APPEAL NO. 92456

A contested case hearing was held in (city), Texas on June 26, 1992, before (hearing officer), hearing officer. A prehearing conference had been held on June 17th. At a May 1st benefit review conference, the benefit review officer concluded that the claimant (appellant herein) had abandoned medical treatment and accordingly entered an interlocutory order suspending payment of temporary income benefits (TIBs). The hearing officer addressed the following issues: (1) is appellant eligible for TIBs after May 1, 1992, in that she should not be presumed to have reached Maximum Medical Improvement (MMI), and (2) should the interlocutory order of May 1, 1992 suspending TIBs be reversed or modified.

The hearing officer basically held that the facts supported respondent's invoking the procedures of the Texas Workers' Compensation Commission (Commission) rule on presumption of MMI, Tex. Workers' Comp. Comm'n, 28 TEX. ADMIN CODE §130.4 (Rule 130.4); that, because of certain facts, portions of that rule did not apply; that appellant has otherwise abandoned medical treatment within the meaning of Rule 130.4, and is presumed to have reached MMI for lack of medical improvement within the meaning of Article 8308-4.23(g). The hearing officer thus held that appellant is not eligible for TIBs, nor is the respondent liable for TIBs, until appellant overcomes the presumption of MMI and establishes that she is eligible for TIBs under Article 8308-4.23. The hearing officer's decision supersedes the May 1, 1992 interlocutory order of the benefit review officer.

Appellant filed a Motion for Stay Pending Challenge to Jurisdiction and Pending Challenge to the Hearing Officer's Findings of Fact Incorporated With Appellant's Request for Appeals Panel Review. The motion for stay has been denied, Texas Workers' Compensation Commission Appeal No. 92004 (Docket No. redacted), decided September 9, 1992.

Appellant otherwise challenges the hearing officer's decision in several regards; because the pleading is quite lengthy these will be summarized briefly and in consolidated form: the decision and order was filed more than 30 days after the close of the hearing and thus was not timely filed; the findings of fact are insufficient to prove that appellant has reached MMI; the entire decision and order is not supported by law, and falls within apparent exceptions to Commission rules which have not been published; the order violates Article 8308-3.01(a), which says an insurance carrier is liable for compensation, and nothing shows that respondent contested liability; the order fails to give appellant notice of how she can overcome the presumption she has reached MMI; the hearing officer did not determine, when suspending TIBs, whether impairment income benefits (IIBs) were due, in accordance with law. Nearly every ground for review contained in the request alleged a violation of due process or other Constitutional right. We have held that this panel is not the proper forum to adjudicate Constitutional questions. *See* Texas Workers' Compensation Commission Appeal No. 92391 (Docket No. redacted), decided September 16, 1992. For each such allegation, we will presume appellant is asking that we determine whether sufficient evidence underlies the hearing officer's decision, and whether the law and rules were

properly applied. Respondent basically replies that the record provides evidence that appellant abandoned medical treatment and is presumed to have reached MMI for lack of medical improvement.

DECISION

We affirm the decision and order of the hearing officer. However, we reform certain language to provide a more accurate statement.

Appellant suffered a back injury in a fall on (date of injury), while employed by (employer). Respondent, employer's workers' compensation insurance carrier, did not contest liability for the injury. The parties to the case stipulated that (Dr. B) was appellant's treating doctor.

(Ms. P), a licensed adjuster who handled appellant's claim on respondent's behalf, testified that in reviewing appellant's file, she noticed that appellant had not seen Dr. B since September 17th. She sent a note to appellant on November 25th, enclosing a copy of Article 8308-4.16 (Required Medical Examinations) and asking whether appellant would agree to an independent medical examination. On December 20th Ms. P wrote Dr. B, stating that it appeared appellant had reached MMI and asking Dr. B to assign an impairment rating. A January 3, 1992 letter to Ms. P from Dr. B assigned a "10% whole body partial permanent physical impairment based on the American Academy of Orthopaedic Surgeons Guide for Physical Impairment." The letter contained no reference to MMI. On December 23rd, Ms. P notified appellant by letter of an appointment with (Dr. L) on January 14, 1992 at 8 a.m. On January 9th Ms. P wrote appellant, enclosing the December 20th letter to Dr. B and his January 3rd response. The letter reminded appellant of the January 14th appointment with Dr. L. Ms. P also informed appellant that pursuant to Article 8308-4.26(e) (which provides that an insurance carrier shall begin to pay IIBs not later than the fifth day after the date on which the carrier receives the doctor's report certifying MMI), respondent had initiated IIBs.

