Claims Resolution

11.4.4.9(A)(10)(c) The rule as written contravenes governing case law and should be amended to reflect the correct statement of the law. *See Castillo v. Northwest Transport Service*, 1991-NMCA-077, 113 N.M. 119, 823 P.2d 919. Furthermore, the rejection of pleadings over small and seemingly unimportant deficiencies is an ongoing problem. As a matter of policy, the Clerk should accept pleadings with a notice of the alleged deficiency, and move it along to a WCJ or the Director to determine the legal effect of the perceived error.

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11.4.4.10(C)(7)(e) The rule should specifically require the employer and the adjuster to appear at the Mediation. It is common for attorneys for Employer/Insurer to appear alone without enough knowledge of the case or enough authority to conduct a meaningful mediation. Furthermore, mediations are most effective when the actual parties involved are able to hear the opposing party's views.

11.4.4.12(B)(2)(a) The WCA should consider incorporating a time limit for the Employer to notify the Worker of its decision to select an HCP or to defer its selection. The time should reflect appellate court rulings on this issue, and it should consider the advantage obtained when Insurer allows Worker to receive some care, then reviews the diagnosis and treatment plan before deciding to send a *Howell* letter. The WCA should also include some penalty to the Insurer who "runs out the clock" on Worker's 60-day selection by refusing to authorize diagnostic testing requested by Worker's HCP. At a minimum, time wasted waiting for approvals should be added to the time that Worker is allowed to control the selection.

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11.4.7.8(B) Consider adding provision for a hearing before a WCJ, short of a full trial, to authorize treatment which has been denied by Employer. Particularly in the case of diagnostic testing, such as MRIs, treatment cannot proceed without a good diagnosis. To take depositions and use up valuable discovery advances, attorney fee cap space, and waste months of Worker's life waiting for a trial date, just to move the case to a point where treatment might commence, and then to repeat that process at some point over issues of MMI and PPD rating is not efficient. In the case of an outright denial of compensability, many inequities would be eliminated by enactment of a rule stating that any Employer/Insurer who denies a claim in its entirety waives the right to rely on the provisions of the Rules regarding selection and payment of health care services. It is fundamentally unfair to allow an Employer to direct care to its selected HCP while simultaneously refusing to pay for any of that care. The current rule can eliminate the option for Worker to use other health insurance while awaiting a trial because the providers available under the health insurance plan may not include the selected HCP. If Worker is forced to go outside of the WC system to get medical treatment, he should be able to seek reimbursement for those services without facing the defense that the provider was not an authorized HCP.

11.4.7.8(D)(6) The reference to "regardless of where those services are provided" should be clarified to indicate that the rule applies to the type of facility where the service is provided rather than the geographic location. This section has been used to limit payment to out-of-state providers to the HCP fee schedule even when the Insurer has denied the claim and those providers have no interest in submitting to New Mexico regulations on a claim which has been denied.

11.4.7.10(E) Denial of claims presents a problem for workers who receive care out of state. Non-NM providers are not subject to the HCP fee schedule unless they agree through the HCP Affidavit. If the claim has been denied, there is no reason to go through the laborious process of getting WCA approval of the out-of-state HCP unless there is going to be payment for those services. I would suggest adding: "In the case of a denial of authorization or payment by the claims payer to an out-of-state provider, where such bills have been paid from another source, the HCP fee schedule shall not apply, and any later payment or reimbursement of such bills shall be determined by the WCJ based on the amount paid by the worker, the amount paid by other applicable insurance, or if the bill remains unpaid, any other reasonable standard within the WCJ's discretion." An alternative solution would be to enact a rule that simply states that any Employer/Insurer who denies a claim in its entirety waives its right to rely on the provisions of the Rules regarding selection and payment of health care services. This is particularly important where the worker is receiving treatment out of state, as the Employer can attempt to direct care without actually providing any.

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11.4.12.11(A) This section should be removed. There is nothing in the enabling legislation that supports this statement.

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Proposed Rule Change 11.4.4.13(N)

I'd like to respectfully voice my concern particularly with the proposed changes to 11.4.4.13(N) NMAC regarding Form Letters. The vast majority that I receive are largely left blank when all sections must be completed; they fail to give the date it was completed, or otherwise lack specificity that is essential for medical and legal conclusions. I've

found that most are filled out by doctor assistants or secretaries who are not familiar with the actual treatment and the busy doctor will just sign the document. Often, (and I stress that this is very routine) the assistants' and doctors' handwriting is not even the same. When my defense attorney has deposed doctors regarding these letters, they're often unaware that one was ever sent or that they signed off on them. While Form Letters certainly have a useful place in workers' compensation claims, particularly with respect to potential MMI dates and lifting restrictions, I don't think they are or should be considered as definitive conclusions of law. Causation under NMSA 1978, Section 52-1-28 has its own specific burden that I respectfully do not believe is completed by checking a box.

