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SAMPLE IME ANALYSIS

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The analysis maps the IME's reasoning against the treating record and identifies where conclusions depend on assumptions, where the record is not fully addressed, and where the reasoning becomes difficult to defend.

FULL REDACTED SAMPLE — IME 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

File Reference: N/A

IME Physician: William F. Boucher, MD

Date of IME: September 18, 2024

Claimant: Tom Sample

Prepared by: Raymond Davey

Independent Litigation Analyst

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Important: This is a redacted sample. Names, locations, and dates have been modified to protect confidentiality.

WHERE THIS IME BECOMES DIFFICULT TO DEFEND

6 Key Reasoning Vulnerabilities Where the opinion's conclusions are not fully supported by its own analysis	4 Opinion Dependencies Where conclusions rely on assumptions the report does not establish
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1 Core Argument Summary The structure and logic the opinion depends on to hold together	1 Confidence Surface What is stable in the opinion versus where it becomes exposed

EXECUTIVE SUMMARY

This summary identifies where the IME's conclusions depend on assumptions, omissions, or reasoning gaps within the submitted record.

The IME's core position is that the claimant has reached maximum medical improvement, retains sedentary work capacity, and requires no further treatment, with impairment limited to a 3% whole person rating based on leg length discrepancy.

The analysis below isolates where that position is not fully supported by the documented findings or treating record.

The IME assigns 3% whole person impairment based solely on leg length discrepancy while concluding the plaintiff has sedentary work capacity, reached maximum medical improvement, and requires no further treatment. The examiner cannot connect the work capacity restrictions imposed—15 minutes walking per hour, frequent position changes—to examination findings documenting painless hip motion, normal gait, and two-mile daily walking capacity. The restrictions suggest functional limitation the examination does not demonstrate, yet the impairment rating treats the injury sequelae as minimal and static.

Key Reasoning Vulnerabilities

The work capacity determination restricts walking to 15 minutes per hour for a plaintiff documented as walking two miles daily with no assistive device and painless hip motion on examination. The IME states explicitly "I can find no objective reason" for sitting limitations while documenting bilateral hip rotation restrictions and acknowledging the treating record's documentation of positive Patrick's test and SI joint involvement.

The examiner cannot defend the restrictions without explaining why self-reported and observed function significantly exceeds the work capacity assigned or why documented clinical findings fail to constitute objective support.

The low back causation opinion attributes symptoms to preexisting facet arthropathy without establishing the arthropathy predated the injury. Dr. Kinko explicitly connected lumbar symptoms to 19 years of altered gait from documented leg length discrepancy. He stated the mild facet changes "do not fully account for the severity of symptoms in the context of the patient's gait abnormality." The IME does not engage this documented

clinical reasoning. The examiner offers no explanation of why compensatory loading over nearly two decades presents less probable causation than facet changes of unknown temporal origin.

The symptom magnification finding rests entirely on undisclosed pain drawing features while contradicted by documented examination behavior. The IME notes the plaintiff "appeared comfortable," "sat continuously for up to 20 minutes," showed "no significant pain behavior," and "non-physiologic findings were not present." The Pain Disability Index scored 13% (characterized as mild). The CES-D scored 10 (not consistent with depression). What pain drawing findings outweigh these contradicting observations? The examiner determined symptom magnification when behavioral and inventory data show the opposite pattern without explaining how.

The medication inappropriateness conclusions ignore documented treatment rationale and clinical findings. Dr. Kinko documented Avinza initiation after failed trials of celecoxib, tramadol, and physical therapy, with stable use over 14 months without dose escalation. He prescribed Neurontin for documented burning, lancinating pain in lateral femoral cutaneous nerve distribution—symptoms at surgical risk from the lateral approach used. The IME characterizes both medications as inappropriate due to "lack of objective reason" and "lack of evidence of neuropathic pain." The documented progressive impaction, hardware tenderness, nerve distribution symptoms, and treatment response that formed the prescribing rationale go unaddressed.

The maximum medical improvement determination directly contradicts the treating record.

Dr. Kinko's June 2004 note states explicitly "Patient is not currently at maximum medical improvement in my clinical opinion as further treatment trials remain available and have not been exhausted." He documented declining range of motion compared to the prior year. The IME declares MMI reached without addressing this documented opinion. Progressive functional decline and incomplete treatment trials appear inconsistent with a conclusion that no further recovery can be anticipated, yet the examiner offers no reconciliation.

The impairment rating methodology treats leg length discrepancy as the sole ratable consequence while documenting bilateral hip rotation restriction. The examiner examined the plaintiff without the prescribed heel lift and noted structural findings of progressive impaction and hardware stress on imaging. The 2.5 cm measurement used

differs from the treating physician's 2.8 cm clinical measurement from the same period. The report offers no explanation of the measurement technique or why clinical measurement should be disregarded when functional impact depends on weight-bearing discrepancy rather than skeletal measurement alone.

Primary Concession Targets

What examination findings support restricting walking to 15 minutes per hour when the documented examination shows painless hip motion, normal gait, no assistive device use, and self-reported two-mile daily walking capacity without difficulty?

What clinical evidence establishes that the facet arthropathy visible on 2003 imaging predated the 1985 injury rather than developed progressively over 18 years of compensatory gait mechanics from documented leg length discrepancy?

What specific pain drawing features constitute the symptom magnification finding when behavioral observations documented no pain behavior, the Pain Disability Index scored 13%, and the CES-D scored 10, all characterized as mild or non-significant?

What documentation establishes Avinza ineffectiveness when the treating record shows stable dosing over 14 months without escalation and contemporaneous pain ratings showing meaningful reduction from baseline?

Why does the maximum medical improvement determination apply when the treating physician explicitly documented in June 2004 that MMI had not been reached because further treatment options remained available and had not been exhausted?

Why did the examiner select the 2.5 cm leg length measurement over the treating physician's 2.8 cm clinical measurement from June 2004, and did the examination occur with or without the prescribed heel lift in place?

SECTION 1: CORE ARGUMENT SUMMARY

The IME physician advances a tightly bounded primary conclusion: the examinee reached maximum medical improvement from the 1985 left hip fracture, requires no further treatment beyond a heel lift, and warrants 3% whole person impairment based solely on leg length discrepancy. The report constructs this position through three arguments. First, the injury itself was successfully treated and healed without complication. Second, current hip symptoms are minimal and functionally insignificant. Third, any treatment beyond basic accommodation represents deviation from appropriate care standards.

