that Dr. VW, respondent's treating physician, recommended a course of physical therapy leading into a work hardening program. Appellant maintained the respondent voluntarily terminated his treatment on or about December 27, 1991 and disregarded the recommendation of the treating doctor for a course of treatment necessary to cure and relieve the effects of the injury. Appellant further contended that the respondent did not have medical documentation to support his lost time claim. Appellant purported to attach (although it was not made a part of this record) a medical narrative from the hospital's psychiatric day treatment program dated January 14, 1992, which stated a diagnosis of major depression; therefore, appellant alleged that the respondent's disability is associated with daily living and not related to his employment. Appellant concluded by asking for an expedited benefit review conference to suspend weekly benefits.

Appellant contests Finding of Fact No. 7 and Conclusion of Law No. 3, which state as follows:

Finding 7: [Appellant] did not notify the Texas Workers' Compensation Commission in writing, and request a medical status report letter be sent by the Texas Workers' Compensation Commission to [respondent's] treating doctor before invoking the presumption [respondent] had reached maximum medical improvement.

Conclusion 3: [Appellant] is not entitled to invoke the presumption that [respondent] has reached maximum medical improvement because [respondent] did not comply with the conditions and procedures required by the Texas Workers' Compensation Commission Rule 130.4.

Appellant says Conclusion of Law No. 3 erroneously concludes that Rule 130.4 requires a carrier to request a medical status report letter; it contends that subsection (e) of the rule provides merely that the carrier may notify the Commission in writing and request

that a medical status letter be sent to the treating doctor.

The 1989 Act provides that TIBs shall be paid so long as an employee has disability, and that they continue until maximum medical improvement (MMI) is reached. Article 8308-4.23(a), (b). It also provides that the Commission shall adopt rules establishing a presumption that MMI has been reached based on a lack of medical improvement in the employee's condition. Article 8308-4.23(g). Pursuant to the Commission's rule, TIBs may be suspended by interlocutory order of a benefit review officer under certain circumstances; one of these is if the employee has missed two or more consecutively scheduled health care appointments or has otherwise abandoned treatment without good cause (hereinafter referred to as abandonment of treatment). Rule 130.4.

Despite the statutory language and the title of the rule ("Presumption that Maximum Medical Improvement has been Reached and Resolution when MMI has not been Certified"), MMI is not presumed but is rather established through a procedure that ultimately will result in a doctor's certification.[1] Thus, to the extent the hearing officer's findings and conclusions speak of invoking a presumption of MMI, they do not correctly reflect the rule's provisions. Apparent abandonment of treatment will, however, allow a benefit review officer to enter an interlocutory order suspending TIBs pending resolution of the ultimate issue of MMI. Thus, the issue in this case is not whether MMI has been reached or whether it may be presumed. Rather, the issue is whether the rule's threshold procedural requirements existed to allow a benefit review officer to issue an interlocutory order in this case based on abandonment of treatment, and if not, whether those procedures are exclusive.

Rule 130.4 says that a carrier that identifies an employee's apparent lack of medical improvement or an apparent failure to attend health care appointments may notify the Commission in writing and request that a medical status request letter be sent by the Commission to the treating doctor. No later than five days from the carrier's request, the Commission is required to send the treating doctor a medical evaluation report form (Form TWCC-69, which includes questions on MMI and impairment) along with the medical status request letter. The letter must notify the doctor of the 1989 Act's requirements concerning MMI, and shall ask the treating doctor whether the employee has reached MMI and whether the employee has failed to attend two or more consecutively scheduled health care appointments, and the dates of the missed appointments. The treating doctor must respond within seven days of receipt of the Commission's request; if he fails to respond timely or if he certifies that the employee has not reached MMI, the carrier may then request a benefit review conference. The carrier's request for a benefit review conference must include either a request for a required medical examination as provided by the 1989 Act, Article

[1]The only true presumption of MMI occurs upon the expiration of 104 weeks from the date TIBs began to accrue, which was not the case here. *See* Article 8308-1.03(32); Rule 130.4(a)

8308-4.16, or a request that a designated doctor be appointed by the Commission if an agreement with the employee is not reached. The Commission must order the required medical examination or direct an examination by a designated doctor concurrent with the scheduling of an expedited benefit review conference. The rule provides contingencies for various circumstances not relevant to the present case, including where a doctor certifies that MMI has or has not been reached, and where there is a disputed determination. However, it provides that the benefit review officer shall enter an interlocutory order directing the carrier to suspend TIBs, and begin payment of impairment income benefits, if any, if the benefit review officer's recommendations state that:

1.the determination of the designated doctor has not been clearly and convincingly rebutted by information, statement, or medical reports; or

2.there has been a lack of improvement in the employee's medical condition, the certification of MMI by the doctor requested under §4.16 is disputed, and a designated doctor is directed to resolve the dispute; or

3.the employee has missed two or more consecutively scheduled health care appointments or has otherwise abandoned treatment without good cause.