Additionally, I've had providers use the Form letter as a return to work status and complete at each visit. I've also had providers that have no experience with workers' compensation complete the form stating permanent restrictions without an FCE and 50% IR where clearly the 6th Ed. AMA guides would not even allow for that high of an IR.

If the Administration does move forward with these changes, my recommendation would be that the Form Letters have instructions on how to complete included, similar to how your PROPA has instructions to the provider on how to complete. In short, I think that Form Letters are useful tools but legally and practically the proposed change accepts insufficient Form Letters as a legal conclusion.

In my years of practice, I have heard from several directors that New Mexico's system should be more able to accommodate unrepresented workers. The fact is that there are many workers who are unable to find legal counsel willing to take on their claims. The form letter to health care provider is a valuable tool for both represented and unrepresented workers to provide a clear opinion regarding most medical issues, including causation.
A more recent debate that has developed as to whether a form letter is testimony versus merely evidence. More broadly, there seems to be a move toward making claims resolution more convoluted and time consuming for both represented and unrepresented workers. To the extent we can simplify any means of having disputed claims resolved more efficiently, we will better comply with the Administration's stated goal of prompt, fair and efficient resolution of disputes.

Claims Resolution

11.4.4.9(A)(10)(c) The rule as written is against current case law and should be amended to reflect the correct statement of the law. *See Castillo v. Northwest Tramport Service,* 1991-NMCA-077, 113 N.M. 119,823 P.2d 919. Furthermore, the rejection of pleadings over small and seemingly unimportant deficiencies is an ongoing problem. There is no reason to punish a party by not staying the period in which a pleading is due or otherwise delay applicable deadlines. Such a punishment serves no purpose other than to increase the risk of protracted litigation and appeals about whether such a rule is valid.

11.4.4.10(C)(l)(a)-(c) Why would the WCA delete (a)-(c)? A party should be required to provide this the informal response at least five days before the mediation and should include the information in (b). The filing party should have the option of filing an answer in lieu of an informal response.

11.4.4.10(C)(7)(b) This should specify that at least the adjuster and the worker must appear. It must be clear that an attorney cannot appear in lieu of their client even if they have authority.

11.4.4.10(C)(7)(e) The rule should specifically require the employer and the adjuster to appear at the Mediation. There are times when cases will move faster if the employer attends and learns of the problems that are keeping the worker from returning to work.

11.4.4.11 A provision should be added allowing each party to excuse the Director's assigned designee.

11.4.4.12(B)(2)(a) The WCA should consider incorporating a time limit for the Employer to notify the Worker of its decision to select an HCP or to defer its selection. The time should reflect appellate court rulings on this issue, and it should consider the advantage obtained when Insurer allows Worker to receive some care, then reviews the diagnosis and treatment plan before deciding to send a *Howe//* letter. The WCA should also include some penalty to the Insurer who "runs out the clock" on Worker's 60-day selection by refusing to authorize diagnostic testing requested by Worker's HCP. At a minimum, time wasted waiting for approvals should be added to the time that Worker is allowed to control the selection.

11.4.4.12(B)(2)(b) This provision should be changed back to the previous version which made it clear that if the choice is not communicated to the worker in accordance with *Howell,* then any treatment is deemed the employer/insurer's choice. Currently, as written, this provision is contrary to law.

11.4.4.13(N)(2)(d) Clarify that medical records of HCPs are sufficient evidence for determination of causation, MMI, release to work and activity restrictions, and other factual issues that may depend on medical evidence, without requiring deposition testimony of those providers. Current published and unpublished cases support this change. See, for example, *Jurado v. Levi Strauss & Co.,* 1995-NMCA-129, ¶¶ 24-25, 120 N.M. 801, 907 P.2d 205 (holding the written medical report of an unauthorized HCP is inadmissible testimony within the meaning of the Act). The biggest delays and the highest costs in litigating cases involve trying to obtain depositions of doctors. When a doctor seeks a referral, that referral should be considered prima facie evidence that the treatment is reasonable and necessary. There should be a rebuttable presumption that the treatment is reasonable and necessary if a doctor recommends a treatment. Allowing the admission of the medical records as testimony will lessen the burden on treating providers as some cases will resolve without the need for their depositions.