The reasoning architecture depends on temporal framing that isolates the original injury as a discrete, resolved event. The report establishes this by tracking the clinical course from December 1985 through June 1986, emphasizing Dr. Kinko's mid-June 1986 documentation of normal gait, healed fracture, and release from care. The physician then jumps directly to the September 2004 examination, treating the eighteen-year interval as clinically silent. The examination findings at IME (painless hip motion, normal gait, no significant pain behavior) confirm that the fracture outcome was durably successful and that current status reflects that original successful outcome.

The impairment rating methodology reinforces this bounded framing. By limiting impairment assessment to leg length discrepancy under AMA Guides Table 17-4, the report converts a complex orthopedic injury with documented progressive changes into a single anatomical measurement. The 2.5 cm discrepancy yields 7% lower extremity impairment converting to 3% whole person. This methodological choice treats the fracture's sequelae as purely structural and static, requiring no analysis of pain, functional limitation, or progressive deterioration documented in the treating record.

The secondary conclusion regarding work capacity follows this same bounded logic. The physician assigns sedentary capacity with specific restrictions: lifting 10 pounds occasionally, sitting and standing with frequent position changes, walking 15 minutes per hour. These restrictions appear substantial but the report frames them as accommodations rather than disability markers. The report states the examinee "assumes that he is unable to sit, but I can find no objective reason why that should be the case." This formulation dismisses reported functional limitation by requiring visible structural pathology to validate restriction. The physician acknowledges leg length

discrepancy but treats it as fully compensable through heel lift, not as a source of ongoing biomechanical stress requiring functional limitation.

The third major conclusion targets Avinza and Neurontin as inappropriate, given "the lack of objective reason for the examinee's pain complaints and the ineffectiveness of the medication." Two unstated premises anchor this position: that objective findings must be visible at IME examination to justify treatment, and that the treating surgeon can prescribe medication over a multi-year period yet the IME can characterize it as ineffective based on a single-day evaluation. The report also faults the failure to address "probable significant depression," though the CES-D administered during the IME produced a score of 10, which the report itself characterizes as "not consistent with a depressed mood."

The reasoning connecting these conclusions to the defense position operates through selective temporal framing. The report acknowledges the December 1985 injury, the surgical repair, and the documented healing by mid-1986. It does not address the June 2003 imaging showing progressive impaction, increased femoral shortening from 8mm to 11mm between 2001 and 2003, cerclage wire deformity under chronic stress, or heterotopic ossification. The physician does not mention the June 2004 treating note documenting declining range of motion, persistent tenderness, positive Trendelenburg sign, and low back pain attributed to compensatory gait mechanics in the clinical history section. The physician does not incorporate these findings into the causation analysis.

The physician presents IME physical examination findings as contradicting ongoing symptom reports. Hip range of motion is measured as "symmetrically decreased in external rotation, but otherwise normal," with external rotation at 15 degrees bilaterally compared to 30 degrees normal. The treating record from June 2004 documents left hip flexion at 95 degrees compared to normal 120, abduction at 25 degrees compared to normal 40, and internal rotation at 15 degrees compared to normal 45. The IME reports no pain with hip motion and no tenderness of hip structures. The treating record documents tenderness over the lateral hip hardware site and pain with resisted abduction rated 4/10.

This divergence in examination findings supports the report's characterization of current complaints as subjectively magnified. The pain drawing reveals "findings suggestive of symptom magnification," though the report does not identify the specific findings. The Pain Disability Index total of 13% represents "mild degree of perceived

disability," framing the examinee's self-assessment as subjective perception rather than documented functional limitation. The report notes the examinee "appeared comfortable" during the visit and "sat continuously for up to 20 minutes" with "no significant pain behavior," presenting these observations as evidence that reported limitations lack objective basis.

The causation analysis employs a bifurcated structure. The report states "to a reasonable degree of medical certainty, there is a causal relationship between the examinee's current left hip complaints and the reported injury." This appears to acknowledge injury-related ongoing symptoms. The immediately following sentence shifts direction: "The examinee's more diffuse low back symptoms are of uncertain origin, given the degree of symptom magnification present. More likely than not, these symptoms are due to pre-existent (mild) facet arthropathy, obesity and symptom magnification."

This formulation separates hip complaints from back complaints, attributes the back symptoms to pre-existing degeneration and symptom magnification, and treats the causal relationship as limited to hip symptoms characterized as minimal throughout the report.

The reasoning structure depends on treating the June 2003 imaging and June 2004 treating records as either irrelevant or confirmatory of the IME position. The report lists the June 2003 x-ray in the diagnostic studies table, noting "fixation hardware in good position; fracture healed with slight impaction." The radiology report language is "fracture has consolidated with bridging trabecular bone across the primary fracture site. However, impaction deformity is present at the intertrochanteric level consistent with prior reports. The impaction pattern has progressed slightly compared to the 2001 films." The IME summary omits the progression finding and the increased leg length discrepancy from 8mm to 11mm.

Dr. Kinko described the original fracture as "significantly comminuted" with "four-part pattern" involving "significant varus angulation" and requiring "cerclage wire fixation of the lesser trochanteric fragment." The operative note states this fracture pattern "is associated with higher rates of malunion, leg length discrepancy, and ongoing functional limitation compared to simple two-part intertrochanteric patterns." The IME history section describes the injury as "left hip fracture, intra trochanteric" without incorporating the comminution severity or the surgical complexity documented in the operative record.

The work capacity analysis illustrates the report's treatment of documented findings as clinically insignificant. The physician states the examinee "can sit and stand for reasonable periods of time, requiring frequent position changes" and "can walk for perhaps 15 minutes per hour." These restrictions acknowledge functional limitation but frame it as minor accommodation rather than disability. The statement "I can find no objective reason" for sitting difficulty treats the leg length discrepancy, documented gait abnormality, positive Trendelenburg sign, and low back pain as insufficient to explain reported sitting intolerance. The report does not engage with the biomechanical relationship between leg length inequality, altered gait mechanics, and compensatory low back pain documented in the treating record.

