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SAMPLE IME ANALYSIS

WHAT A DEFENSE IME LOOKS LIKE WHEN ITS REASONING IS MAPPED

This is a redacted IME Rebuttal Analysis from a real plaintiff-side matter.

It shows the full analytical output — not a summary, not a teaser.

10 Structural Vulnerabilities Identified	10 Deposition Clusters	4 Admissibility Exposure Points
Across causation, impairment, work capacity, and treatment appropriateness	Derived directly from the reasoning gaps in the report	Assessed under the Ohio Daubert standard

Five Things This IME Got Wrong (And How Each One Creates Deposition Exposure)

Each finding below is documented in the full analysis. The primary scrutiny targets for each are identified in the Executive Summary.

Symptom Magnification — No Disclosed Methodology

The magnification finding rests entirely on a pain drawing with no scoring criteria, no Waddell signs, and no validated interpretive framework. It then does load-bearing work in the causation section, displacing back pain from the injury without methodological support.

Deposition exposure: High.

Admissibility exposure: Secondary.

Back Pain Causation — Treating Physician's Theory Not Addressed

The treating orthopaedic surgeon documented a direct compensatory causation opinion supported by biomechanical findings. The IME attributes back pain to degeneration and magnification. The word "gait" does not appear in the causation analysis.

Deposition exposure: High.

Impairment Rating — Measurement Conflict With Direct Damages Consequence

The IME measures leg length discrepancy at 2.5 cm using a non-standard landmark method. The treating physician's contemporaneous clinical block measurement is 2.8 cm — a figure that crosses the threshold to the next AMA Guides Table 17-4 increment, doubling the lower extremity impairment rating from 7% to 14%.

Deposition exposure: High.

Admissibility exposure: Specific Daubert vector.

Work Capacity — Examination Conducted Without Prescribed Orthotic

The gait assessment was conducted without the patient's heel lift. The report acknowledges the resulting pelvic elevation but treats gait as normal. Every relevant functional finding conflicts with the treating record from three months earlier.

Deposition exposure: High.

Treatment Appropriateness — Circular Reasoning on Both Medications

Both medication criticisms rest on the prior finding that pain lacks objective support — a finding the report itself establishes. Neither conclusion engages the treating record's documented trial-and-fail history, the Crohn's disease constraint on NSAIDs, or the 40% documented response to gabapentin.

Deposition exposure: Moderate.

Admissibility exposure: Highest concentration in the report.

WHAT THIS FULL ANALYSIS CONTAINS

The sample below follows the standard seven-section framework used in every IME Rebuttal Analysis engagement.

IME Core Argument Summary

How the report's architecture functions and where the concession/minimization pattern operates

Logical and Methodological Weaknesses

Where the reasoning fails on its own terms

Record Contradictions

Nine specific conflicts between the IME and the treating record, each with named source documents

Analytical Fragility Points

The four vulnerabilities most exposed under deposition pressure, with admissibility assessment for each

Deposition Pressure Points

Ten question clusters derived directly from the identified gaps, ready to use in prep

Admissibility Framework Note

Four specific Daubert exposure areas assessed under Ohio Evid. R. 702

Record Clarifications Needed

Nine specific documents or addenda that would strengthen the plaintiff's position

The number of findings, deposition clusters, and admissibility observations varies by engagement depending on the report, the supporting record, and the complexity of the opinions being challenged. The admissibility analysis in this sample applies the Ohio Daubert standard.

Every engagement is assessed under the reliability framework applicable to your jurisdiction and court.

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The same framework applied to your IME report, your treating record, and your jurisdiction.

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FULL REDACTED SAMPLE — IME REBUTTAL ANALYSIS

This is the complete analysis. Names, dates, and identifying details have been redacted. The analytical framework is identical to what is applied in every engagement.

Prepared for: REDACTED REFERENCE SAMPLE – CAUSATION CLARITY

File Reference: N/A

Date of Delivery: September 19, 2024

IME Physician: William F. Boucher, MD

Date of IME: September 18, 2024

Claimant: Tom Sample

Jurisdiction: Ohio — Daubert Reliability Standard

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This document is confidential and prepared solely for the use of the receiving attorney. It does not constitute legal advice, medical opinion, or expert testimony.

Important: This is a redacted sample. Names, locations, and dates have been modified to protect confidentiality. This example applies the Daubert reliability standard as it would be evaluated in an Ohio filing. Analysis can be tailored to any applicable reliability framework, whether under Daubert, Frye, or a state-specific standard, in either federal or state court.

ANALYTICAL REVIEW NOTICE

This document is an independent analytical review of the submitted IME report and supporting record materials. It is produced by an independent litigation analyst and does not constitute legal advice, medical opinion, or expert testimony. No attorney-client relationship, expert relationship, or professional advisory relationship is created by the preparation or delivery of this document.

The findings, observations, and identified vulnerabilities in this analysis reflect structured adversarial review of the written materials provided. They represent analytical judgment about where weaknesses, contradictions, and evidentiary risks appear to exist based on the submitted record — not conclusions of law, findings of fact, or predictions of litigation outcome. Nothing in this document should be treated as a guarantee, warranty, or assurance about how any argument, motion, deposition, or proceeding will resolve.

The strength of any identified vulnerability depends on facts, documents, and circumstances beyond what was submitted. The analysis is limited to the written record provided. Material not submitted may affect or alter any finding in this document. Where documents were absent the relevant sections are flagged accordingly, but the absence of a flag does not mean the analysis is complete — it means it is complete on the materials received.

This document is intended to inform the professional judgment of the receiving attorney. It is not a substitute for that judgment. The attorney is responsible for independently evaluating every analytical observation before acting on it, for verifying that the identified vulnerabilities hold against the full case record, and for making all strategic decisions independently.

This analysis was prepared using structured analytical methodology applied to the submitted written materials. It reflects the analyst's independent judgment and is not produced, endorsed, or verified by any medical professional, legal professional, or credentialed expert.

EXECUTIVE SUMMARY

The analysis identifies several structural vulnerabilities in the IME opinion that warrant focused attention before deposition preparation begins.

Key IME Vulnerabilities

Symptom magnification as unsupported causal displacement.

The report concludes that low back symptoms are attributable to pre-existing facet arthropathy, obesity, and symptom magnification. The magnification finding rests entirely on a pain drawing characterization — no scoring criteria disclosed, no Waddell signs documented, no validated interpretive framework identified. That finding then does load-bearing work in the causation analysis: remove it and the back pain attribution rests solely on a mild, partially visualized facet arthrosis finding that the treating physician explicitly characterizes as insufficient to account for symptom severity. The methodology underlying this conclusion is not disclosed in the report and cannot be reconstructed from it.

Back pain causation opinion constructed without engaging the treating physician's documented biomechanical theory.

Dr. Kinko's June 2004 note documents a direct causal opinion — that the low back pain is compensatory to progressive leg length discrepancy and long-standing gait alteration — supported by examination findings including a positive Trendelenburg sign, antalgic gait, and left SI joint involvement. The IME's causation section attributes back symptoms to degeneration and magnification. The word "gait" does not appear in the causation analysis. The treating physician's biomechanical theory is neither acknowledged nor refuted. This is not a close analytical dispute — it is a demonstrated gap in the opinion's analytical foundation.

Impairment rating built on a measurement methodology that conflicts with the treating record and the AMA Guides.

The 3% whole person impairment rating rests entirely on a 2.5 cm leg length discrepancy measured via lateral pelvic rim to lateral tibial plateau landmarks — a non-standard approach under the AMA Guides Fifth Edition. Dr. Kinko's contemporaneous clinical block measurement, conducted three months earlier, documents 2.8 cm. That figure crosses the threshold for the next Table 17-4 increment, which assigns 14% lower

extremity impairment rather than 7%. The report does not acknowledge the discrepancy, does not justify its measurement method over Kinko's, and does not analyze the impairment consequence of the treating physician's figure. The methodological deviation is specific and quantifiable, and its damages consequence is direct.

Work capacity opinion derived from an examination that omits the patient's prescribed orthotic and conflicts with the treating record on every relevant functional finding.

The gait assessment was conducted without the patient's prescribed heel lift — acknowledged in the report through the elevated PSIS notation — yet the work capacity analysis treats the resulting gait observation as normal. Dr. Kinko's examination three months earlier documented antalgic gait, shortened left stance phase, a positive Trendelenburg sign, restricted hip range of motion across all planes, and pain with resisted abduction. The IME documents normal gait, near-normal range of motion, and no pain with resisted motion. The work capacity conclusion is built on examination findings that are materially inconsistent with the contemporaneous treating record, and the report provides no explanation for the divergence.

Treatment appropriateness conclusions that ignore the documented prescribing rationale.

Both the Avinza and Neurontin criticisms are circular: each rests on the prior finding that objective support for pain is insufficient, without engaging the treating record's documented trial-and-fail history, the constraint Crohn's disease places on NSAID use, the anatomically grounded neuropathic pain presentation, or the 40% documented response to gabapentin. The IME's "no evidence of neuropathic pain" conclusion is stated without any examination of the lateral femoral cutaneous nerve distribution, despite the treating physician's documented explanation of why that nerve is at risk from the lateral surgical approach used in 1985.