On January 13th, at respondent's request, a Commission disability determination officer wrote Dr. B, requesting that he complete a Form TWCC-69 (Report of Medical Evaluation), certifying whether appellant had reached MMI and assigning an impairment rating. The record below does not show that Dr. B completed any Form TWCC-69.

On January 14th, Dr. L informed Ms. P that appellant failed to keep her appointment. The next day, Ms. P by letter notified appellant of another appointment with Dr. L, this one for January 29th at 8 a.m. Appellant testified she never received this letter, although she said she uses the post office box given in the letter. She also testified that she found out about the January 14th appointment "about one day prior" to the appointment, and that she verbally informed Ms. P she could not attend. Ms. P stated, in response to a question by appellant, that she started sending correspondence and checks to appellant's post office box, rather than her street address, after appellant claimed she had problems receiving mail at the street address; however, Ms. P did not remember when the change occurred.

On January 22nd appellant wrote Ms. P, objecting to the contention that she had reached MMI and requesting reinstatement of TIBs. She also stated she was opposed to seeing Dr. L, based on her understanding that the carrier and the claimant were to agree on another doctor if impairment was disputed. She did not attend any appointments with Dr. L. On January 21, 1992, Dr. B wrote Ms. P as follows:

> My last letter dated January 3, 1992, was a response to your request for an impairment rating on the above noted patient. No where (sic) in that dictation nor in my office dictation have I ever stated that [appellant] has reached [MMI] or that she is released from my care or that she is released back to her previous employment. Indeed, [appellant] has a herniated disc in her lower lumbar spine and continues to have quite a lot of pain from this and is not expected to reach [MMI] for some time. She may in fact require a surgical procedure in order to fix this problem.

On January 30th appellant wrote Ms. P claiming, among other things, that she was not consulted before the appointments were set. She also stated she would never be able to come to an 8 a.m. appointment.

A benefit review conference was held at appellant's request on February 4, 1992. That conference resulted in a signed agreement between the parties wherein appellant agreed to an independent medical examination with Dr. L, and the respondent agreed to reinstate TIBs retroactive to January 3rd. Because of the agreement between the parties, the benefit review officer withdrew the order she had signed requiring a medical examination. On February 6th and 10th, Ms. P notified appellant of a February 25th appointment with Dr. L, and of the fact that Dr. L only scheduled independent medical examinations at 8 a.m. On February 18th respondent notified appellant of a rescheduled appointment with (Dr. M) on February 27, 1992. (Ms. P testified that, at the benefit review officer's request, respondent changed doctors to accommodate appellant.) There was a delay in appellant's being seen by Dr. M because her medical records had not been delivered. Because she said she could not stay past 5 p.m., she left without being examined by Dr. M. A sworn statement of Dr. M's secretary/receptionist says that on February 27th Ms. P was contacted to send the records by messenger, and that appellant was at no time told that Dr. M would not be able to see her. Appellant was never examined by Dr. M.

A rehabilitation nurse hired by respondent, (Ms. K) wrote appellant on February 10th and enclosed a prescription for a work hardening program prescribed by Dr. B. on February 3rd. (This prescription was the result of a meeting arranged by Ms. P between Ms. K's employer, (GRS), and Dr. B.) Appellant was notified by certified mail at both her street address and post office address of scheduled appointments at (Hospital), although the certified letter sent to the post office box was returned unclaimed. Appellant testified that she received the letter from Ms. K but not the prescription. However, appellant did not

attend either of the appointments with two doctors for work hardening sessions which had been scheduled because, she said she did not believe the program had been prescribed for her by Dr. B and because she did not know why Ms. K was involved in her case.

Appellant testified that she did not see Dr. B between September 1991 and January 1992 because medicine he had prescribed inflamed her stomach lining, and Dr. B's office referred her to (Dr. E) for treatment of esophagitis. She also said that during that period she was to have made a decision whether to have back surgery. She said she told Dr. B sometime around February that she had decided not to have surgery, and that he replied that she could "sit back and just watch and see what my back would do."