The appropriateness of care section advances the position that ongoing pain management represents treatment excess. The report identifies Avinza as inappropriate due to "lack of objective reason for the examinee's pain complaints and the ineffectiveness of the medication." The treating record documents Dr. Kinko's clinical rationale: Dr. Kinko initiated Avinza in February 2003 after failed trials of celecoxib (discontinued for GI intolerance related to Crohn's disease), tramadol (inadequate analgesia), and two courses of physical therapy (temporary benefit only). The treating physician states "patient has demonstrated stable use without dose escalation over fourteen months" and characterizes the pain as "consistent with documented structural findings and not disproportionate to objective findings."

The physician similarly characterizes the Neurontin prescription as inappropriate given "lack of evidence of neuropathic pain." The treating record documents the clinical basis: "burning, lancinating pain in a distribution consistent with the lateral femoral cutaneous nerve, which is at risk during the lateral surgical approach used in his 1985 ORIF procedure." Dr. Kinko states Neurontin "produced approximately 40 percent reduction in this specific pain component per patient report." The IME does not address the documented nerve distribution, the surgical approach exposure, or the reported treatment response.

The report's critique of depression management creates tension with its own diagnostic testing. The IME administers the CES-D producing a score of 10, which the report characterizes as "not consistent with a depressed mood." The recommendation section then faults the treating physician for "failure to address the examinee's probable significant depression." The treating record from June 2004 documents PHQ-9 screening with a score of 7 "consistent with mild depression," acknowledges the patient's low

mood "related to chronic pain and inability to return to prior employment," and documents behavioral health referral placed that day. The IME does not reconcile its own depression screening result with its criticism of depression management.

The maximum medical improvement determination follows directly from the bounded temporal framing. The report 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 physician concludes "the examinee has achieved maximum medical improvement." This determination treats the clinical status as stable and requires no analysis of the progressive impaction documented on serial imaging, the declining range of motion documented between 2003 and 2004, or the treating surgeon's June 2004 statement that "patient is not currently at maximum medical improvement in my clinical opinion as further treatment trials remain available and have not been exhausted."

The prognosis statement ("the overall prognosis is good") completes the bounded framing. This characterization sits alongside documentation of progressive structural deterioration, declining function, and ongoing pain requiring opioid management. The report does not define what "good prognosis" means in this context or what clinical trajectory it anticipates. The recommendation section states "no further diagnostic testing or consultation is indicated" and "no other treatment will be necessary for his left hip condition" beyond heel lift adjustment. These recommendations treat the current status as static and the fracture outcome as complete, requiring no ongoing orthopedic management.

The argumentative architecture depends on several recognizable IME patterns. The temporal isolation pattern treats the injury as a discrete event with resolution documented at Dr. Kinko's June 1986 discharge, allowing the report to characterize current status as reflecting that resolved injury rather than ongoing deterioration. The subjective magnification signaling pattern uses pain drawing interpretation, behavioral observation, and the gap between reported and observed limitation to suggest complaints exceed objective findings. The treatment excess pattern characterizes long-term pain management as deviation from standards without engaging the documented treatment rationale or the constraints Crohn's disease imposed on NSAID use.

The degeneration attribution pattern appears in the causation section's treatment of low back pain. The report attributes back symptoms to "pre-existent (mild) facet arthropathy, obesity and symptom magnification" rather than to the documented

biomechanical consequences of leg length discrepancy and altered gait. The June 2003 imaging does document "mild facet arthrosis at L4-5 and L5-S1," but the treating physician characterizes this as "a structural substrate for this pain" that "does not fully account for the severity of symptoms in the context of the patient's gait abnormality." The IME adopts the imaging finding as primary explanation without addressing the gait mechanics analysis.

Force insufficiency framing appears implicitly in the report's treatment of the ground-level fall mechanism. The injury description states Mr. Sample "fell on the ice landing on his left hip." The operative note documents the injury as "high-energy injury pattern despite the ground-level mechanism, likely attributable to the patient's positioning and direct impact on the greater trochanteric region." The fracture pattern (four-part comminuted intertrochanteric fracture with significant soft tissue injury) supports the surgical team's characterization. The IME does not challenge injury causation but treats the successful surgical outcome as determinative, suggesting the injury's resolution rather than its severity defines current status.

The report's internal logic treats the 1985-1986 treatment course as the relevant analytical window and the September 2004 examination as confirmation that the injury resolved successfully. The physician does not incorporate progressive changes documented between 2001 and 2004 into this framework. The physician characterizes the treating surgeon's ongoing management as excessive rather than responsive to documented deterioration. The work capacity restrictions acknowledge functional limitation but frame it as minor accommodation. The impairment rating methodology reduces complex orthopedic sequelae to a single measurement. Each component supports the central defense position: this injury resolved successfully, current complaints reflect subjective magnification and treatment excess, and the examinee's functional capacity exceeds his reported limitations.

SECTION 2: REASONING GAPS AND RECORD MISALIGNMENT

The IME report presents a narrative of uncomplicated recovery from a 1985 hip fracture. It uses that narrative to limit permanent impairment to 3% whole person based solely on leg length discrepancy. The report treats the treating record as supporting this conclusion, but the documented findings show something different. Dr. Kinko's June 2004 note describes progressive functional decline, expanding pain patterns, and compensatory lumbar spine involvement that the IME either does not acknowledge or dismisses without analysis.

The gaps between what the IME characterizes and what the treating record shows create significant exposure in the report's causal and impairment conclusions.

Clinical Course Characterization

Dr. Boucher states the examinee "has done very well" and describes the fracture as having healed without complication. The treating record does not support this framing.

Dr. Kinko's operative note from December 1985 documents a four-part comminuted intertrochanteric fracture requiring cerclage wire fixation of the lesser trochanteric fragment, significant soft tissue stripping at the greater trochanter, and partial avulsion of the vastus lateralis. The operative note characterizes this as a "high-energy injury pattern despite the ground-level mechanism." Dr. Kinko explicitly noted that 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."

The IME report does not address the documented comminution. It does not reference the cerclage wire fixation. It does not acknowledge the surgical findings of soft tissue trauma that Dr. Kinko documented as predicting prolonged recovery.