Primary Deposition Targets

Symptom magnification methodology.

Boucher must identify, on the record, what interpretive framework he applied to the pain drawing, what threshold was crossed, and how a magnification finding derived

from that instrument is reconciled with the absence of non-physiologic findings on examination. There is no answer in the report that bridges those two observations.

Back pain causation and the biomechanical gap.

Boucher must either confirm he reviewed Dr. Kinko's June 2004 note and chose not to address the compensatory mechanism, or acknowledge the mechanism was not adequately considered. Both answers require explanation the report does not provide.

Leg length measurement and the impairment calculation.

Boucher must explain why his 2.5 cm measurement controls over Kinko's contemporaneous 2.8 cm clinical block measurement, what methodology he applied, and whether he analyzed the impairment consequence of the treating physician's figure. The Table 17-4 threshold consequence makes this quantitatively concrete.

Work capacity examination conditions.

Boucher must address whether conducting the gait assessment without the patient's prescribed orthotic device affected his findings, and whether the work capacity opinion accounts for the antalgic gait and Trendelenburg sign documented by Kinko three months earlier.

The July 2004 surgery reference.

Boucher must identify the source for the July 2004 surgical reference in the work capacity section — a procedure for which no operative record, consent, or post-operative note appears anywhere in the submitted materials. The answer will either identify undisclosed records or expose an unsupported clinical assumption embedded in the functional analysis.

SECTION 1: IME CORE ARGUMENT SUMMARY

The IME report's primary conclusion is straightforward: Mr. Sample's left hip condition is causally related to the 1985 injury, he has reached maximum medical improvement, he retains at least sedentary work capacity, and his whole person impairment is 3%. That framing appears concessive on causation but systematically minimizes the severity, complexity, and functional consequences of the injury throughout. The report acknowledges the fracture and the surgery, then constructs a picture of near-complete recovery that the structural findings within the report itself do not consistently support.

Reading the conclusions in sequence, rather than in isolation, reveals how the architecture functions. Each secondary conclusion narrows what the primary causal acknowledgment actually delivers to the plaintiff.

The Causation Concession

The report concedes a causal relationship between the December 18, 1985 injury and the examinee's current left hip complaints. This acknowledgment is not neutral. It functions as a structural anchor that makes the subsequent minimization appear grounded and balanced. By conceding causation on the hip, the report positions itself as objective — which lends credibility to the places where it displaces causation for other complaints and sharply curtails the functional and impairment findings.

This is a recognized structural pattern in IME reporting: limited causation acknowledgment paired with aggressive minimization of severity, functional consequence, and impairment. The concession on the central complaint becomes the credibility device that carries the contested conclusions.

The causation concession is also narrowly scoped. The report explicitly limits causal acknowledgment to "left hip complaints" and separately addresses "more diffuse low back symptoms," attributing them to pre-existent facet arthropathy, obesity, and symptom magnification. That bifurcation is central to the report's architecture. Back pain is placed outside the causal chain through attribution to degenerative findings and symptom magnification, with no analysis of the biomechanical relationship between a 2.5 cm leg length discrepancy and lumbar loading.

Symptom Magnification as a Displacement Mechanism

The symptom magnification signal is introduced through the pain drawing notation — "this drawing did reveal findings suggestive of symptom magnification" — and then deployed in the causation section as a basis for discounting low back complaints. The report states: "The examinee's more diffuse low back symptoms are of uncertain origin, given the degree of symptom magnification present."

A single instrument, the pain drawing, generates a finding described as "suggestive of" symptom magnification. That finding then appears in the causation section not merely to express caution about back pain severity, but as affirmative evidence shifting the origin of back symptoms away from the injury. The qualifier "suggestive of" in the pain inventory section does not survive the transition to the causation section, where symptom magnification is presented as a settled explanatory factor.

This escalation in certainty — from a behavioral instrument's tentative signal to a definitive causal conclusion — is a recognizable IME argumentation pattern. Symptom magnification, introduced through a single behavioral instrument, ends up redirecting attribution for symptoms that lack a competing structural explanation in the report's own findings.

Degeneration Attribution for Back Complaints

For the low back, the report attributes causation to "pre-existent (mild) facet arthropathy, obesity and symptom magnification." The facet arthropathy reference corresponds to the partially visualized finding on the 2003 imaging — mild facet arthrosis at L4-5 and L5-S1. The obesity attribution is more problematic. It appears as a causal factor without any documented BMI measurement or body composition finding in the examination itself. The report records height and weight as self-reported: 5'7", 160 pounds. That body habitus does not correspond to a BMI associated with clinical obesity. The obesity attribution appears in the causation conclusion without an evidentiary basis in the documented examination.

The degeneration attribution pattern runs throughout the report's argument. Preexisting degenerative findings are offered as the primary causal explanation for current symptoms, with no analysis of whether the documented facet changes are consistent with or independent of the gait alteration and leg length discrepancy that has been present and progressive since 1985.

Work Capacity: Inference Without Functional Assessment

The work capacity section describes the examinee as capable of sedentary work with specific functional parameters. The report states: "He assumes that he is unable to sit, but I can find no objective reason why that should be the case." This is a conclusion drawn from the absence of a negative finding, not from a positive functional assessment. The report does not document any structured functional capacity evaluation. The stated limitations and capacities — 10 pounds occasionally, five pounds frequently, 15 minutes walking per hour, occasional bending and twisting — are presented as clinical conclusions without citing a documented physical performance test, a validated functional capacity instrument, or any methodology beyond the examining physician's inference from physical examination findings.

The behavioral observation that the examinee "sat continuously for up to 20 minutes" without observable discomfort during the examination is the closest the report comes to functional documentation for the sitting capacity conclusion.

A short-duration observation in a controlled, low-demand clinical setting does not support a conclusion about occupational sitting capacity.

There is also a gender pronoun error in the work capacity section: "She should avoid driving a motor vehicle or operating machinery due to her multiple sedating medications." This is the only instance of female pronoun use in a report that otherwise identifies the examinee as male throughout. The error is a minor internal inconsistency, but it is consistent with a templated or formulaic drafting process for this portion of the report.

Medication Criticism Without Pharmacological Analysis

The appropriateness of care section concludes that Avinza is inappropriate "given the lack of objective reason for the examinee's pain complaints and the ineffectiveness of the medication," and that Neurontin is inappropriate "given the lack of evidence of neuropathic pain." Both conclusions are circular. Each rests on the prior finding that objective findings are insufficient — a finding the report itself establishes — and then uses the medication as further evidence of treatment excess. Neither conclusion engages with the treating physician's stated clinical rationale, the specific analgesic options that were tried and failed, the constraint imposed by Crohn's disease on NSAID

use, or the documented neuropathic quality of the proximal thigh pain the treating physician describes in detail.

The report also concludes that "failure to address the examinee's probable significant depression has been inappropriate." This creates a problem the report generates for itself. The CES-D administered during the examination produced a score of 10, which the report describes as "not consistent with a depressed mood." The report nonetheless refers to the examinee's "probable significant depression" in the appropriateness of care section without reconciling the conflict between the instrument's result and the conclusion about the severity of his depression and the adequacy of its treatment.

Impairment Quantification: Narrow Scope

The permanent impairment rating is based solely on the 2.5 cm limb length discrepancy under AMA Guides Fifth Edition Table 17-4, yielding 7% lower extremity impairment and 3% whole person impairment. The report does not perform or discuss a range of motion impairment analysis, despite documenting restricted and asymmetric range of motion on physical examination. External rotation measured 15 degrees bilaterally against a stated normal of 30 degrees — a 50% deficit. This is a significant measured finding present in the examination data, and its exclusion from the impairment rating is unexplained.

The report limits the impairment calculation to a single metric while the examination itself documents multiple objective findings that would typically be evaluated for impairment contribution under the AMA Guides.

The MMI Conclusion: Assertion Without Analysis

Maximum medical improvement is stated as a conclusion: "The examinee has achieved maximum medical improvement." The report provides the definitional language — "the date after which further recovery and restoration of function can no longer be anticipated" — but no analytical basis for why Mr. Sample's condition satisfies that definition at this point in time. There is no discussion of whether the progressive impaction noted on the 2003 imaging bears on the MMI analysis, whether the leg length discrepancy has stabilized or continues to progress, or whether the documented functional decline in range of motion since prior examinations affects the prognosis framing. The report states that no further treatment is necessary for his left hip condition and recommends only continuation of the heel lift at 1.5 cm.

The MMI conclusion is asserted, not argued. It forecloses further treatment without engaging the trajectory of Mr. Sample's documented objective findings.

The Overall Structural Logic

Taken together, the report's argumentative architecture moves through a consistent sequence. It concedes the primary causal link to avoid appearing dismissive, then minimizes severity through selective examination findings, behavioral observations, and pain inventory interpretation. Back complaints are displaced from the causal chain through degeneration attribution and symptom magnification. Functional consequence is capped through a work capacity opinion derived from inference rather than documented functional testing. Treating physician decisions are criticized without engaging the treating physician's documented clinical rationale. The impairment rating is narrowed by limiting the analysis to a single metric while leaving documented examination findings outside the calculation.