A second benefit review conference was held at respondent's request, on May 1, 1992. The respondent based its March 10th request for the conference on the following: failure of appellant to attend appointment with agreed upon doctor without good cause; failure to reschedule appointment within seven days; failure to attend health care treatment prescribed by treating physician; failure to attend two or more scheduled health care appointments. Ms. P stated that the respondent did not at that time request that the Commission issue a medical examination order because the parties had mutually agreed to such an examination at the first benefit review conference. She also said no designated doctor was requested because, at that point, respondent had still been unable to get an opinion from its doctor, hence there was no dispute for a designated doctor to resolve. The benefit review officer recommended that appellant be presumed to have reached MMI, based on her failure to seek medical treatment since January 17, 1992, and her failure to attend prescribed work hardening sessions nor to consult her doctor about them. The benefit review officer also noted appellant's failure to attend three scheduled medical examination appointments in January and February. The benefit review officer accordingly issued an order suspending TIBs effective May 1, 1992.

A May 28, 1992 letter from Dr. B to Ms. P states as follows:

> I have learned from you that [appellant] never went through the work hardening program as was prescribed on February 3, 1992. I really have nothing further to offer this patient other than referral to the work hardening program and am enclosing another prescription that will be sent to [appellant] for her to be evaluated and treated . . . I do not feel she will have reached [MMI] until she has completed the work hardening program. Based on the AMA Guide to Evaluation of Permanent Impairment, Third Edition, I would rate her as having a 7% impairment to the whole person based on this injury once she has completed the work hardening program. I am referring her to . . . the Memorial Southwest Hospital, Rehabilitation Dept., and do not need to see her for another evaluation.

Dr. B's answers to a deposition on written questions which were made part of the record also stated that appellant would reach MMI once she has completed a work

hardening program. He stated that he had spoken to appellant on May 29, 1992, but had not seen her since January 17th. He said that she cancelled an appointment with him on June 2nd.

At the outset, we address appellant's Objection to Issue for Contested Case Hearing of June 25, 1992 Incorporated With Motion for Restatement of Issue, which was presented at the hearing below and made a part of the record. Essentially, appellant argues that respondent, at the second benefit review conference, failed to follow the procedures contained in Rule 130.4, and that the issue at the contested case hearing should be changed as follows: [i]s [appellant] eligible for TIBs after May 1, 1992 in that she had not reached MMI. The 1989 Act provides that a contested case hearing is limited to the disputed issues from the benefit review conference, unless additional issues are added by agreement of the parties or upon a finding of good cause by the hearing officer. Article 8308-6.31(a). A June 17, 1992 order from the prehearing conference states that the parties agreed to the two issues as stated in his decision. The hearing officer refused to find good cause to add the issue of whether IIBs should be paid appellant based on a 10% impairment rating. We find no abuse of discretion in that decision.

With regard to appellant's claim that the hearing officer's decision was not timely filed, we note that the record shows that, following the hearing on June 26th, the hearing officer issued his decision on July 23rd and it was transmitted to the parties on July 31st. Article 8308-6.34(g) provides in part that the Commission shall by rule prescribe the times within which the hearing officer shall file decisions with the Commission, and that the Commission shall send a copy of the decision to each party. Rule 142.16 provides that no later than the tenth day after the close of the hearing, the hearing officer shall file all decision with the Commission Division of Hearings and Review, which shall mail or deliver the decision to the parties no later than seven days after the decision was filed.

As the Texas Supreme Court has said:

there is no absolute test by which it may be determined whether an agency rule or regulation is mandatory or directory . . . Provisions which do not go to the essence of the act to be performed, but which are for the purpose of promoting the proper, orderly, and prompt conduct of business, are not ordinarily regarded as mandatory. If the provision directed doing of a thing in a certain time without any negative words restating it afterwards, the provision as to time is usually directory.

Lewis v. Jacksonville Building and Loan Association, 540 S.W.2d 307 (Tex. 1976). We find the time limits contained in Commission rule fall within the above test, and thus are not mandatory. Because of this, the order is not void for failure to issue it in 30 days.