Progressive Structural Changes

The June 2003 imaging report provides a second conflicting data point. Radiologist Dr. Connors documented "progressive settling pattern" with impaction deformity that had worsened between 2001 and 2003. The report states: "This progressive settling pattern is consistent with chronic hardware stress and weight-bearing load across the healed but

impacted fracture site." Dr. Connors also documented mild cerclage wire deformity "suggesting chronic ambulatory stress without wire failure."

The IME report references the June 2003 x-ray in the diagnostic studies table and notes "fracture healed with slight impaction," but it does not address the progressive nature of the impaction, the chronic hardware stress findings, or the cerclage wire deformity. The radiologist's language indicates ongoing structural change under load, not a stable healed fracture. When the radiology report documents a structurally compromised repair under chronic stress, treating it as a simple healed fracture creates tension with the expert's later work capacity conclusions.

Leg Length Discrepancy Measurement Selection

Dr. Boucher measured a 2.5 cm limb length discrepancy from the lateral pelvic rim to the lateral tibial plateau. Dr. Kinko measured 2.8 cm clinically using the block method without lift compensation in the same month. Dr. Connors measured 1.1 cm radiographically.

The IME report uses the 2.5 cm measurement to assign 7% lower extremity impairment converting to 3% whole person, but does not explain the discrepancy between the radiographic and clinical measurements or acknowledge Dr. Kinko's treating measurement from the same time period. Dr. Kinko's June 2004 note explicitly addresses this: "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."

The report does not explain why it selected the 2.5 cm figure over the treating physician's contemporaneous 2.8 cm clinical measurement. The choice affects impairment rating, but the reasoning for selecting one measurement over another is not visible.

Range of Motion Discrepancies

Dr. Boucher documented symmetrically decreased external rotation at 15 degrees bilaterally but otherwise normal hip motion. He stated the examinee had "no pain with hip motion."

Dr. Kinko's June 2004 examination documented left hip flexion at 95 degrees (normal 120), abduction at 25 degrees (normal 40), internal rotation at 15 degrees (normal 45),

and external rotation at 20 degrees (normal 45). Dr. Kinko noted "decreased range of motion in all planes compared to 2003 visit, most notably in internal and external rotation" and documented tenderness over the lateral hip hardware site with resisted abduction producing 4/10 pain.

The IME examination occurred three months after Dr. Kinko's examination. The report does not explain the difference in measured ranges of motion. It does not address Dr. Kinko's documentation of progressive decline in hip motion over serial examinations. It does not acknowledge the treating record's documentation of pain with resisted motion. The IME's conclusion that hip motion was "otherwise normal" is not consistent with the treating physician's contemporaneous documentation of restricted motion in all planes.

Causation Analysis for Low Back Pain

The IME's causation analysis for low back pain relies on a factual premise not supported by the record. Dr. Boucher concluded that the examinee's "more diffuse low back symptoms are of uncertain origin" and attributed them "more likely than not" to "pre-existent (mild) facet arthropathy, obesity and symptom magnification." The attribution to pre-existing facet arthropathy assumes the facet changes predated the injury. The treating record does not establish this.

Dr. Connors' June 2003 imaging report documents "mild facet arthrosis at L4-5 and L5-S1" on lumbar spine images that were incidentally captured during hip imaging, but no imaging of the lumbar spine prior to the 1985 injury was provided. Dr. Kinko's June 2004 note addresses the low back pain directly and states: "Low back pain with left SI joint involvement, most likely compensatory given the prolonged leg length discrepancy and altered gait mechanics. This is a recognized complication of untreated or undertreated leg length inequality. The facet arthrosis identified on 2003 imaging at L4-5 and L5-S1 represents a structural substrate for this pain, but I do not believe it fully accounts for the severity of symptoms in the context of the patient's gait abnormality."

Dr. Kinko attributes the lumbar pain to compensatory mechanics from the documented leg length discrepancy, not to pre-existing degeneration.

The IME does not address Dr. Kinko's competing causal theory. It does not explain why the facet changes should be considered pre-existing rather than progressive changes developing over eighteen years of altered gait mechanics.

Symptom Magnification Finding

Dr. Boucher states the pain drawing "did reveal findings suggestive of symptom magnification" but does not specify what those findings were or how they support the conclusion that the lumbar symptoms are magnified rather than genuine.

The Pain Disability Index scored 13%, which Dr. Boucher characterized as "mild perceived disability." The CES-D depression screen scored 10, which Dr. Boucher characterized as "not consistent with a depressed mood." These scores do not obviously support a symptom magnification conclusion. Dr. Kinko's June 2004 note documents a PHQ-9 depression score of 7, consistent with mild depression, and notes the patient "acknowledges low mood related to chronic pain and inability to return to prior employment."

The IME report does not reconcile its conclusion that the patient is not depressed with the treating physician's contemporaneous documentation of mild depression and behavioral health referral. The symptom magnification finding appears to rest entirely on the undescribed pain drawing findings. The report does not address the conflicting depression screening results or the treating physician's clinical impression.

Work Capacity Analysis

Dr. Boucher concluded the examinee has "at least a sedentary work capacity" and stated: "He assumes that he is unable to sit, but I can find no objective reason why that should be the case. In truth, it is likely that he could sit and stand for reasonable periods of time, requiring frequent position changes."

The treating record does not document that the examinee reported inability to sit. Dr. Kinko's June 2004 note documents Patrick's test positive on the left reproducing left SI pain and documents that the patient reports low back pain worsening with "prolonged sitting or activity." The treating record describes sitting intolerance related to documented SI joint involvement, not a subjective assumption without objective basis. When the treating record documents a clinical finding (positive Patrick's test) that correlates with the reported sitting intolerance, treating the sitting limitation as unsupported creates a gap in the IME's reasoning.

Dr. Boucher concluded the examinee "can walk for perhaps 15 minutes per hour" but also stated the examinee "is currently walking two miles per day with no difficulty" and

documented that the examinee reported walking "for up to two miles" during the functional status portion of the evaluation. The restriction to 15 minutes of walking per hour is not explained in relation to the documented two-mile daily walking capacity. The report does not address this apparent inconsistency or explain how someone walking two miles daily with no documented gait abnormality at the IME examination would be limited to 15 minutes of walking per hour in a work context.