11.4.4.13(P)(7) Add a provision authorizing the WCJ to award costs after a trial in accordance with the Rules of Civil Procedure (Rule 1-054).

11.4.4.15 Clarify that fees paid to attorneys for Employer/Insurer are also subject to review by the WCJ and may not be paid until an order has been entered allowing them. This procedure would avoid the problem of defense attorneys being paid prior to conclusion of the case, or receiving fees in excess of the cap. It would also ensure that fees paid for pre-filing work, such as an opinion letter, is included under the cap.

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11.4.7.8(B) Consider adding provision for a hearing before a WCJ, short of a full trial, to authorize treatment which has been denied by Employer. Particularly in the case of diagnostic testing, such as MRIs, treatment cannot proceed without a good diagnosis. To take depositions and use up valuable discovery advances, attorney fee cap space, and waste months of Worker's life waiting for a trial date, just to move the case to a point where treatment might commence, and then to repeat that process at some point over issues of MMI and PPD rating is not efficient. In the case of an outright denial of compensability, many inequities would be eliminated by enactment of a rule stating that any Employer/Insurer who denies a claim in its entirety waives the right to rely on the provisions of the Rules regarding selection and payment of health care services. It is fundamentally unfair to allow an Employer to direct care to its selected HCP while simultaneously refusing to pay for any of that care. The current rule can eliminate the option for Worker to use other health insurance while awaiting a trial because the providers available under the health insurance plan may not include the selected HCP. If Worker is forced to go outside of the WC system to get medical treatment, he should be able to seek reimbursement for those services without facing the defense that the provider was not an authorized HCP.

11.4.7.8(D)(6) The reference to "regardless of where those services are provided" should be clarified to indicate that the rule applies to the type of facility where the service is provided rather than the geographic location. This section has been used to limit payment to out-of-state providers to the HCP fee schedule even when the Insurer has denied the claim and those providers have no interest in submitting to New Mexico regulations on a claim which has been denied.

11.4.7.10(E) Denial of claims presents a problem for workers who receive care out of state. Finding a out-of-state provider who will accept NM MAPS is almost impossible for a worker. Currently, the WCA Rules treat workers unfairly in that they require an order to have an out-of-state provider accepted, but an Employer/Insurer does not have to go through the same process: they can just agree to pay a bill and make the provider an authorized health care provider that way. Non-NM providers are not subject to the HCP fee schedule unless they agree through the HCP Affidavit. If the claim has been denied, there is no reason to go through the laborious process of getting WCA approval of the out-of-state HCP unless there is going to be payment for those services. I would suggest adding: "In the case of a denial of authorization or payment by the claims payer to an out-of-state provider, where such bills have been paid from another source, the HCP fee schedule shall not apply, and any later payment or reimbursement of such bills shall be determined by the WCJ based on the amount paid by the worker, the amount paid by other applicable insurance, or if the bill remains unpaid, any other reasonable standard within the WCJ's discretion." An alternative solution would be to enact a rule that simply states that any Employer/Insurer who denies a claim in its entirety waives its right to rely on the provisions of the Rules regarding selection and payment of health

care services. This is particularly important where the worker is receiving treatment out of state, as the Employer can attempt to direct care without actually providing any.

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11.4.4.13(N)(3) *ADJUDICATION PROCESS*

The proposed rule changes include the following:

N. Admissibility of evidence:

(1) Live medical testimony shall not be permitted, except by an order of the judge.

(2) A judge may admit ~~the following documentary~~ evidence, including hearsay evidence, provided that the evidence is relevant, has sufficient indicia of reliability and authenticity, and will assist the judge in determining a fact or issue in dispute, including, but not limited to:

(a) personnel records, payroll records, or other employment files for worker;

(b) pre-injury medical records of treatment received for a period of 10 years prior to the date of injury through the time of hearing on the merits;

(c) form letters approved by the WCA;

(d) records of authorized health care providers and their referrals, including functional capacity evaluations;

(e) reports of independent medical examinations ("IMEs") performed pursuant to the act or as otherwise agreed by the parties may be sufficient testimonial evidence to establish a causal connection under Section 52-1-28 1979 NMSA;

(f) toxicology or drug and alcohol test reports;

(g) records of the office of medical examiner, including autopsy and toxicology reports; or

(h) records of the New Mexico board of pharmacy prescription monitoring program.