Turning to the merits, the 1989 Act provides that TIBS shall be paid so long as an employee has disability, and that they continue until MMI is reached. Article 8308-4.23(a)

and (b). (Disability, defined in Article 8308-1.02(b) as the inability to obtain and retain employment at wages equivalent to the preinjury wage because of a compensable injury, was not made an issue in this case, and no evidence was adduced.) The Act also requires the Commission to 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). The rule adopted by the Commission, Rule 130.4, states that if no doctor has certified that an injured employee has reached MMI, an insurance carrier may follow the procedure outlined in the rule to resolve whether the employee has reached MMI. The rule says the carrier shall presume, only to invoke this procedure, that an employee has reached MMI, if:

1. the compensable injury is not an occupational disease other than a repetitive trauma injury;

2. the treating doctor has examined the employee at least twice for the same compensable injury;

3. the number of days between the two of the examinations is greater than 60 (with certain stated exceptions not relevant here);

4. the two examinations were held after the date on which TIBs began to accrue; and

5. the treating doctor's medical reports, as filed with the insurance carrier for all examinations and reports conducted after the first of the two examinations indicate a lack of medical improvement in the employee's condition from the first of the two examinations. Rule 130.4(b).

The insurance carrier may also follow the rule's procedures if it appears that the employee has failed to attend two or more consecutively scheduled health care appointments. Rule 130.4(c).

The hearing officer concluded that the prerequisites for invoking the procedures of Rule 130.4(b) were met in this case. He also held that physical rehabilitation to be provided by the work hardening program constituted "health care" within the meaning of Article 8308-1.03(20), so that the requirements of Rule 130.4(c) were met (Conclusions of Law Nos. 6 and 7). Upon our review of the record in this case, we find that sufficient evidence existed to support these conclusions.

The hearing officer next addressed whether the procedures of Rule 130.4 itself were met. Rule 130.4(e) provides that an insurance carrier that identifies an apparent lack of medical improvement (as set forth in subsection (b) of the rule) or an apparent failure to attend health care appointments by an employee may notify the Commission in writing, and request that a medical status request letter be sent by the Commission to the treating doctor. Rule 130.4(f) says that the Commission shall send a Form TWCC-69, along with a medical status request letter, to the treating doctor and shall ask the doctor whether the employee

has reached MMI and whether he or she has failed to attend two or more consecutively scheduled health care appointments, and the dates of same. As stated above, a letter complying with this rule was sent to Dr. B by the Commission on January 13, 1992. Rule 130.4(g) requires the treating doctor to complete the form no later than seven days after receipt, but Rule 130.4(h) provides that if the treating doctor fails to respond, or certifies that the employee has not reached MMI, the carrier may request a benefit review conference on the ground of apparent lack of improvement in medical condition or failure to attend health care appointments. The hearing officer concluded that the facts of the case demonstrate that the procedural requirements of Rule 130.4(f),(g), and (h) were met and the respondent's request for the second benefit review conference was proper (Conclusion of Law No. 8).

Rule 130.4(i) provides that the insurance carrier shall include with its request for a benefit review conference either a request for a required medical examination as provided by Article 8308-4.16, or a request for a designated doctor to be appointed by the Commission. Rule 130.4(k) says that the Commission shall order the requested medical examination or direct an examination by a designated doctor, concurrent with the scheduling of an expedited benefit review conference. No such request was made by respondent, nor did the benefit review officer order any medical examination be made. The hearing officer concluded, however, that because the parties had agreed on an independent medical examination on or about December 23, 1991, and because the parties on February 4, 1992 entered into an agreement for an independent medical examination as part of a benefit review conference, which agreement had not been fulfilled by appellant, the respondent need not submit another request for a required medical examination order along with its request for a benefit review conference as a procedural prerequisite for the conference (Conclusion of Law No. 9). He also held that because the parties had agreed to a medical examination pursuant to Article 8308-4.16 at a prior benefit review conference, and because the Commission had previously ordered an independent medical examination but canceled its order because of the parties' agreement, the Commission did not need to enter a further order to meet the requirements of Rule 130.4(k), citing Rule 126.6 (Conclusion of Law No. 10).

Rule 130.4(l) says the benefit review conference may be cancelled by the Commission, without prejudice, if the examining doctor ordered under subsection (i) certifies that the employee has not reached MMI, or by agreement of the parties, when a designated doctor certifies that the employee has reached MMI and assigns an impairment rating. The hearing officer held that this section does not apply under the facts of this case (Conclusion of Law No. 11).