Each element supports the same endpoint: the injury caused a limited, largely resolved orthopedic problem; the examinee has reached MMI with minimal impairment; he retains meaningful work capacity; and his treating physician has been providing inappropriate care. The individual conclusions are sequenced to reinforce each other. The concession on causation gives the overall structure a surface appearance of balance that the underlying reasoning does not uniformly sustain.

SECTION 2: LOGICAL AND METHODOLOGICAL WEAKNESSES

The report states that the pain drawing "did reveal findings suggestive of symptom magnification" and uses that conclusion to discount the low back complaints entirely. No scoring methodology is cited. No validated scoring system is identified as the interpretive basis. The report does not describe which elements of the drawing triggered the finding, does not reference the clinical literature on pain drawing interpretation, and does not acknowledge the established limitations of pain drawings as standalone clinical tools. A bare conclusion that a drawing is "suggestive" of magnification, without any disclosed interpretive framework, is not a methodology. It is a label applied to a finding the report never substantiates.

That unsupported magnification finding then does the heavy lifting in the causation section, where it appears alongside obesity and pre-existing facet arthropathy as one of three explanations for the low back symptoms. Remove the magnification label and the causation displacement argument loses a significant portion of its foundation. The report uses an unsubstantiated behavioral conclusion to reframe a clinical question.

The report's characterization of the leg length discrepancy contradicts its own physical examination findings. The IME records a clinical measurement of 2.5 cm leg length deficit using lateral pelvic rim to lateral tibial plateau methodology. The June 2003 radiology report documents 1.1 cm of radiographic femoral shortening on AP imaging — a figure the radiologist explicitly notes represents femoral shortening only, with clinical correlation recommended. Dr. Kinko's June 2004 examination documents a clinical block measurement of 2.8 cm without lift compensation, noting that the radiographic figure does not capture soft tissue changes and functional pelvic tilt. The IME physician's own goniometric data show 2.5 cm of clinical shortening. Yet the report limits the permanent impairment rating to that 2.5 cm figure under Table 17-4 of the AMA Guides Fifth Edition — converting to 7% lower extremity impairment and 3% whole person impairment — without any engagement with the treating physician's methodology or the radiologist's explicit recommendation for clinical correlation.

The IME selects the more restrictive of two competing measurement approaches without disclosed justification, producing an impairment rating that does not account for the full clinical picture documented in the record.

The low back causation analysis rests on an assumption the report never supports. The report attributes the low back symptoms to "pre-existent (mild) facet arthropathy,

obesity and symptom magnification." The facet arthropathy finding comes from the June 2003 radiology report, which identifies mild facet arthrosis at L4-5 and L5-S1 as an incidental, partially visualized finding on a hip film — not a dedicated lumbar study. No basis is offered for concluding that mild facet arthrosis identified in this context is sufficient to account for the degree of low back pain the patient reports. More critically, the report makes no engagement with the treating physician's causation theory: that the low back pain is compensatory, arising from prolonged gait alteration and leg length inequality attributable to the 1985 injury. Dr. Kinko's June 2004 note explicitly identifies compensatory low back pain as a recognized complication of undertreated leg length discrepancy and documents left SI joint involvement and a mild positive Trendelenburg sign consistent with that mechanism.

A causation analysis that identifies one possible contributor and ignores a documented alternative theory advanced by the treating orthopaedic surgeon is methodologically incomplete. The report reaches a conclusion — that the back symptoms are not causally related to the 1985 injury — without addressing the biomechanical pathway the treating physician identified in the record.

The obesity rationale compounds the problem. The report asserts obesity as a causation factor for low back pain without documenting the patient's weight or BMI anywhere in the analysis. The physician records height as 5'7" and weight as 160 pounds, which by standard BMI calculation places the patient at approximately 25.1 — borderline normal and overweight, not obese by any standard clinical threshold. "Obesity" nevertheless appears in the causation section as one of three explanations displacing causal attribution to the injury. The report never reconciles this. It cites obesity as a contributing cause while the only weight data in the record does not establish obesity. This is not a minor drafting imprecision; it is an assertion of a causation factor that the report's own documented findings do not support.

The work capacity opinion references a July 2004 hip surgery that does not appear anywhere in the submitted record. The work capacity section states: "Prior to his July 2004 hip surgery, he would have had essentially the same work restrictions." The submitted records contain no reference to a July 2004 surgical procedure. The examination was conducted September 18, 2004. The clinical records reviewed are stated to run through June 14, 2004, the date of Dr. Kinko's last documented visit. Dr. Kinko's June 2004 note indicates the patient preferred to defer hardware removal. There

is no operative note, no surgical consent, no pre-operative evaluation, and no post-operative record anywhere in the submission for a July 2004 procedure.

The physician either reviewed records not disclosed to the examining client, reviewed records not provided for this analysis, or introduced a clinical fact without documented basis. Because the basis for the opinion is not in the record, the methodology cannot be evaluated — and this gap creates significant deposition exposure.

The Avinza inappropriateness conclusion ignores the documented prescribing rationale in the treating record. The report concludes that Avinza is inappropriate due to "the lack of objective reason for the examinee's pain complaints and the ineffectiveness of the medication." Dr. Kinko's June 2004 note documents a fourteen-month trial at stable dose without escalation, preceded by sequential failure of celecoxib (discontinued due to Crohn's-related GI intolerance), tramadol (discontinued for inadequate analgesia), and two separate courses of physical therapy. The treating physician's note explicitly documents the prescribing rationale, the prior treatment failures, and the clinical basis for continued use, including documented functional benefit.

The IME's characterization of the medication as serving "complaints" without "objective reason" does not engage with the range of motion findings, tenderness findings, or gait observations documented at the treating physician's most recent examination — decreased range of motion in all planes, hardware site tenderness, positive resisted abduction, and a clinical picture consistent with chronic post-surgical hip pain. The conclusion sits in direct tension with those documented findings.

The Neurontin analysis presents the same structural problem. The report states Neurontin is inappropriate due to "the lack of evidence of neuropathic pain." Dr. Kinko's June 2004 note documents initiation of gabapentin in August 2003 for burning, lancinating pain in the lateral hip and proximal thigh distribution, identified as consistent with lateral femoral cutaneous nerve irritation — a recognized risk of the lateral surgical approach used in the 1985 ORIF. The treating physician documented the clinical basis in the August 2003 visit note and documented approximately 40% reduction in this specific pain component on Neurontin.

A conclusion that there is "no evidence of neuropathic pain" is not supportable on the record reviewed. The treating physician's note identifies the neuropathic pain syndrome, explains the anatomical mechanism, and documents clinical response to treatment. The IME does not acknowledge that a lateral surgical approach to the

proximal femur carries documented risk to the lateral femoral cutaneous nerve, does not address the treating physician's documented clinical rationale, and offers no basis for the conclusion beyond the assertion itself.

The appropriateness section then criticizes "the failure to address the examinee's probable significant depression." Dr. Kinko's June 2004 note documents PHQ-9 screening with a score of 7, clinical discussion of mild depression with the patient, and a behavioral health referral placed at that visit. The IME examination occurred September 18, 2004 — three months after the treating physician screened for depression and made the referral. The conclusion that depression was not addressed is factually inconsistent with the last treating record in the reviewed set.

The report also administers the CES-D at the IME examination, returning a score of 10 described as "not consistent with a depressed mood." The prior PHQ-9 score of 7 from June 2004 suggested mild depression. The IME report neither acknowledges the prior PHQ-9 finding nor explains the discrepancy between the two measures taken three months apart, and states that depression was not addressed — a conclusion the June 14, 2004 visit note directly contradicts.

The hip range of motion findings reveal a further internal inconsistency. The IME's own goniometric measurements show external rotation of 15 degrees bilaterally against a stated normal of 30 degrees — a symmetrical bilateral deficit. The report characterizes this as "symmetrically decreased in external rotation, but otherwise normal" and describes the examination as showing "no pain with hip motion." Dr. Kinko's June 2004 measurements show materially different values: flexion at 95 degrees against the IME's finding of 120, internal rotation at 15 degrees, external rotation at 20 degrees, and decreased range in all planes compared to 2003, with tenderness on resisted abduction at 4/10. The IME's reported range of motion values are more favorable than those documented by the treating orthopaedic surgeon three months earlier. The report makes no note of this discrepancy and does not account for why the patient's range of motion would have improved between June and September 2004.

The treating physician specifically noted declining range of motion relative to the 2003 visit. The IME reports values that exceed what the treating physician documented as the starting point for that decline. This incongruity is not addressed anywhere in the report.

The MMI conclusion is reached without engaging the treating physician's documented contrary opinion. Dr. Kinko's June 2004 note explicitly states: "Patient is not currently at

maximum medical improvement in my clinical opinion as further treatment trials remain available and have not been exhausted." The plan documents an increased heel lift prescription, continuation of current medications, a behavioral health referral, and deferred consideration of hardware removal as a remaining treatment option.