(3) When completed by an authorized health care provider, the WCA approved Form Letter to Health Care Provider may be sufficient testimonial evidence to establish a causal connection under Section 52-1-28 1978 NMSA.

Comments: We are concerned this provision would materially change the meaning of NMSA § 52-1-28(B) and tip the balance of contested claims, contrary to the statute. The construction of these proposed amendments will also add uncertainty and confusion. Some of the likely consequences will be to prompt a new wave of litigation around the admission and weight of Form Letters, and effectively shift the burden of proof from the worker to the employer. Other potential effects may be to increase filings of requests for mediation, reduce the number of successful mediations, and increase claims of bad faith. To the extent the rule does shift the burden of proof, the rule itself may also be susceptible to a legal challenge.

A form letter is already admissible evidence under existing rules. *See* NMAC 11.4.4.13(N)(2) ("…a judge may admit…form letters approved by the WCA.").

What the proposed rule would do is go beyond the question of admissibility and instruct judges on *sufficiency* and *weight*.

The sufficiency of the evidence is already determined by longstanding judicial canon and the Act. The Agency's rulemaking authority does not extend to appellate standards of review, and declaring by rule that a specific form of evidence may be sufficient will not make it so. The appellate courts will determine whether the WCJ has applied the correct standard, and whether there is sufficient evidence on the record to support the WCJ's findings

of fact and conclusions of law. *See Trujillo v. City of Albuquerque,* 1993-NMCA-114, ¶¶ 14-21 (holding improper for a WCJ to rely upon opinion testimony that does not meet statutory definitions and rendering it "incorrect as a matter of law").

Making any statement in rule as to sufficiency of evidence runs the risk of contradicting, or at least confusing, existing appellate standards. There is a rather lengthy and complex body of case law interpreting NMSA § 52-1-28(B), and the sufficiency of expert medical testimony is a nuanced, fact-specific inquiry. The Court of Appeals have cited numerous factors bearing on the sufficiency of evidence, including whether the doctor was fully informed of the worker's prior medical history; whether the injury claimed was an aggravation of a preexisting injury; whether there is contrary medical evidence, etc. An authorized health care provider must have "experience and familiarity" with the worker for the provider's testimony to be admissible. *Grine v. Peabody Nat. Res.*, 2006-NMSC-031, ¶ 25 (finding ten-minute consultation with a patient does not qualify provider as treating provider). An opinion must "logically and rationally connect the cause and effect" of the accident and the alleged injury. *Smith v. Aramark Servs./Los Alamos Nat'l Lab'y*, No. A-1-CA-37210, 2020 WL 1819932, at *3 (N.M. Ct. App. Mar. 25, 2020). The court in *Smith* held worker failed to logically and rationally connect cause and effect where the provider's testimony regarding "injuries to the knees" did not clearly reference the ongoing knee injury. *Id.* (affirming the WCJ's finding that causation was not established where "the experts' testimony lacked foundation and were vague and equivocal."). Foundation should include the basis of the medical provider's opinion—the accident as they understand it, and the records, representations, or observations upon which they relied. *See, e.g., Hernandez v. Mead Foods, Inc.*, 1986-NMCA-020, ¶ 14 (even uncontradicted medical testimony need not be accepted as true if it is based on the worker's own misrepresentations, suspicious circumstances, is equivocal or contains inherent improbabilities).

It is highly unlikely that a Form Letter, alone, will satisfy the requirements above. A rule purporting to tip the scale on one or more of these factors without the full analysis is an invitation for more litigation.

The proposed rule would compound an already existing problem with the reliability of Form Letters. The Act defines a "health care provider" to include entire organizations such as hospitals or "any other facility…" NMSA § 52-4-1(A),(Q). There is thus a risk that Form Letters may be completed by office administrators, medical assistants or other professionals within a medical facility who are not the *individual* treating the worker. Existing practice, along with the broad definition of health care provider, do not support the singling out of Form Letters as "sufficient" expert medical testimony establishing causation.

To the extent the proposed rule is intended to reflect the status quo, then the adoption of the rule isn't likely necessary. If a party appeals a WCJ decision that a single Form Letter under certain circumstances meets worker's burden, the Court of Appeals will apply the same analysis regardless of whether the proposed rule was adopted. Outside of the appellate process, however, adoption of the proposed rule will more than likely be interpreted to mean something *more* than the status quo.