Rule 130.4(m) says if a benefit review conference is held and there is no signed settlement or agreement on the dispute on MMI, the benefit review officer shall presume that the finding of a designated doctor is correct, unless there is information, statements, or medical reports that clearly and convincingly rebut a determination of MMI. The rule further says that if a doctor ordered pursuant to Article 8308-4.16 finds that MMI has been reached and this finding is disputed, the benefit review officer shall direct an examination by a

designated doctor. The hearing officer held that because there was no signed agreement of the parties on MMI and no designated doctor appointed, the benefit review officer was not required to direct an examination of appellant by a designated doctor pursuant to this section (Conclusion of Law No. 12).

Finally, Rule 130.4(n) says the benefit review officer shall enter an interlocutory order directing the insurance carrier to suspend TIBS and begin payment of IIBs, 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 Article 8308-4.16 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.

The hearing officer concluded that because the benefit review officer could have found that appellant had not gone to work hardening on two occasions, without good cause, and that she failed to keep at least one medical examination without good cause, the benefit review officer could recommend that appellant abandoned medical treatment without good cause, within the meaning of Rule 130.4(n), and was specifically authorized to enter an interlocutory order under that rule and under Article 8308-6.15(e) (Conclusion of Law No. 13). He also held that because appellant knowingly did not see her treating doctor from September 17, 1991 through January 17, 1992; knew of her treating doctor's prescription for work hardening and did not attend such work hardening; did not seek other medical attention for her injury from September 17, 1991 through May 10, 1992; and did not attend any appointment with any independent medical examination doctor at any time, and did so with the intention not to have any medical examination; and, knowing the consequences of failure to seek medical attention appellant has otherwise abandoned medical attention within the meaning of Rule 130.4 and is presumed to have reached MMI for lack of medical improvement within the meaning of Article 8308-4.23(g) (Conclusion of Law No. 14).

In Conclusion of Law No. 16, the hearing officer said that because appellant is presumed to have reached MMI under Article 8308-4.23(g), she is no longer eligible for TIBs under Article 8308-3.01.

The Decision and Order of the hearing officer were as follows:

DECISION

[Appellant] is presumed to have reached maximum medical improvement for lack of medical improvement under Rule 130.4 and Article 8308-4.23(g). [Appellant] is therefore not eligible for temporary income benefits until she overcomes the presumption of maximum medical improvement and establishes that she is eligible for temporary income benefits under Article 8308-4.23. The carrier is not liable for temporary income benefits until such time as [appellant] overcomes the presumption of reaching maximum medical improvement and establishes that she is eligible for temporary income benefits under Article 8308-4.23. This decision neither reverses nor modifies the 1 May 1991 interlocutory order but supersedes it.

ORDER

The carrier is not liable for temporary income benefits until such time as [appellant] overcomes the presumption that she has reached maximum medical improvement and establishes that she is eligible for temporary income benefits under Article 8308-4.23. The carrier is ordered to pay benefits to [appellant] in accordance with this decision, the Act, and the implementing Rules.

The record below reveals the respondent's good faith quest to determine the medical status of appellant, a quest which, it appears, was consistently blocked. In its effort to determine whether appellant had reached MMI, respondent utilized procedures other than, and in addition to, those contained in Rule 130.4. We have previously held that the provisions of that rule are not exclusive. *See* Texas Workers' Compensation Commission Appeal No. 92389 (Docket No. redacted), decided September 16, 1992. Nor was the respondent prevented from acting, as appellant suggests, because it had not contested compensability. At the outset, respondent sought appellant's agreement to being examined by respondent's choice of doctor pursuant to Article 8308-4.16, which says the Commission may require an employee to submit to medical examinations to resolve any question (including MMI), following the insurance carrier's attempt to receive concurrence from the employee. In order to determine whether a dispute existed over MMI, respondent also contacted appellant's treating doctor, who on January 3rd gave her an impairment rating not based on the statutorily required version of the American Medical Association Guidelines (*see* Article 8308-4.24), and did not certify MMI. Respondent then asked the Commission to send Dr. B a medical status letter, as is contemplated by Rule 130.4. Dr. B did not respond to the Commission.