The report itself defines MMI as "the date after which further recovery and restoration of function can no longer be anticipated, based upon a reasonable degree of medical probability." The treating physician documented at minimum three active treatment modifications underway or pending as of the last clinical visit. The IME reaches the opposite conclusion without any engagement with that documented clinical picture.

One analytical gap warrants explicit flagging. The August 2003 visit note documenting the initial Neurontin prescription and the clinical basis for the neuropathic pain diagnosis is referenced in Dr. Kinko's June 2004 note but was not included in the submitted materials. The Neurontin analysis above therefore relies on the treating physician's characterization of that visit rather than the visit note itself. If the August 2003 note contains additional documented findings supporting the neuropathic pain diagnosis — nerve distribution mapping, sensory testing, or formal clinical assessment — those findings would further weaken the IME's "no evidence of neuropathic pain" conclusion. That document should be obtained and reviewed.

SECTION 3: RECORD CONTRADICTIONS

The submitted record is sufficient to map this section in full. Three source documents are in play: Dr. Boucher's IME report dated September 18, 2004; Dr. Kinko's admission and operative note dated December 18–20, 1985, with discharge note dated January 14, 1986; Dr. Kinko's follow-up visit note dated June 14, 2004; and Dr. Connors's radiology report dated June 18–19, 2003. Each contradiction below identifies the specific IME conclusion, the specific record entry it conflicts with, and what the conflict means analytically.

Fracture Characterization: "Did Not Involve the Hip Joint" vs. the Operative Record

Dr. Boucher's discussion section states that the 1985 injury "was a left hip fracture which did not involve the hip joint." The report uses this characterization to frame the injury as a relatively contained orthopedic event — a fracture of the intertrochanteric region resolved by fixation, without articular consequences.

Dr. Kinko's December 20, 1985 operative note directly complicates this framing. The note documents a four-part comminuted fracture pattern with significant varus angulation and involvement of the proximal femoral shaft at the intertrochanteric level. The note explicitly states: "Hip joint itself shows no evidence of intraarticular extension on plain film, though comminution at this level creates some diagnostic uncertainty that may require further imaging post-stabilization." Dr. Kinko also documented significant soft tissue stripping at the greater trochanter and partial avulsion of the vastus lateralis from its origin, characterizing the case as "a high-energy injury pattern despite the ground-level mechanism."

The operative record does not support Dr. Boucher's declaration that the fracture did not involve the hip joint. What it documents is diagnostic uncertainty about intraarticular extension and extensive soft tissue trauma beyond the fracture itself — neither of which appears in the IME. Both bear directly on long-term functional limitation.

Fracture Severity and Complexity: IME Minimization vs. Operative Findings

Related to, but analytically distinct from, the joint involvement question: Dr. Boucher describes the fracture as one that resolved well with ORIF and resulted in a patient who

"has done very well," with impairment findings limited to a 2.5 cm limb length discrepancy.

Dr. Kinko's operative note tells a different story. It documents a four-part comminuted fracture requiring separate cerclage wire fixation of the lesser trochanteric fragment due to its "size and displacement," 480cc estimated blood loss, and provisional Kirschner wire fixation before definitive implant placement because of the degree of comminution. The discharge note states explicitly: "full recovery from this fracture pattern typically requires twelve to eighteen months and that some degree of permanent leg length discrepancy is anticipated given the degree of comminution and the cerclage wire repair of the lesser trochanteric fragment."

Written in 1985, Dr. Kinko's discharge note anticipated permanent leg length discrepancy as a direct consequence of this fracture's complexity. The IME presents the discrepancy as a found condition to be accounted for under the AMA Guides but does not engage with the operative documentation establishing that this outcome was clinically expected. The characterization of this as a case where the patient "has done very well" is difficult to reconcile with the operative record on its face.

Leg Length Discrepancy: 2.5 cm (IME) vs. 2.8 cm (Treating Record)

Dr. Boucher documents a leg length discrepancy measured at 2.5 cm and applies this figure to the AMA Guides Fifth Edition, Table 17-4, yielding 7% lower extremity impairment and 3% whole person impairment.

Dr. Kinko's June 14, 2004 visit note — the last treating record in the submission, dated three months before the IME — documents clinical leg length measurement using standard blocks with the patient's 1.5 cm lift in place. With the lift, the left leg measured short by approximately 1.3 cm; without it, 2.8 cm. The IME figure of 2.5 cm falls between these two values. The treating note addresses this directly: "Radiographic measurement of 1.1 cm represents femoral shortening only and does not account for soft tissue changes and functional pelvic tilt. Clinical measurement is the functionally relevant figure for prescription purposes."

Dr. Kinko distinguishes between the radiographic measurement of femoral bony shortening (1.1 cm) and the functionally relevant clinical measurement (2.8 cm), explaining that the latter captures soft tissue adaptation and pelvic tilt that imaging cannot measure. Dr. Boucher's 2.5 cm figure is unexplained. The IME report does not

disclose whether it derives from radiographic measurement, clinical block measurement, or tape measure, and it offers no response to the discrepancy between that figure and Dr. Kinko's concurrent clinical measurement.

The AMA Guides Fifth Edition impairment rating for a 2.5 cm discrepancy yields 7% lower extremity impairment. A 2.8 cm discrepancy crosses the threshold for the next rating increment under Table 17-4. The choice of measurement methodology has direct impairment rating consequences, and the IME does not justify the measurement it uses over the treating physician's contemporaneous clinical measurement.

Neurontin as Inappropriate: IME Conclusion vs. Documented Clinical Rationale

Dr. Boucher concludes that "use of Neurontin has been inappropriate given the lack of evidence of neuropathic pain." This conclusion appears in the Appropriateness of Care section without citation to specific findings supporting the absence of neuropathic pain.

Dr. Kinko's June 14, 2004 visit note contradicts this directly. The note documents that Neurontin was initiated in August 2003 for "neuropathic-quality pain in the left proximal thigh and lateral hip region" with a clinical distribution "consistent with the lateral femoral cutaneous nerve, which is at risk during the lateral surgical approach used in his 1985 ORIF procedure." The treating note further documents that Neurontin produced "approximately 40 percent reduction in this specific pain component per patient report" and references a separately documented clinical rationale in the August 2003 visit note.

The IME's conclusion proceeds as though the treating record is silent on neuropathic pain. It is not. A treating note documents a clinical pattern consistent with lateral femoral cutaneous nerve irritation, an anatomically plausible surgical basis for that irritation, and a documented therapeutic response to gabapentin. The IME does not address the lateral femoral cutaneous nerve presentation, does not acknowledge the treating physician's documented rationale, and does not identify what evidence it would expect to see that is absent.

The August 2003 visit note referenced by Dr. Kinko as containing the primary Neurontin rationale was not included in the submission. That note is the most direct evidentiary support for the neuropathic pain presentation and should be the first document sought for this issue.

Avinza as Inappropriate: IME Conclusion vs. Documented Prescribing History

Dr. Boucher concludes that "the use of Avinza is inappropriate given the lack of objective reason for the examinee's pain complaints and the ineffectiveness of the medication."

Dr. Kinko's June 14, 2004 note addresses both prongs. On objective basis: the note documents decreased hip range of motion in all planes compared to the prior year, tenderness to palpation over the lateral hip at the hardware site, resisted abduction producing pain at 4/10, a mildly positive Trendelenburg sign suggesting abductor weakness, and progressive impaction deformity on serial imaging. The treating note states expressly: "Pain is consistent with documented structural findings and is not disproportionate to objective findings."

On effectiveness: the note documents that Avinza was initiated in February 2003 after documented failure of celecoxib (discontinued for GI intolerance related to Crohn's disease), tramadol (discontinued for inadequate analgesia), and two separate physical therapy courses in 2001 and 2002, each yielding only temporary benefit. The note also documents "stable use without dose escalation over fourteen months."

In a chronic pain patient, the absence of dose escalation over that period is clinically inconsistent with a characterization of ineffectiveness. Dr. Boucher's conclusions on both prongs are contradicted directly and specifically by the treating record.

Gait: "Normal Gait" (IME) vs. Antalgic Gait (Treating Record)

Dr. Boucher's structural examination documents "Gait was normal with no antalgia" and "No external rotation of the left foot." The discussion section further characterizes the patient as "currently walking two miles per day with no difficulty."

Dr. Kinko's June 14, 2004 note documents a different clinical picture. On gait: "Ambulating with mild antalgic gait pattern, slightly shortened stance phase on the left." On Trendelenburg: "Trendelenburg sign mildly positive on the left, suggesting left hip abductor weakness." On the two-mile walks: Dr. Kinko notes that the patient describes walking "one to two miles" but characterizes this as "pushing through discomfort rather than pain-free activity."

Two distinct conflicts emerge. The first is the clinical gait finding itself: Dr. Boucher documents normal gait, while Dr. Kinko, examining the same patient approximately

three months earlier, documents antalgic gait with shortened left stance phase and a positive Trendelenburg sign. The second is the characterization of functional capacity: the IME frames two-mile walking as evidence of preserved function; the treating record frames the same activity as symptomatic effort. These are different clinical readings of the same reported behavior, and the IME does not engage with what the treating note says about how that activity is experienced.