Treatment Appropriateness Analysis

Dr. Boucher states: "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 2004 note documents the clinical rationale for Avinza prescription in detail: chronic left hip and proximal thigh pain unresponsive to non-opioid analgesia after failed trials of celecoxib (discontinued due to GI intolerance from Crohn's disease), tramadol (inadequate analgesia), and two separate courses of physical therapy (temporary benefit only). Dr. Kinko noted: "Avinza was initiated after careful consideration of risks and benefits given patient's chronic pain presentation, documented objective findings, and functional limitations. Patient has demonstrated stable use without dose escalation over fourteen months."

The IME report does not address Dr. Kinko's documented treatment rationale. It does not acknowledge the failed prior treatment trials. It does not explain what objective findings would be required to justify extended-release opioid use for chronic post-surgical pain.

The characterization of Avinza as "ineffective" is not supported by the treating record. Dr. Kinko's note does not document treatment failure or medication ineffectiveness. The note documents stable use without dose escalation, which typically indicates adequate pain control in chronic pain management. The IME report does not cite any treating record entry documenting medication ineffectiveness and does not explain the basis for this conclusion.

The conclusion that "use of Neurontin has been inappropriate given the lack of evidence of neuropathic pain" conflicts with the documented clinical findings. Dr. Kinko's June 2004 note states: "Neurontin (gabapentin) 300mg three times daily — initiated August 2003 for neuropathic-quality pain in the left proximal thigh and lateral hip region. Patient described burning, lancinating pain in a distribution consistent with the lateral

femoral cutaneous nerve, which is at risk during the lateral surgical approach used in his 1985 ORIF procedure. Neurontin produced approximately 40 percent reduction in this specific pain component per patient report. Clinical rationale for this prescription is documented in the August 2003 visit note."

The treating record documents neuropathic pain symptoms, identifies an anatomical basis (lateral femoral cutaneous nerve injury risk from surgical approach), and documents treatment response. The IME report does not address these documented findings. It does not explain why the described pain pattern and treatment response would not constitute evidence of neuropathic pain.

Depression Management

The conclusion that "the failure to address the examinee's probable significant depression has been inappropriate" is not consistent with the documented care. Dr. Kinko's June 2004 note documents: "Depression screening today using PHQ-9 produced a score of 7, consistent with mild depression. Patient acknowledges low mood related to chronic pain and inability to return to prior employment. I discussed this with the patient and provided referral to behavioral health. Patient is receptive. This is documented in today's visit."

The treating physician identified depression, discussed it with the patient, and provided a behavioral health referral in the visit note that predates the IME by three months. The IME report does not acknowledge this documented intervention.

Maximum Medical Improvement Determination

Dr. Boucher states: "The examinee has achieved maximum medical improvement." Dr. Kinko's June 2004 note 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 treating physician explicitly documented that MMI had not been reached. The IME report does not address this direct conflict or explain why the IME physician's opinion should supersede the treating physician's contemporaneous assessment.

Injury Mechanism and Initial Presentation

The IME report states the examinee "fell on the ice landing on his left hip" and describes the fracture as "left intra trochanteric fracture" without additional characterization.

Dr. Kinko's admission note describes a "four-part comminuted intertrochanteric fracture with significant comminution involving the lesser trochanter" with "significant varus angulation" and notes that "fracture pattern is significantly comminuted with involvement of the proximal femoral cortex. This degree of comminution is associated with higher rates of malunion, leg length discrepancy, and ongoing functional limitation compared to simple two-part intertrochanteric patterns."

The IME report does not reference the four-part pattern. It does not address the documented comminution. It does not acknowledge the treating surgeon's statement that this fracture pattern carries higher rates of ongoing functional limitation. The omission affects the report's characterization of expected outcome and permanent limitations.

Gait Assessment Discrepancies

Dr. Boucher documented "Gait was normal with no antalgia. There was no external rotation of the left foot." Dr. Kinko's June 2004 examination documented "mildly antalgic with shortened left stance phase" and "Trendelenburg sign mildly positive on the left, suggesting left hip abductor weakness."

The IME examination occurred three months after the treating examination. The report does not explain the difference in gait assessment. It does not address the treating physician's documentation of antalgic gait and positive Trendelenburg sign indicating abductor weakness.

Impairment Rating Methodology

Dr. Boucher assigned impairment "on the basis of a 2.5 cm limb length discrepancy" using Table 17-4 and concluded this imparts 7% lower extremity impairment converting to 3% whole person. The AMA Guides Fifth Edition permits multiple methods for rating lower extremity impairment, including diagnosis-based estimates, range of motion method, and other approaches.

The report does not explain why leg length discrepancy alone captures the full impairment picture when the treating record documents restricted hip range of motion in all planes, progressive hip dysfunction, compensatory lumbar spine involvement with positive clinical findings, documented abductor weakness, and antalgic gait. The report does not address whether additional impairment should be considered for hip range of motion loss, hip pain with documented structural correlates, or lumbar spine involvement that the treating physician attributed to the compensatory mechanics from the leg length discrepancy.

Future Treatment Recommendations

The statement that "no further diagnostic testing or consultation is indicated" and "no other treatment will be necessary for his left hip condition" does not acknowledge the treating physician's documentation of treatment options not yet exhausted. Dr. Kinko's June 2004 note documents: "Discussed possibility of hardware removal if lateral hip pain increases, though patient prefers to defer surgical intervention."

The treating record indicates hardware removal remains a treatment option that has been discussed but deferred by patient preference, not a treatment that has been determined to be unnecessary. The IME report does not address whether hardware removal could be appropriate if symptoms progress or whether the current symptom pattern supports hardware removal consideration.

Medication Documentation

The IME lists medications including "See list" under past medical history but does not provide the actual medication list or specify which medications were reviewed. Dr. Kinko's June 2004 note provides a detailed medication review including Avinza, Neurontin, and heel lift prescription. The IME report references these medications in the treatment appropriateness section, indicating Dr. Boucher was aware of them, but the report does not document reviewing the treating physician's rationale for each medication as documented in the June 2004 note.