Despite including the permissive "may" in the proposed rule, we are concerned that in practice it will come to mean that a Form Letter alone establishes causation unless the employer can *disprove* causation or discredit the Form Letter. The proposed language does not provide any guidance as to when a Form Letter would be sufficient, or when it would not be sufficient.

The practical effect will be to shift the burden of proof to employer, contrary to the Act. Workers would have no need to depose providers or establish foundation. Under the Act workers are not required to prove negligence or fault; they are not required to produce experts for live testimony at trial; they do not have to produce biomechanical engineers, accident reconstructionist, or other extrinsic expert witnesses; and they are not required to qualify their experts or expert opinions under *Alberico/Daubert*. We caution against a rule change that would further lower the threshold for compensability under the Act.

The construction of the proposed changes to 11.4.4.13(N)(2) exacerbates the problems created by the proposed 11.4.4.13(N)(3). Paragraph (N)(2) currently enumerates documents that are admissible *as long as they are relevant, reliable, authentic, and assist the finder of fact.* The construction of the proposed amendments creates three problems:

1) By adding the phrase "including, but not limited to" after the qualifiers, it can be interpreted as stating the legal conclusion that the enumerated documents are, *per se*, relevant, reliable, and authentic, rather than stating that they are admissible only if they are relevant, reliable, and authentic.
2) The proposed addition to paragraph (N)(2)(e) does not fit the construction of that paragraph. The sentence would now read thus:

> "A judge may admit evidence…including, but not limited to…reports of independent medical examinations ("IMEs") performed pursuant to the act or as otherwise agreed by the parties may be sufficient testimonial evidence to establish a causal connection under Section 52-1-28 1979 NMSA."

The underlined language makes the sentence grammatically incorrect, which further adds to the uncertainty as to how this paragraph is to be applied.
3) The proposed language in (N)(2) and (N)(3), taken together, seems to make the assertion that both provider form letters and IME's may be sufficient testimonial evidence to establish a causal connection under Section 52-1-28. Both provider form letters and IME's appear in paragraph (N)(2), but only provider form letters are broken out in a new paragraph to address sufficiency. It is unclear why one is modified within paragraph (N)(2) and the other is broken out into its own paragraph.

While seemingly small, these proposed changes—and the manner in which they are constructed—present a significant risk of disruption to the system as a whole.

Suggestion: We urge the Agency to omit the proposed paragraph. Alternatively, we urge the Agency to omit any changes to paragraph (N)(2), and to amend the proposed paragraph (N)(3) to simply state that both provider form letters and IME's are considered testimonial evidence, without reference to sufficiency.

Claims Resolution

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11.4.12.11(C)-(E) While I do not believe that the legislature gave the WCA the authority to limit payments of disability benefits from the Fund, I do agree that the existing limits are not justified by the current balance in the UEF. I generally agree with raising the limits, and I would urge the Director to raise the limits to the maximum amount possible.

I'd like to respectfully voice my concern particularly with the proposed changes to 11.4.4.13(N) NMAC regarding Form Letters. In theory, I understand why this would be an expeditious method for resolving issues. However, in my own practice a properly completed Form Letter is the exception, not the rule. The vast majority that I receive are largely left blank when all sections must be completed; they fail to give the date it was completed, or otherwise lack specificity that is essential for medical and legal conclusions. I've found that most are filled out by doctor assistants or secretaries who are not familiar with the actual treatment and the busy doctor will just sign the document. Often, (and I stress that this is very routine) the

assistants' and doctors' handwriting is not even the same. When I've deposed doctors regarding these letters, they're often unaware that one was ever sent or that they signed off on them. While Form Letters certainly have a useful place in workers' compensation claims, particularly with respect to potential MMI dates and lifting restrictions, I don't think they are or should be considered as definitive conclusions of law. Causation under NMSA 1978, Section 52-1-28 has its own specific burden that I respectfully do not believe is completed by checking a box. Form Letters are not subject to cross-examination nor will they be considered a rebuttable piece of evidence under the new proposed changes. I've also routinely had opposing counsel drop Form Letters on me from doctors that I and my client are not familiar with immediately prior to a mediation or hearing as "proof' that a certain burden has been successfully met. In short, I think that Form Letters are useful tools but legally and practically the proposed change accepts insufficient Form Letters as a legal conclusion and effectively eviscerates the requirement for compensable claims proof by workers under the act.

I support the proposed change making.

I've read the public comments against the change and find them without basis.

The rule change will not increase litigation. If anything it will expedite litigation and prevent unnecessary litigation.

Finally, the rule does not preclude any party from deposing the doctor who wrote the form letter to cross examine her on the opinions in the letter.