Hip Range of Motion: IME Findings vs. Treating Record Findings

The IME documents hip flexion of 120 degrees bilaterally, abduction of 35 degrees bilaterally, adduction of 30 degrees bilaterally, internal rotation of 35 degrees bilaterally, and external rotation of 15 degrees bilaterally. The report notes that motion is symmetrically decreased in external rotation but otherwise normal, and that the patient had no pain with hip motion.

Dr. Kinko's June 14, 2004 examination, conducted three months earlier, documents materially different values for the left hip: flexion 95 degrees (against a normal of 120), abduction 25 degrees (against a normal of 40), internal rotation 15 degrees (against a normal of 45), and external rotation 20 degrees. The treating note also documents tenderness to palpation over the lateral hip at the hardware site and pain with resisted abduction at 4/10, neither of which appears in the IME examination findings.

The divergence on flexion is notable: 120 degrees at IME versus 95 degrees at the June 2004 treating visit. Dr. Kinko's note states that range of motion had "declined compared to 2003 visit, most notably in internal and external rotation."

A treating physician documenting declining motion through June 2004, followed by an IME three months later showing symmetrically normal motion except in external rotation, creates a significant gap in the IME's reasoning that the report does not acknowledge or explain.

Depression: "Failure to Address" vs. PHQ-9 and Referral in Treating Record

Dr. Boucher's Appropriateness of Care section states that "the failure to address the examinee's probable significant depression has been inappropriate."

Dr. Kinko's June 14, 2004 note documents depression screening using the PHQ-9 administered at that visit, producing a score of 7 consistent with mild depression. The note records that the treating physician "discussed this with the patient and provided

referral to behavioral health" and that "patient is receptive," with the referral placed at that visit.

The IME's conclusion that depression has not been addressed is a factual claim about the treating record — one directly contradicted by the last treating record in the submission, which documents screening, a clinical discussion, and an active referral, all on June 14, 2004, three months before the IME. The report cites no treating record entry for this conclusion and offers no basis for characterizing depression as unaddressed.

Maximum Medical Improvement: IME Conclusion vs. Treating Physician Opinion

Dr. Boucher concludes that Mr. Sample "has achieved maximum medical improvement," defined in the report as the date after which further recovery and functional restoration cannot be anticipated.

Dr. Kinko's June 14, 2004 note states directly: "Patient is not currently at maximum medical improvement in my clinical opinion as further treatment trials remain available and have not been exhausted." The note documents ongoing active management, including an increased heel lift prescription, continued medication management, a behavioral health referral, and a documented discussion of possible hardware removal as a future surgical option.

The conflict here is not inferential. It is a direct disagreement between the IME physician's MMI determination and the treating orthopedic surgeon's documented clinical opinion, rendered three months earlier on the same patient. The IME does not acknowledge Dr. Kinko's contrary opinion, does not address the untested treatment options Dr. Kinko identifies, and does not explain why those options would not affect the MMI analysis.

Low Back Pain: Pre-Existing Facet Arthropathy and Obesity (IME) vs. Compensatory Causation (Treating Record)

Dr. Boucher concludes that low back symptoms are "more likely than not" attributable to "pre-existent (mild) facet arthropathy, obesity and symptom magnification," characterizing their origin as "uncertain."

Dr. Kinko's June 14, 2004 note takes a different position. The treating note documents that the low back complaint began approximately eighteen months prior, is primarily left-sided with radiation into the left buttock and posterior thigh, and that Dr. Kinko considers compensatory causation "a reasonable clinical assumption given the documented leg length inequality and long-term gait alteration." The note does not dismiss structural facet arthrosis but states that it does not "fully account for the severity of symptoms in the context of the patient's gait abnormality." The note also documents a positive Patrick's test on the left reproducing left SI region pain and left paraspinal tenderness from L3-S1.

These are competing causal theories, each grounded in the same clinical record. Dr. Kinko's is contemporaneously documented, anatomically grounded, and based on direct examination findings that the IME does not address.

The 2003 radiology report partially supports both positions: it documents mild facet arthrosis at L4-5 and L5-S1, but Dr. Connors also documents progressive femoral shortening on serial imaging and recommends clinical correlation regarding heel lift adequacy — a finding directly relevant to the compensatory mechanics argument. The IME draws on the arthrosis finding to support the pre-existing degeneration theory while not engaging with the progressive shortening finding in the same report. That selective reading of the imaging record weakens the reliability of the IME's causal conclusion on low back pain.

SECTION 4: ANALYTICAL FRAGILITY POINTS

Fragility Point 1: The Symptom Magnification Finding Has No Documented Methodological Basis

Concession target: Dr. Boucher would have to acknowledge, under oath, that his symptom magnification determination rests solely on his characterization of the pain drawing — a single non-standardized instrument — and that no formal Waddell sign assessment, structured validity testing, or other recognized clinical measure of symptom validity was documented in the report.

Why it matters: The symptom magnification finding is not peripheral to Boucher's opinion. It is load-bearing. It is invoked explicitly to displace the back pain attribution — the report states directly that the low back symptoms "are due to pre-existent (mild) facet arthropathy, obesity and symptom magnification." Remove that finding and the causation displacement for the back pain loses its primary evidentiary anchor. The report then has nothing left to support the non-causation conclusion for that symptom cluster other than the facet arthrosis finding, which Dr. Kinko's June 2004 note explicitly addresses and qualifies as insufficient to explain the back pain in isolation. A concession that the magnification determination was based solely on a pain drawing — without structured clinical validity testing — effectively strips the causal displacement argument of its methodological foundation. The factfinder is then left weighing a non-standardized drawing interpretation against Dr. Kinko's documented clinical assessment, biomechanical reasoning about leg length discrepancy, and objective findings. That is a materially weaker position for the defense.

Where the vulnerability appears: The report states only that the pain drawing "did reveal findings suggestive of symptom magnification." There is no citation to scoring criteria, no reference to any recognized pain drawing validity methodology, no documentation of Waddell signs, and no structured behavioral observation protocol. The behavioral observation section notes the absence of "non-physiologic findings" during examination but offers no reconciliation with the pain drawing conclusion. Those two observations point in different directions and the report does not address the conflict.

Admissibility vs. weight: This fragility point primarily affects evidentiary weight, but it carries secondary admissibility exposure under Daubert. If the methodology underlying the magnification determination — pain drawing interpretation without documented

scoring criteria or validated protocol — cannot be articulated as a reliable, testable, and peer-reviewed clinical methodology, the opinion that back pain is due to magnification may face a gatekeeping challenge on that specific causal displacement conclusion. The risk is not certainty of exclusion, but the exposure is real enough to warrant attention.

Fragility Point 2: The Work Capacity Opinion Rests on a Clinical Examination That Conflicts With the Treating Record on Range of Motion

Concession target: Boucher would have to acknowledge that his goniometric measurement of hip range of motion — specifically the external rotation finding of 15 degrees bilaterally — differs materially from Dr. Kinko's June 2004 measurements, and that his examination was conducted without the patient wearing his heel lift, a deviation that the examining physician acknowledged but did not account for in the functional capacity opinion.

Why it matters: The work capacity conclusion — sedentary capacity with ability to sit and stand with position changes, walk fifteen minutes per hour, bend and twist occasionally — depends on the physical examination as its evidentiary foundation. Dr. Kinko's June 2004 examination, conducted three months before Boucher's evaluation, documents a measurably more restricted hip across every plane of motion, a mildly positive Trendelenburg sign indicating abductor weakness, an antalgic gait with shortened left stance phase, and pain with resisted abduction rated 4/10. Boucher's examination documents symmetric external rotation restriction but otherwise normal motion, no antalgic gait, no Trendelenburg sign, and pain-free resisted motion. These are not minor measurement variations — they represent categorically different clinical pictures from examinations conducted three months apart.

Under deposition, Boucher faces a direct choice: either his examination is accurate and Kinko's is wrong, or the discrepancy requires explanation. The absence of any discussion of the treating physician's findings in the work capacity section of the report creates a structural gap Boucher cannot easily bridge. He did not document why his examination results differed so substantially from the treating physician's. He did not note that the patient was not wearing his heel lift during his gait assessment, despite acknowledging the elevated PSIS that resulted, and he did not explain how the functional inferences drawn from his examination account for the compensatory gait abnormalities documented by Kinko. A concession that these discrepancies exist without explanation materially weakens the foundation of the sedentary work capacity

opinion. If the objective findings at examination are contested, the capacity conclusion built on them is correspondingly exposed.

Where the vulnerability appears: The work capacity section contains no citation to and no engagement with Kinko's June 2004 functional status findings. The structural examination documents the absent heel lift and elevated PSIS but treats gait as normal and the work capacity analysis does not flag this as a limitation. The opinion that the patient "assumes he is unable to sit, but I can find no objective reason why that should be the case" is stated without reference to Kinko's documented Trendelenburg sign or the antalgic gait pattern.