The work capacity section includes a restriction to "avoid driving a motor vehicle or operating machinery due to her multiple sedating medications," but the report does not identify which medications are sedating or explain the pronoun error referring to the male examinee as "her." The restriction is not explained in relation to the documented medication list.

Behavioral Observations and Symptom Magnification

The report documents behavioral observations stating "there was no significant pain behavior" and "non-physiologic findings were not present," but these observations are not reconciled with the later conclusion that symptom magnification is present. The report states the pain drawing revealed findings suggestive of symptom magnification but documents normal behavioral presentation during the examination. The report does not explain how symptom magnification was determined to be present when behavioral observations and examination findings did not demonstrate it.

Clinical Course Chronology Gaps

The IME report states: "By mid March 2004, Dr. Kinko noted essentially normal gait with painless hip motion. Hip motion was not measured at that time." No March 2004 treating note was provided in the submission. The report appears to reference a treating note that was not included in the materials provided to this analyst.

If the March 2004 note exists and documents painless hip motion, it would represent improvement that subsequently declined by June 2004 when Dr. Kinko documented pain with resisted motion and progressive range of motion restriction. The characterization depends on a document not available for verification against the treating record provided.

Heel Lift Usage and Examination Conditions

The structural examination notes "the right PSIS was elevated (as the examinee was not wearing his heel lift)." The gait examination states "the examinee is not wearing his lift today for the gait assessment." Later in the report, Dr. Boucher states the examinee "does generally use a heel lift" and recommends "the examinee will continue to require a heel lift of perhaps 1.5 cm."

The report documents the examinee was not wearing the lift during the examination, which affects the observed pelvic asymmetry and gait assessment, but the work capacity analysis and functional conclusions do not account for this. Dr. Kinko's June 2004 note documents prescribing a 2.0 cm lift after measuring 2.8 cm clinical leg length discrepancy. The IME recommends continuing a 1.5 cm lift. The report does not explain why the recommended lift height differs from the treating physician's prescription or address whether the difference in lift height would affect functional capacity.

Functional Status and Work Capacity Inconsistency

The examinee reported ability to sit for up to two hours, stand for up to two hours, and walk for up to two miles. The work capacity section restricts sitting and standing to "reasonable periods of time, requiring frequent position changes" and restricts walking to "perhaps 15 minutes per hour."

The report does not explain how the self-reported functional capacity translates to the more restricted work capacity determination, particularly for walking where the examinee's reported capacity far exceeds the work restriction imposed.

Employment Status

The report does not address Dr. Kinko's documentation that the patient last worked January 12, 2004, which was six months prior to the June 2004 treating visit and approximately nine months prior to the September 2004 IME. Dr. Kinko's note documents the patient is "seeking new job" but does not work currently. The report does not analyze whether the work separation relates to documented functional limitations or address Dr. Kinko's opinion that the patient has not reached maximum medical improvement and continues to have treatment options available.

Postoperative Course Description

The report characterizes the postoperative course as uncomplicated other than pulmonary edema that "resolved promptly with treatment." Dr. Kinko's discharge note documents the patient was discharged postoperative day 27, which represents a prolonged hospitalization for hip fracture surgery. The note documents pain rated 7/10 with transfers at discharge and states the patient was advised "full recovery from this fracture pattern typically requires twelve to eighteen months and that some degree of permanent leg length discrepancy is anticipated."

The report does not address the prolonged hospitalization, the documented discharge pain level, or the documented expectation of prolonged recovery.

Imaging Interpretation Alignment

The IME report states in the diagnostic studies table: "Fixation hardware in good position; fracture healed with slight impaction." Dr. Connors' radiology report

documents progressive impaction worsening between studies, cerclage wire deformity suggesting chronic stress, and progressive femoral shortening from 8mm in 2001 to 11mm in 2003. The radiologist's impression emphasizes progression and ongoing structural change. The IME characterizes the same imaging as showing stable healing with slight impaction.

The difference in characterization matters because the radiologist's interpretation supports ongoing structural compromise and the treating physician's opinion that MMI has not been reached, while the IME's characterization supports a conclusion of stable healed fracture with no need for further treatment.

SECTION 3: OPINION DEPENDENCY POINTS

The IME's conclusions rest on four dependency points where the reasoning structure requires assumptions or evidentiary inputs that are either absent from the documented record or stated without demonstration. Each represents a point where the overall opinion becomes vulnerable if the underlying assumption cannot be supported under scrutiny.

Dependency One: The Progressive Impaction Finding as Benign Healing Rather Than Structural Failure

The IME assigns a 3% whole person impairment based solely on the 2.5 cm leg length discrepancy identified during examination. This rating depends entirely on the premise that the progressive impaction documented in the treating record and imaging represents normal healing rather than structural deterioration requiring separate impairment consideration.

The June 2003 imaging report documents progressive settling at the fracture site with an additional 3mm of impaction compared to 2001 films. The radiologist explicitly notes this pattern is "consistent with chronic hardware stress and weight-bearing load across the healed but impacted fracture site." Dr. Kinko's June 2004 note documents declining hip range of motion compared to the prior year and describes "progressive impaction deformity on serial imaging." Both sources characterize this as an ongoing process rather than a static condition.

The IME does not address this progressive pattern. The report states the examinee "has done very well" following surgery and references healing "with some ongoing impaction" in the clinical history section. The discussion section contains no analysis of whether progressive impaction over an eighteen-year period represents continued structural compromise. The impairment section treats the leg length discrepancy as the sole ratable consequence of the injury.

The AMA Guides Fifth Edition provides separate impairment pathways for limb length discrepancy and for restricted hip range of motion. The IME documents bilaterally decreased external rotation but rates this as zero impairment without explanation. If the restricted motion documented in the examination were attributed to the 1985 fracture rather than treated as a non-ratable finding, the impairment rating would increase.

The opinion that the leg length discrepancy alone captures the functional consequence of this injury depends on the unstated premise that the progressive impaction and associated motion loss either arose from non-injury causes or represent expected healing that does not warrant separate consideration. The treating record does not support this premise. Dr. Kinko's June 2004 note explicitly connects the declining range of motion to the fracture sequelae, stating "functional range of motion has declined compared to prior year" in the context of assessing chronic pain status post-fracture. The radiologist's characterization of chronic hardware stress and progressive settling suggests ongoing structural change rather than static post-healing status. The IME provides no analysis of why this pattern should be excluded from impairment consideration.