The issue of MMI was obviously before the benefit review officer at the first benefit review conference, as a medical examination order was entered pursuant to Article 8308-4.16 and Rule 126.6. The order was withdrawn only because the parties had entered into a written agreement for a medical examination. Rule 126.6(a) provides that such an agreement has the same effect as a formal order of the Commission. Article 8308-6.15(c) provides that a benefit review conference agreement signed by an unrepresented claimant

is binding on him or her "through the final conclusions of all matters relating to the claim while the claim is pending before the Commission, unless the Commission for good cause shall relieve the claimant of the effect of such agreement." The record does not show that this agreement has ever been set aside. Appellant also refused to attend work hardening sessions prescribed by Dr. B, even though the evidence showed she received notice of them. These sessions are encompassed within the Act's definition of "health care," Article 8308-1.03(20). As the evidence shows, these sessions were more than just missed health care appointments for purposes of presumption of MMI; according to Dr. B, they were the key to appellant's reaching MMI.

What this case demonstrates is veritable gridlock on respondent's attempts to have MMI certified. We agree with the hearing officer that the facts of the case show that the requirements of Rule 130.4 were met, to allow the suspension of TIBs under that rule.

However, we disagree with the language in the hearing officer's Decision and in Conclusions of Law No. 14 and 16, that appellant is "presumed to have reached MMI," in the absence of a doctor's certification or the expiration of 104 weeks. As we have previously held, the only true presumption of MMI occurs at the expiration of 104 weeks from the date TIBs first began to accrue. Article 8308-1.03(32); Rule 130.4(a). MMI otherwise is never presumed, but is established through a doctor's certification. *See* Texas Workers' Compensation Commission Appeal No. 92389, *supra*. Rule 130.4 states that a carrier may "presume" MMI only if facts exist to invoke the rules procedure; those facts were found to exist in this case.

A reading of the hearing officer's Decision indicates, however, that he did not intend the effect that his language might otherwise indicate. A claimant either has reached MMI or has not; once that determination has been made TIBs would cease entirely. The hearing officer's Decision clearly says that the ordered suspension of TIBs could be lifted at a future date if appellant can demonstrate eligibility. We therefore reform the hearing officer's Decision and Order to clarify that, pursuant to the procedures of Rule 130.4, appellant has been found to have abandoned medical treatment without good cause, thus justifying suspension of TIBs. We also note our concern with references to "benefit review conference" or "benefit review officer" in Conclusions of Law Nos. 11, 12, and 13, in that these could imply that the hearing officer was reviewing the benefit review officer's decision rather than deciding the case before him on its own merit. We would thus reform Conclusions 11 and 12 to refer to "Commission," and would disregard No. 13 as superfluous. We otherwise are in agreement with the hearing officer's decision, and uphold the suspension of TIBs.

Finally, appellant says the hearing officer failed to determine whether IIBs were due, and the order fails to give her notice of how she can overcome the presumption of MMI. As stated earlier, we uphold the hearing officer's refusal not to add the issue of impairment. Furthermore, we note that nothing in the record would have allowed the hearing officer to order that IIBs be paid. Article 8308-4.26(a) provides that awards of impairment benefits

shall be based on a rating using the edition of the AMA Guides referenced in Article 8308-4.24. As a matter of law, Dr. B's January 3rd impairment rating, which was based on a totally different document, would not qualify. Dr. B gave a seven percent impairment rating on May 28th, contingent upon appellant completing the work hardening program. He also did not certify MMI. Article 8308-4.26(c) and (d) provide that entitlement to IIBs does not begin until after MMI has been certified.

This case demonstrates the necessity of a claimant's compliance with medical review in the course of a workers' compensation case. Appellant appears to have thwarted all efforts of respondent to determine whether she had reached MMI, or indeed even whether a dispute existed. Moreover, appellant's refusal to attend work hardening sessions prevented her own doctor from evaluating her medical condition. As we have stated earlier, the effect of the hearing officer's order is only to suspend TIBs pending appellant's return to health care treatment and resolution of the issue of MMI. It is then up to the parties to move this case to the next level of determination--the appellant by voluntarily complying with her own doctor's orders and the written agreement for medical examinations, or the respondent by such means provided by statute and rule.

We reform the decision of the hearing officer, as stated herein, and affirm.

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Lynda H. Nesenholtz
Appeals Judge

CONCUR:

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Joe Sebesta
Appeals Judge

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Susan M. Kelley
Appeals Judge