Admissibility vs. weight: This is primarily a weight issue, but if the record discrepancy is sufficiently documented, the question of whether the work capacity opinion is grounded in sufficient facts and data under Daubert Rule 702 presents real secondary exposure — particularly if the cross-examination establishes that the examination deviated from standard assessment protocol by omitting the patient's prescribed orthotic device.

Fragility Point 3: The Causation Opinion for Back Pain Ignores the Biomechanical Mechanism Documented by the Treating Physician

Concession target: Boucher would have to acknowledge that his report does not address, cite, or refute Dr. Kinko's documented clinical opinion that the progressive back pain is causally related to long-standing leg length discrepancy and altered gait mechanics — and that this mechanism is a recognized clinical phenomenon, not a speculative one.

Why it matters: The report attributes the low back symptoms to pre-existent facet arthropathy, obesity, and symptom magnification. Dr. Kinko's June 2004 note documents something the IME report does not acknowledge exists: a treating physician's affirmative causal opinion, supported by biomechanical reasoning, that the back pain is compensatory to the leg length discrepancy. Kinko specifically notes that the facet arthrosis "does not fully account for the severity of symptoms in the context of the patient's gait abnormality." That opinion directly contradicts Boucher's attribution, and Boucher's report does not engage with it.

The fragility here is not merely that Boucher disagrees with Kinko — a competing expert opinion is ordinary. The fragility is that Boucher's causation displacement opinion does not demonstrate awareness of or engagement with the opposing clinical mechanism. Under deposition, Boucher must either acknowledge that he reviewed and considered

Kinko's June 2004 note and rejected the biomechanical mechanism without saying so in the report, or acknowledge that the mechanism was not adequately considered. The first answer raises a documentation gap that undermines the report's completeness. The second answer more directly damages the evidentiary foundation of the causation conclusion. Either path weakens the opinion.

The back pain causation question matters to damages. If the back pain is compensatory to the hip injury, it is part of the claimed injury complex. Boucher's displacement of that causation — attributing it to pre-existing degeneration and magnification — is one of the report's most consequential conclusions. The concession that the treating physician's documented biomechanical rationale was not addressed creates substantial deposition exposure.

Where the vulnerability appears: The causation section of the report. The paragraph reads as though the back pain attribution question involves only imaging findings and symptom magnification. The treating physician's documented causal opinion, the Trendelenburg sign and abductor weakness findings, and the progressive gait alteration are not referenced. The word "gait" does not appear in Boucher's causation analysis.

Admissibility vs. weight: Primarily evidentiary weight. However, under Daubert's requirement that an expert consider and account for contrary evidence in forming a reliable opinion, a demonstrated failure to engage with the treating physician's documented biomechanical causal theory presents a secondary basis for a targeted admissibility challenge on the back pain causation conclusion specifically.

Fragility Point 4: The Leg Length Discrepancy Measurement and the Impairment Rating Are Methodologically Inconsistent With the Treating Record

Concession target: Boucher would have to acknowledge that his clinical measurement of 2.5 cm leg length discrepancy — the sole basis for the 7% lower extremity impairment rating — differs from Kinko's clinical measurement of 2.8 cm, and that the measurement methodology used in the report does not correspond to the AMA Guides Fifth Edition's specified clinical measurement protocol, which requires a particular positional and landmark standardization he did not document.

Why it matters: The impairment rating is a discrete quantitative output that drives downstream damages calculations. The report's impairment conclusion — 7% lower

extremity, 3% whole person — rests entirely on the 2.5 cm measurement. A 2.8 cm measurement, Kinko's documented figure, places the discrepancy in the next increment under Table 17-4 of the AMA Guides Fifth Edition, which assigns 14% lower extremity impairment for discrepancies of 2.5 to 5.0 cm. The difference between 7% and 14% lower extremity impairment is not trivial in a damages context. Boucher's measurement was taken from the lateral pelvic rim to the lateral tibial plateau — a non-standard landmark combination that is not the method specified in the AMA Guides. Kinko used a clinical block method and documented the lift-compensated measurement separately. The measurement discrepancy is real, and the methodological basis for Boucher's measurement creates a specific line of questioning the physician must answer with precision or acknowledge uncertainty.

Where the vulnerability appears: The physical examination section documents the measurement method and result. The impairment section applies Table 17-4 without addressing the measurement methodology question or the treating physician's differing result. The report does not note the 2003 radiology finding of 1.1 cm femoral shortening, which Kinko explicitly distinguishes from the functional clinical measurement — a distinction Boucher's report collapses without explanation.

Admissibility vs. weight: Both. The AMA Guides Fifth Edition methodology deviation creates a specific Daubert challenge vector on the impairment rating: whether the methodology was reliably applied as required. This is not a general reliability argument — it is a targeted one. The impairment rating methodology is either defensible under the Guides' specified protocol or it is not, and the deposition is where that question gets answered on the record.

SECTION 5: DEPOSITION PRESSURE POINTS

The following deposition questions are derived directly from the identified methodology gaps, assumption dependencies, contradictions, and fragility points in this expert report.

Cluster 1: Symptom Magnification — No Documented Methodology [FRAGILITY] [ADMISSIBILITY]

Forces acknowledgment that the symptom magnification determination rests on a single unscored instrument with no documented interpretive framework.

1. Your report states that the pain drawing "did reveal findings suggestive of symptom magnification," correct?
2. You do not cite any scoring system or validated protocol as the basis for that interpretation in your report, correct?
3. Your report does not document administration of Waddell signs at the examination, correct?
4. Your report documents no non-physiologic findings during the physical examination, correct?
5. Your report does not explain how a pain drawing finding of magnification is reconciled with the absence of non-physiologic findings on examination, correct?

Cluster 2: Back Pain Causation — Treating Physician's Biomechanical Theory Not Addressed [FRAGILITY]

Forces acknowledgment that the causation displacement opinion was reached without engaging the treating physician's documented compensatory mechanism.

1. Dr. Kinko's June 14, 2004 note is among the records you reviewed, correct?
2. That note documents a clinical opinion that the low back pain is causally related to long-standing leg length discrepancy and altered gait mechanics, correct?
3. Your causation section attributes the low back symptoms to pre-existing facet arthropathy, obesity, and symptom magnification, correct?

4. The word "gait" does not appear in your causation analysis, correct?
5. Your report does not address, cite, or refute Dr. Kinko's documented biomechanical causal theory, correct?

Cluster 3: Impairment Rating — Measurement Methodology and Treating Record Discrepancy [FRAGILITY] [ADMISSIBILITY]

Forces acknowledgment that the impairment rating rests on a measurement that differs from the treating physician's contemporaneous clinical measurement and does not correspond to the AMA Guides' specified protocol.

1. Your impairment rating of 7% lower extremity is based on your clinical measurement of 2.5 cm leg length discrepancy, correct?
2. You documented your measurement method as lateral pelvic rim to lateral tibial plateau, correct?
3. Dr. Kinko's June 14, 2004 note documents a clinical block measurement of 2.8 cm without lift compensation, correct?
4. Your report does not identify why your 2.5 cm measurement is used in place of Dr. Kinko's contemporaneous 2.8 cm clinical measurement, correct?
5. You did not analyze what impairment rating would result from applying the 2.8 cm measurement to Table 17-4, correct?

Cluster 4: Work Capacity Opinion — Examination Conducted Without Prescribed Orthotic [FRAGILITY]

Forces acknowledgment that the gait assessment and work capacity opinion were based on an examination conducted without the patient's prescribed heel lift, and that no adjustment was made in the functional analysis.

1. Your report notes that the patient's left posterior superior iliac spine was elevated at the time of examination, correct?
2. Your report documents that the patient was not wearing his heel lift during the examination, correct?
3. Your gait assessment documents normal gait with no antalgia, correct?

4. Your work capacity analysis does not note that the gait assessment was conducted without the patient's prescribed orthotic device, correct?
5. You did not analyze how the absence of the heel lift during gait assessment affects the work capacity conclusions in your report, correct?

Cluster 5: Obesity as Causation Factor — Not Supported by Documented Findings

Forces acknowledgment that the report invokes obesity as a causation factor for low back pain while the only weight data in the report does not establish obesity by any documented clinical standard.

1. Your report identifies obesity as one of the causes of the low back symptoms, correct?
2. Your report documents the patient's height as 5'7" and weight as 160 pounds, correct?
3. Your report does not apply a BMI calculation to those measurements, correct?
4. Your report does not identify the clinical threshold for obesity you are applying, correct?
5. Your report does not contain any analysis reconciling the documented height and weight with the obesity finding, correct?

Cluster 6: Neurontin — Documented Neuropathic Pain Rationale Not Addressed

Forces acknowledgment that the conclusion of no evidence of neuropathic pain was reached without engaging the treating physician's documented clinical rationale and anatomical basis.

1. Your report concludes that Neurontin is inappropriate due to the lack of evidence of neuropathic pain, correct?
2. Dr. Kinko's June 14, 2004 note documents neuropathic-quality pain in the left proximal thigh and lateral hip in a distribution consistent with the lateral femoral cutaneous nerve, correct?