The 3% whole person rating represents the entire permanent consequence assigned to a comminuted four-part intertrochanteric fracture with documented progressive impaction over nearly two decades.

If the progressive structural change warrants separate impairment consideration under the Guides methodology, the rating understates the functional loss. The IME does not explain why it does not.

Dependency Two: The Symptom Magnification Conclusion Based on Selective Clinical Indicators

The causation section states that the examinee's "more diffuse low back symptoms are of uncertain origin, given the degree of symptom magnification present." This conclusion depends on a symptom magnification finding drawn from the pain drawing alone, despite other assessment tools in the same report demonstrating the opposite pattern.

The IME administered three formal pain assessment instruments. The Pain Disability Index produced a total score of 9 out of 70, yielding a 13% disability rating that the report characterizes as "mild." The CES-D depression scale produced a score of 10, which the report states "is not consistent with a depressed mood." The pain drawing reveals "findings suggestive of symptom magnification," but the report does not specify what those findings are or how the examiner scored them.

The behavioral observations section states the examinee "appeared comfortable," "sat continuously for up to 20 minutes," showed "no significant pain behavior," and had

"non-physiologic findings were not present." This language typically signals the absence of magnification indicators during direct observation. The functional status section documents the examinee can walk two miles, sit for two hours, stand for two hours, and lift substantial weight. These self-reported capacities exceed what you would expect from someone actively magnifying symptoms.

The report does not reconcile these contradictory signals. Two formal instruments and the direct behavioral observations suggest minimal symptom exaggeration. One instrument (the pain drawing) shows magnification sufficient to render low back symptom causation "uncertain." The IME provides no methodology for why the pain drawing outweighs the other indicators or what specific findings on the drawing support the magnification conclusion.

The symptom magnification finding is the sole stated basis for separating the hip complaints from the back complaints causally. The report concludes the hip pain is causally related to the 1985 injury but attributes the back pain to "pre-existent (mild) facet arthropathy, obesity and symptom magnification."

The treating record documents a different causal sequence. Dr. Kinko's June 2004 note describes the low back pain as "most likely compensatory given the prolonged leg length discrepancy and altered gait mechanics" and identifies L4-5 and L5-S1 facet arthrosis as "a structural substrate for this pain" but states "I do not believe it fully accounts for the severity of symptoms in the context of the patient's gait abnormality."

The IME does not engage with Dr. Kinko's compensatory injury theory. The report cites the same facet arthrosis Dr. Kinko acknowledged but reaches the opposite causal conclusion without addressing why the leg length discrepancy and nineteen-year gait alteration would not produce the back symptoms documented. The symptom magnification finding provides the mechanism for dismissing the compensatory injury theory, but that finding rests on an unexplained methodological choice to prioritize the pain drawing over contradicting assessment data.

If the symptom magnification conclusion cannot be demonstrated through the documented assessment results, the basis for separating the back complaints from injury causation disappears. The treating physician's compensatory injury theory becomes the medically supported explanation. The IME's contrary conclusion lacks foundation in the examination findings it purports to rely upon.

Dependency Three: The Medication Appropriateness Determination Without Documented Treatment Trial History

The appropriateness of care section concludes that Avinza and Neurontin prescriptions are inappropriate based on "lack of objective reason for the examinee's pain complaints" and "lack of evidence of neuropathic pain." Dr. Kinko's June 2004 note states Avinza was "initiated February 2003 for chronic left hip and proximal thigh pain unresponsive to non-opioid analgesia." The note documents prior treatment failures: celecoxib discontinued due to GI intolerance related to Crohn's disease, tramadol discontinued due to inadequate analgesia, and two separate physical therapy courses in 2001 and 2002 producing only temporary benefit. Dr. Kinko states Avinza "was initiated after careful consideration of risks and benefits given patient's chronic pain presentation, documented objective findings, and functional limitations" and that the patient "has demonstrated stable use without dose escalation over fourteen months."

Dr. Kinko documents the Neurontin prescription with similar specificity. The note states the medication was "initiated August 2003 for neuropathic-quality pain in the left proximal thigh and lateral hip region" with the patient describing "burning, lancinating pain in a distribution consistent with the lateral femoral cutaneous nerve, which is at risk during the lateral surgical approach used in his 1985 ORIF procedure." The note documents Neurontin "produced approximately 40 percent reduction in this specific pain component per patient report" and states "clinical rationale for this prescription is documented in the August 2003 visit note."

The IME examination documented tenderness over the lateral hip hardware site and pain with resisted abduction rated 4/10. The report states the examinee reported pain worsened by lying on the left side, which is anatomically consistent with hardware irritation in the lateral surgical approach region. The IME does not explain why these findings fail to constitute objective evidence supporting analgesic treatment or why pain in a nerve distribution at risk from the documented surgical approach does not constitute evidence of neuropathic pain.

The inappropriateness conclusion depends on the assumption that the documented pain complaints and examination findings do not rise to the level justifying the prescribed medications. But the IME does not establish what threshold would justify these prescriptions or why Dr. Kinko's documented stepwise treatment approach

(moving to Avinza only after multiple non-opioid failures) falls below the standard of care.

The report states the Avinza prescription is inappropriate given "the ineffectiveness of the medication," but the treating record does not document ineffectiveness. Dr. Kinko's note describes stable use without escalation, which in pain management typically signals adequate efficacy at the prescribed dose.

The treating record demonstrates a clinically appropriate escalation pathway with documented rationale at each step.

The inappropriateness conclusion requires either demonstrating that Dr. Kinko's documented findings were fabricated or establishing that the standard of care prohibits these medications despite the documented treatment history. The IME does neither. The conclusion rests on the unexplained premise that the objective findings supporting these prescriptions are absent when the treating record explicitly documents them.

If Dr. Kinko appropriately prescribed the medications for injury-related pain, their continued necessity nineteen years post-injury supports ongoing causal connection and suggests functional impairment beyond what the 3% rating captures. If the IME's inappropriateness conclusion cannot withstand the documented treatment rationale, it undermines the opinion that the examinee's current complaints lack objective medical foundation.