A positive change in my opinion.

I would like to comment on the proposed change of 11.4.4,13(N) of the NM Workers' Compensation Rules. Specifically, my comments will address the proposed changes to section of the rule regarding Form Letters (3).

The proposed change states that "When completed by an authorized health care provider, the WCA approved Form Letter to Healthcare Provider may be sufficient testimonial evidence to establish a causal connection under Section 52-1-281978 NMSA".

While I understand that the Form Letter to HCP can be a valuable tool for addressing various issues including restrictions and MMI. The letter alone does not meet the definition of sufficient testimonial evidence.

First, if one is lucky enough to receive a requested Form Letter back at all, it is often very clear that the letter was not completed by the authorized healthcare provider. These letters are often completed by clerical staff, sometimes by the worker or the worker's attorney. In order to be accepted as sufficient testimonial evidence, the identity of the person completing the Form Letter would have to be clear. If the point of the rule change is to expedite the judicial process, how is that accomplished when the employer has to arrange a deposition just to establish whether or not the letter was completed by the HCP?

Second, the letters often cause just as much uncertainty as and as they do clarity. Letters are often sparsely completed, with many sections left blank. They are also often completed with no reference to the actual medical records, but with a verbal history taken from the worker by a staff member, then placed in front of a doctor for signature or rubber stamping. How can such a letter be used to make medical, let alone legal decisions?

Finally, the Form Letter is not testimonial evidence. The completion of a form letter is not done under oath, it cannot be cross examined, nor is there any penalty for perjury that applies to a Form Letter. If the Form Letter cannot be held to same standards of testimonial evidence as in-person testimony by a medical provider or submission of actual medical records, then it also cannot be relied upon in the same way.

Although it would be a wonderful thing to be able to free up our WC Judges and streamline our WC adjudication system. Allowing Form Letters to be weighed as heavily as expert testimony has very real ramifications that will only lead to further litigation and expense.

While I understand goal of the Administration to expedite the adjudication process and I do believe a Form Letter completed correctly and by the appropriate provider can be a useful tool, I do not believe that such a letter can replace medical testimony and or records that are needed to establish causation. I also believe that allowing such evidence via this rule change will have the opposite effect of that what was intended, to ease and expedite the judicial process.

In conclusion, I respectfully request that the Administration reconsider the proposed rule changes.
Thank you for the opportunity to offer comment.

I believe that form letters are already sufficient evidence of causation, but I welcome the proposed change as a step in the right direction. This clarification would eliminate uncertainty about whether form letters are sufficient evidence of causation, streamline the litigation process, reduce the need for redundant depositions of healthcare providers, and lower discovery costs. Further, the fast majority of pro-se litigants do not have the experience or ability to obtain a causation opinion from a doctor at a deposition.

In addition, I would encourage a clarification that medical records of authorized HCPs can also be sufficient evidence for determination of causation and any other factual/medical issues that depend on medical evidence.

Proposed Rule Change 11.4.4.13(N)
I'd like to respectfully voice my concern particularly with the proposed changes to 11.4.4.13(N) NMAC regarding Form Letters. In theory, I understand why this would be an expeditious method for resolving issues. However, in my own practice a properly completed Form Letter is the exception, not the rule. The vast majority that I receive are largely left blank unless opposing counsel fills it out for the doctor themselves. When I send them, the physician's staff tend to complete them from information they glean from the medical records; much is left incomplete. The specificity asked in the letter is essential for medical and legal conclusions. I've found that most are filled out by doctor assistants or secretaries who are not familiar with the actual treatment and the busy doctor will just sign the document. Often, (and I stress that this is very routine) the assistants' and doctors' handwriting is not even the same. When I've deposed doctors regarding these letters, they're often unaware that one was ever sent or that they signed off on them. While Form Letters certainly have a useful place in workers' compensation claims, particularly with respect to potential MMI dates and lifting restrictions, I don't think they are or should be considered as definitive conclusions of law without a specific provision for an opportunity to depose the provider. Form Letters are not subject to cross-examination nor will they be considered a rebuttable piece of evidence under the new proposed changes. Other concerns include: 1. opposing counsel filling out the form letter, 2. the doctor's staff filling out the form letter, 3. doctors stating in deposition that they don't know who filled out the form letter, 4. the new rule says nothing about the parties' rights to address a form letter in deposition, and 5. the rule implies that a form letter without a deposition sufficiently addresses a slew of issues from MMI to restrictions.