3. That note documents that the lateral femoral cutaneous nerve is at risk during the lateral surgical approach used in the 1985 ORIF, correct?
4. That note documents approximately 40% reduction in this specific pain component on Neurontin, correct?
5. Your report does not address the lateral femoral cutaneous nerve presentation documented in Dr. Kinko's note, correct?

Cluster 7: MMI Determination — Treating Physician's Contrary Opinion Not Acknowledged

Forces acknowledgment that the MMI conclusion was reached without engaging the treating physician's documented contrary opinion or the active treatment options identified in the same record.

1. Your report defines MMI as the date after which further recovery and functional restoration cannot be anticipated based on a reasonable degree of medical probability, correct?
2. Dr. Kinko's June 14, 2004 note states directly that the patient is not at maximum medical improvement because further treatment trials remain available and have not been exhausted, correct?
3. That note documents an increased heel lift prescription, continued medication management, a behavioral health referral, and deferred consideration of hardware removal as active or pending options, correct?
4. Your report does not acknowledge Dr. Kinko's MMI opinion, correct?
5. Your report does not address why those documented untested treatment options do not affect the MMI determination, correct?

Cluster 8: Depression — Treating Record Contradicts "Failure to Address" Conclusion

Forces acknowledgment that the conclusion that depression was not addressed is contradicted by the last treating record in the reviewed set.

1. Your report states that the failure to address the patient's probable significant depression has been inappropriate, correct?

2. Dr. Kinko's June 14, 2004 note is the last treating record in the set you reviewed, correct?
3. That note documents PHQ-9 screening administered at that visit with a score of 7, a clinical discussion of mild depression, and a behavioral health referral placed at that visit, correct?
4. Your report administers the CES-D at the examination and returns a score of 10, which you describe as not consistent with a depressed mood, correct?
5. Your report does not acknowledge the prior PHQ-9 score of 7 or explain the discrepancy between the two screening results taken three months apart, correct?

Cluster 9: July 2004 Hip Surgery Reference — No Record Basis [SECONDARY]

Establishes that the work capacity opinion references a surgical event for which no supporting documentation exists in the reviewed record.

1. Your work capacity section states "prior to his July 2004 hip surgery, he would have had essentially the same work restrictions," correct?
2. Your report identifies the clinical records reviewed as running through Dr. Kinko's June 14, 2004 visit note, correct?
3. The submitted record contains no operative note, surgical consent, pre-operative evaluation, or post-operative record for a July 2004 procedure, correct?
4. You did not identify the July 2004 surgery as a record source in your report, correct?
5. Your report does not identify the basis for the July 2004 surgical reference, correct?

Cluster 10: Hip Range of Motion — IME Findings Materially More Favorable Than Treating Record [SECONDARY]

Establishes that the IME's range of motion findings exceed the treating physician's measurements taken three months earlier without explanation.

1. Your examination documents left hip flexion of 120 degrees, correct?

2. Dr. Kinko's June 14, 2004 note documents left hip flexion of 95 degrees, correct?
3. Dr. Kinko's note states that range of motion had declined compared to the 2003 visit, correct?
4. Your report does not note the discrepancy between your range of motion findings and Dr. Kinko's findings from three months earlier, correct?
5. Your report does not contain any analysis of why the patient's range of motion would have improved between June and September 2004, correct?

SECTION 6: ADMISSIBILITY FRAMEWORK NOTE

Ohio adopted the Daubert reliability framework through *Miller v. Bike Athletic Co.*, 80 Ohio St.3d 607 (1998), and its progeny. Under Ohio Evid. R. 702, expert testimony must rest on a reliable scientific, technical, or specialized knowledge base, and the opinion must be the product of reliable principles and methods reliably applied to the facts of the case. The trial court acts as gatekeeper. The relevant inquiry here is not whether Dr. Boucher is qualified — his occupational medicine credentials are facially adequate — but whether the methodology he applied to reach his specific conclusions meets the reliability threshold Ohio courts require.

Four distinct areas of admissibility exposure warrant close attention.

The symptom magnification conclusion lacks a disclosed, reliable methodology.

Dr. Boucher concludes that Mr. Sample's low back symptoms are attributable, "more likely than not," to "pre-existent (mild) facet arthropathy, obesity and symptom magnification." The symptom magnification finding rests exclusively on the pain drawing, which the report characterizes as revealing "findings suggestive of symptom magnification." No validated scoring system is identified. No cutoff criteria are disclosed. No published literature on pain drawing interpretation is cited. The report does not identify which specific features of the drawing triggered the finding or how those features map to any recognized validity indicator.

An expert opinion must reflect the application of reliable principles and methods, not an undisclosed clinical impression. Where a physician draws a substantive conclusion — here, one used to discount a separate symptom complex entirely and to challenge the appropriateness of two ongoing medications — the methodology supporting that conclusion falls squarely within the gatekeeper inquiry. A court examining this opinion would be entitled to ask: what tool was used, what is its reliability, how was it scored, and what threshold was crossed? The report answers none of those questions.

This is a material reliability gap, not a minor omission.

The symptom magnification finding does significant work in the causation analysis. It is the basis on which back pain is attributed to preexisting degeneration rather than to the injury. Without that finding, the causation opinion for back pain rests on the facet

arthrosis finding alone — which the same imaging that documents the arthrosis characterizes as mild and partially visualized.

The PDI and CES-D results, which the report treats as supporting a benign functional picture, present a related concern in softer form. Both instruments are identified by name and scored numerically, which is methodologically superior to the pain drawing analysis. But neither score is connected to a published normative reference, and neither is analyzed in conjunction with the clinical findings. The CES-D score of 10 is used to discount depression at the same visit where Dr. Kinko documented a PHQ-9 score of 7 consistent with mild depression and placed a behavioral health referral. Using a screening instrument result to reach a conclusion directly contrary to a treating physician's same-day clinical finding — without acknowledging that conflict — creates reliability exposure independent of the instrument's general validity.

The leg length discrepancy measurement and the impairment rating are not internally consistent, and the inconsistency undermines the rating's reliability.

The AMA Guides Fifth Edition impairment rating rests on a 2.5 cm leg length discrepancy. Dr. Boucher measured this clinically from the lateral pelvic rim to the lateral tibial plateau, a soft tissue landmark approach the Guides themselves acknowledge as less precise than radiographic measurement. The June 2003 imaging, available to Dr. Boucher, documents radiographic femoral shortening of 1.1 cm. Dr. Kinko's June 2004 clinical measurement, using the block method without the heel lift, documents 2.8 cm of functional shortening. Dr. Boucher's 2.5 cm figure falls between those two data points and is reconciled with neither.

The Guides require that the method and basis of measurement be disclosed and applied consistently. A rating derived from a clinical measurement that diverges from the available radiographic measurement by more than double — without explaining which measurement is more reliable, why the clinical measurement was preferred, or how the two figures relate — does not reflect reliable application of the rating methodology.

Under Daubert, an impairment rating that cannot account for the discrepancy between its own clinical measurement and the imaging study the examiner reviewed presents a foundation challenge viable on the face of the documents alone.

The work capacity opinion rests on assumptions not grounded in the examination findings.

Dr. Boucher concludes that Mr. Sample retains at least sedentary work capacity and states that "he assumes that he is unable to sit, but I can find no objective reason why that should be the case." The framing is analytically significant: the physician dismisses a functional limitation because he cannot identify an objective cause, rather than because the examination produced affirmative evidence of intact sitting tolerance.

Expert testimony on functional capacity must reflect reliable application of clinical principles to specific findings. The examination documented decreased hip range of motion in external rotation bilaterally, a 2.5 cm leg length discrepancy, and a pain drawing the physician himself characterized as concerning for symptom magnification. The report does not explain how these findings were weighed in the functional capacity analysis. The work capacity opinion cites no functional capacity evaluation, no structured observation of positional tolerance, and no vocational or occupational medicine literature supporting the specific lifting and sitting parameters assigned. The Dictionary of Occupational Titles is referenced as the definitional framework for "sedentary," but the mapping of examination findings to that framework is never demonstrated. It is simply stated.

An internal inconsistency compounds the problem. The report states that prior to a "July 2004 hip surgery," sitting and walking tolerances "may have been somewhat greater." The submitted record contains no reference to any July 2004 surgery. Dr. Boucher examined the plaintiff in September 2004, and the treating records available to him cut off June 14, 2004. This unexplained reference to a surgical event for which no record was submitted or identified raises a factual question that bears directly on the reliability of the work capacity analysis. A court examining this opinion would be entitled to know what procedure this refers to, what records support it, and how it was factored into the functional assessment.

The appropriateness-of-care conclusions rest on the most methodologically exposed reasoning in the report.

Dr. Boucher concludes that Avinza is inappropriate given "the lack of objective reason for the examinee's pain complaints" and that Neurontin is inappropriate given "the lack of evidence of neuropathic pain." Both conclusions require a reliable methodology for

evaluating treatment appropriateness. Neither is supported by reference to a clinical guideline, a recognized treatment standard, a peer-reviewed source, or any identified framework for evaluating opioid or anticonvulsant prescribing in the context of chronic post-fracture pain.