We read the above rule to allow a carrier which has identified an apparent abandonment of treatment to initiate the process contained therein. In order to establish a presumption of abandonment sufficient to suspend TIBs under this rule, the rule requires that the treating doctor's confirmation of the missed medical appointments must be sought; furthermore, the Commission and not the carrier must establish the contact with the treating doctor. This is not an onerous requirement upon a carrier; indeed, if the treating doctor fails to respond within seven days the carrier can proceed to a benefit review conference and, in the absence of an employee's showing of good cause, is entitled to suspension of TIBs during the period of time the issue of MMI is being resolved, provided that abandonment of treatment without good cause is shown. The evidence in this case shows that the appellant filed a written request for a benefit review conference based on its having identified an apparent failure of respondent to attend at least two consecutively scheduled health care appointments. The appellant did not specifically request the Commission to send the treating doctor a medical status request letter or otherwise initiate the process contained in Rule 130.4

While the appellant clearly did not follow the procedures of Rule 130.4, we do not find that those procedures are exclusive. Rule 130.4 says a carrier "may" follow the procedure of the rule and "may" notify the Commission to request a medical status letter be sent to the treating doctor. While permissive words may be given a mandatory significance in order to effectuate legislative intent American Mortgage Corporation v. Samuell, 108 S.W.2d 193 (Tex. 1937), the fact that Rule 130.4 also provides that the Commission, the carrier, or the doctor "shall" take certain stated actions indicates that the drafters meant to

distinguish between actions that "shall" or "may" be taken. The broad powers of the benefit review officer, which include mediating and resolving disputed issues before him, and entering interlocutory orders recommending that benefits be paid, or not be paid, Article 8308-6.15, is cumulative of the procedures contained in Rule 130.4. The benefit review officer in this case at a duly convened benefit review conference had before him an articulated issue which was appropriate to mediation and resolution in an informal dispute resolution setting. Further, he had evidence that an apparent treating doctor had noted missed medical appointments after the initial consultation, and in the absence of a respondent to present any controverting evidence or any showing of good cause, he was entitled to enter an interlocutory order as he did. We therefore reverse the hearing officer's decision that appellant is not entitled to suspend respondent's temporary income benefits.

We wish to emphasize with this opinion our recognition that the process outlined by Rule 130.4 is designed to move a claimant out of TIBs and into IIBs under certain stated conditions. We also recognize that medical involvement in this process is crucial in certifying MMI and assigning impairment, and that abandonment of medical treatment standing alone cannot dispose of this issue. For that reason the parties, or the Commission on its own motion, will have to take whatever steps are appropriate to move this dispute to its ultimate conclusion. While we do not hold that the procedures of Rule 130.4 are exclusive, we do not mean, by this ruling, to diminish the significance of those procedures, and we emphasize, once again, the time, effort and expense that can be saved by following procedures set forth in Commission rules.

The hearing officer's decision is reversed and the benefit review officer's order suspending TIBs is reinstated.

_____

Lynda H. Nesenholtz
Appeals Judge

CONCUR:

_____

Stark O. Sanders, Jr.
Chief Appeals Judge

CONCURRING OPINION

I concur in the result and in the analysis of Rule 130.4, insofar as the analysis recognizes that Rule 130.4 provides for suspension of TIBs based on abandonment of treatment without good cause, and that MMI under that rule is not really presumed, but rather requires the carrier to follow the procedures outlined in the rule ultimately resulting in a doctor's certification of MMI. However, I believe that the decision would be better grounded on a determination that Dr. VW's initial medical report to the Commission stating that "Patient did not show for scheduled appointments," together with her outpatient notes indicating that respondent did not return for scheduled appointments after his initial evaluation, constitute, under the circumstances presented in this case, the response from the treating doctor concerning missed health care appointments contemplated in Rule 130.4(f), especially in the absence of any evidence to the contrary. Thus, using Dr. VW's reports, the benefit review officer could properly conclude that respondent abandoned treatment without good cause and suspend TIBs under Rule 130.4(n)(3) while the carrier proceeds under Rule 130.4 to obtain the treating doctor's opinion on MMI and to have an MEO doctor under Article 8308-4.16, or a designated doctor give an MMI certification.

_____

Robert W. Potts
Appeals Judge