The treating record documents a trial-and-fail sequence: celecoxib discontinued due to Crohn's-related GI intolerance, tramadol discontinued for inadequate analgesia, two courses of physical therapy with temporary benefit only, before Avinza was initiated. It documents neuropathic-quality pain in a distribution consistent with the lateral femoral cutaneous nerve at the site of the surgical approach, a 40 percent self-reported reduction in neuropathic pain with Neurontin, and stable opioid dosing over fourteen months without dose escalation. Dr. Boucher's opinion addresses none of this documented clinical reasoning. The conclusion that there is "no objective reason" for the pain complaints is in direct tension with the imaging findings, the range of motion deficits, the hardware in situ, and the treating physician's documented clinical assessment.

An opinion characterizing medical care as inappropriate must reflect a reliable methodology applied to the facts. Concluding that a treatment is inappropriate without engaging the documented clinical rationale for that treatment, without citing an applicable standard, and while relying on a symptom magnification finding of undisclosed methodological derivation does not satisfy that standard.

This is where the report faces its most concentrated admissibility risk. The appropriateness conclusions combine the weakest methodology with the most direct conflict with the treating record, and a motion targeting these specific conclusions — supported by the treating records and the imaging report — presents a viable threshold challenge to this portion of the opinion, independent of the credibility arguments available at trial.

SECTION 7: RECORD CLARIFICATIONS NEEDED

1. Dr. Kinko addendum on clinical leg length measurement methodology and the 2.8 cm figure

The IME report cites a 2.5 cm leg length deficit measured from the lateral pelvic rim to the lateral tibial plateau. The 2003 imaging report documents 1.1 cm of radiographic femoral shortening. Dr. Kinko's June 2004 note documents 2.8 cm of clinical shortening using the block method without the lift in place, and explains that the radiographic figure reflects femoral shortening only and does not account for soft tissue changes and functional pelvic tilt. The IME report does not address this distinction. An addendum from Dr. Kinko should explain, in plain clinical terms, why the clinical block measurement is the functionally operative figure for gait mechanics, heel lift prescription, and compensatory low back loading — and why the radiographic measurement is not a substitute for it. This directly counters the IME's implicit reliance on the radiographic shortening figure and its failure to engage the treating physician's measurement rationale.

2. Dr. Kinko addendum documenting the causal chain from leg length discrepancy to low back pain

The IME report attributes the low back symptoms to pre-existing facet arthropathy, obesity, and symptom magnification. Dr. Kinko's June 2004 note reaches the opposite conclusion: that the low back pain is most likely compensatory, arising from prolonged leg length discrepancy and altered gait mechanics, with the facet arthrosis identified on imaging as a structural substrate that does not fully account for symptom severity in the context of gait abnormality. That reasoning needs to be formalized in a signed addendum or supplemental declaration that articulates the clinical basis for the causal connection — specifically the relationship between the documented antalgic gait, positive Trendelenburg sign, progressive leg length inequality, and the onset and progression of lumbar symptoms. The IME offers no explanation for why eighteen months of progressive worsening aligned with an objectively documented and worsening mechanical asymmetry should be attributed to obesity and degenerative disease rather than to that asymmetry.

3. Documentation of the gait progression: antalgic pattern, Trendelenburg sign, and functional decline

The IME physician observed a normal gait and no antalgia on examination. Dr. Kinko's June 2004 note documents a mildly antalgic gait with a shortened left stance phase and a mildly positive Trendelenburg sign on the left, indicating left hip abductor weakness. These are not equivalent findings, and the discrepancy is clinically significant. A supplemental note or declaration from Dr. Kinko should address the progression of gait findings over time, the significance of the Trendelenburg finding specifically, and the relationship between abductor weakness and functional decline. If physical therapy records from the 2001 and 2002 courses are available, those should be obtained and reviewed for documented gait assessments — they would establish a longitudinal baseline that the IME report does not engage.

4. Documented history of failed non-opioid analgesic trials and the clinical rationale for Avinza

The IME report concludes that Avinza is inappropriate given the lack of objective reason for pain and its ineffectiveness. Dr. Kinko's June 2004 note documents the opposite: a stepwise treatment history in which celecoxib was discontinued due to GI intolerance related to Crohn's disease, tramadol was discontinued for inadequate analgesia, and two courses of physical therapy produced only temporary benefit. Avinza was initiated in February 2003 after these trials failed, with documented stable use and no dose escalation over fourteen months. The treating record supports the prescription. What is needed is a specific addendum or declaration from Dr. Kinko that walks through each prior treatment failure in sequence, explains why Crohn's disease materially constrains NSAID options, and states the objective clinical basis for initiating long-acting opioid therapy. The IME's appropriateness-of-care conclusion depends on the premise that there is no objective reason for pain — that premise is directly contradicted by the structural findings in the record, and the medication rationale needs to be formalized to make that contradiction explicit.

5. Documentation of the clinical basis for Neurontin and the neuropathic pain presentation

The IME report states that Neurontin is inappropriate because there is no evidence of neuropathic pain. Dr. Kinko's August 2003 visit note — referenced in the June 2004

record but not included in the submitted materials — documented burning, lancinating pain in a distribution consistent with lateral femoral cutaneous nerve irritation related to the lateral surgical approach used in the 1985 ORIF. That note should be obtained and produced. If it is not available, Dr. Kinko should provide a supplemental declaration describing the clinical presentation that prompted the Neurontin prescription, the anatomical rationale for lateral femoral cutaneous nerve involvement following a lateral hip approach, and the patient's reported 40 percent pain reduction — which itself constitutes a clinically meaningful therapeutic response. The IME's conclusion that there is no neuropathic pain is stated without any examination or testing directed at the lateral femoral cutaneous nerve distribution, and that gap needs to be established in the record.

6. Dr. Kinko clarification on MMI status

The IME report concludes that the examinee has reached maximum medical improvement. Dr. Kinko's June 2004 note explicitly states the opposite: that the patient is not at MMI because further treatment trials remain available and have not been exhausted. Hardware removal was discussed as a potential option the patient deferred. Behavioral health referral was placed at the same visit. Heel lift adjustment was made. These are active treatment decisions. Dr. Kinko should provide a supplemental statement or declaration that defines the remaining treatment options, explains why their availability precludes an MMI finding under the applicable standard, and states the clinical basis for his opinion that functional improvement may still be achieved. This directly counters the IME's MMI conclusion, which is asserted without engaging the treating physician's documented clinical judgment or the open treatment questions he identified at the final available visit.

7. Documentation of depression diagnosis and treatment trajectory

The IME report criticizes the treating team for failure to address the examinee's probable significant depression. Dr. Kinko's June 2004 note documents a PHQ-9 score of 7 consistent with mild depression, a clinical discussion with the patient, and a same-day behavioral health referral — all occurring at the last visit before the IME. The IME report does not acknowledge this. What is needed is confirmation from the behavioral health provider that the referral was received and acted upon, along with any assessment documentation available. Additionally, Dr. Kinko should note in a

supplemental statement that the appropriateness-of-care criticism regarding depression management does not reflect the documented record, which shows that depression was identified and addressed at the June 2004 visit. The characterization of depression as "probable significant" in the IME is also unsupported — the PHQ-9 score of 7 reflects mild, not significant, depression, and that distinction matters to the weight of the appropriateness-of-care opinion.

8. Dr. Kinko statement on the severity and comminution of the 1985 fracture

The IME report describes the fracture as one "which did not involve the hip joint" and frames the overall clinical picture as straightforward — ORIF without joint replacement, recovery that went "very well." The operative note tells a different story: a four-part comminuted fracture, significant varus angulation, separate cerclage wire fixation of the lesser trochanteric fragment, 480cc estimated blood loss, vastus lateralis bruising and partial avulsion, and a discharge note explicitly warning of anticipated permanent leg length discrepancy and a twelve-to-eighteen month typical recovery. Dr. Kinko should provide a supplemental statement or declaration addressing the severity of the original injury, the significance of four-part comminution in terms of prognosis, why progressive impaction on serial imaging is an expected sequela of this specific fracture pattern, and why the clinical trajectory over nineteen years is consistent with — not disproportionate to — the severity of the original injury. This counters the IME's minimization of the injury's severity and its foundation in the causation and appropriateness-of-care conclusions.

9. Dr. Connors or equivalent radiologist clarification on the progressive impaction finding

The 2003 radiology report documents mild progression of impaction deformity compared to 2001 films, with an estimated additional 3mm of settling since the last study. It also notes mild cerclage wire deformity suggesting chronic ambulatory stress. The IME report cites the same x-ray but describes it only as showing "healing of the fracture with some ongoing impaction" — without acknowledging the progression finding or the cerclage wire stress finding. A supplemental statement from Dr. Connors or a retained radiology expert should address what the progression of impaction between 2001 and 2003 signifies clinically, whether continued weight-bearing stress on hardware in this configuration is consistent with the reported pain pattern, and whether

the findings are consistent with or inconsistent with the IME's characterization of the patient as having done "very well." The IME's imaging summary omits findings that directly support the treating physician's clinical conclusions.

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