Dependency Four: The Sedentary Work Capacity Opinion Based on Undocumented Physical Demand Assumptions

The work capacity section concludes the examinee has "at least a sedentary work capacity" with specific restrictions including lifting 10 pounds occasionally and 5 pounds frequently, sitting and standing "for reasonable periods of time, requiring frequent position changes," and walking "perhaps 15 minutes per hour." These restrictions represent a significant functional limitation, but the opinion that this capacity level existed both before and after an unidentified "July 2004 hip surgery" creates internal inconsistencies the report does not resolve.

The work capacity section states: "Prior to his July 2004 hip surgery, he would have had essentially the same work restrictions, except that his duration for sitting, standing and walking may have been somewhat greater." No July 2004 surgery appears anywhere else in the IME report. The clinical history section describes the December 1985 ORIF as the

sole surgical intervention and states "the examinee has required no further treatment for his left hip condition." The treating record through June 2004 contains no reference to planned or performed surgery in July 2004.

Either the IME physician confused this case with another examination performed around the same time, or the report intended to reference a different date and the error went uncaught during review. Both explanations suggest the work capacity analysis may have incorporated assumptions or restrictions from a different clinical scenario. The opinion that work capacity remained essentially unchanged before and after a surgery that does not appear in the documented record cannot be verified against any clinical findings.

Beyond this internal inconsistency, the work capacity restrictions themselves depend on assumptions about physical demand tolerance the examination findings do not demonstrate. The IME documented the examinee could sit for two hours, stand for two hours, and walk two miles according to self-report in the functional status section. The work capacity section reduces these tolerances dramatically (sitting and standing require "frequent position changes" and walking is limited to 15 minutes per hour) without explaining what clinical findings support this reduction from the self-reported capacities.

The examination documented hip range of motion restrictions and pain with resisted abduction, but the report does not connect these findings to specific work restrictions. The behavioral observations noted the examinee "appeared comfortable" and "sat continuously for up to 20 minutes" during the examination. If the examinee can sit comfortably for 20 minutes during an examination and self-reports two-hour sitting tolerance, the basis for requiring frequent position changes in sedentary work is not explained.

Dr. Kinko's June 2004 note states "patient is not currently at maximum medical improvement in my clinical opinion as further treatment trials remain available and have not been exhausted" and describes "functional capacity remains limited by chronic pain, leg length discrepancy, and abductor weakness." This characterization suggests functional limitations beyond sedentary capacity, but the IME does not address why Dr. Kinko's ongoing treatment plan and functional limitations assessment should be disregarded in favor of a sedentary capacity opinion.

The work capacity opinion depends on undisclosed assumptions about how the documented examination findings translate into specific physical demand tolerances. The Dictionary of Occupational Titles defines sedentary work as requiring sitting most of the time with occasional walking and standing. The IME's restriction requiring frequent position changes potentially elevates the functional demand beyond sedentary level, but the report does not acknowledge this or explain why the documented findings necessitate this restriction pattern.

The work capacity opinion cannot be connected to specific examination findings through documented reasoning.

The reference to a non-existent July 2004 surgery suggests the work capacity section may reflect analysis from a different case or rely on assumptions imported from outside the documented examination findings. Either explanation makes the work capacity opinion dependent on inputs not visible in the submitted materials and therefore not defensible through the IME's own documentation.

SECTION 4: STRATEGIC PRESSURE POINTS

The IME's argument breaks most visibly at three locations where the documented findings contradict the conclusions advanced. Each point creates immediate leverage because the IME physician either ignored documented evidence, mischaracterized clinical findings to support his position, or reached conclusions unsupported by his own examination. These are not subtle analytical weaknesses. They are structural failures that cannot be defended without retreating from the report's primary conclusions.

The work capacity determination contradicts the physician's own examination findings and the treating physician's documented functional observations. The IME physician concludes the plaintiff has "at least a sedentary work capacity" with ability to sit and stand for "reasonable periods of time" requiring frequent position changes. He states explicitly "I can find no objective reason why [sitting limitations] should be the case." This conclusion is flatly contradicted by his own examination, which documented symmetrically decreased external rotation bilaterally and measured external rotation at 15 degrees on each side against a normal range of 30 degrees. The restriction is bilateral and symmetric, which undermines any suggestion that this is magnification or exaggeration. More significantly, Dr. Kinko's June 2004 examination documented progressive functional decline compared to the prior year, including decreased range of motion in all planes with internal rotation declining to 15 degrees and external rotation to 20 degrees on the left. The IME physician documented less left hip external rotation than Dr. Kinko found, suggesting either measurement error or progression between June and September 2004.

The treating record shows the plaintiff was walking one to two miles daily but was "pushing through" discomfort rather than performing pain-free activity. Dr. Kinko documented this explicitly and characterized it as consistent with the structural findings rather than disproportionate to them. The IME physician's work capacity conclusion requires ignoring this documented pattern and substituting his own interpretation that the plaintiff "assumes" he cannot sit without objective basis. The treating physician's progressive documentation of functional decline over three years, combined with the IME's own measurement of restricted bilateral hip motion, makes this work capacity determination unsupportable. In negotiation, this creates direct exposure because the defense cannot simultaneously rely on the IME's finding that hip motion is restricted bilaterally while arguing that sitting limitations lack objective support. The two positions are incompatible.

The work capacity conclusion also depends entirely on the IME physician's interpretation that symptom magnification undermines the plaintiff's credibility. Yet the only basis cited for symptom magnification is the pain drawing, which the report describes as "suggestive of" magnification without explaining what features produced that conclusion or how they were identified. The Pain Disability Index score of 13 percent indicates mild perceived disability. The CES-D score of 10 is not consistent with depressed mood per the IME's own interpretation. These findings do not support a conclusion that symptom presentation is unreliable. The work capacity determination stands on the assertion of magnification alone, and that assertion is not demonstrated by the inventories the physician administered or the examination he documented. This creates negotiation leverage because the defense must either produce the analytical basis for the magnification finding or concede that the work capacity conclusion rests on unsupported interpretation.

The causation opinion for low back pain contradicts the imaging report and dismisses the treating physician's documented clinical correlation without addressing it. The IME physician concludes the plaintiff's low back symptoms are "more likely than not" due to preexisting facet arthropathy, obesity, and symptom magnification. This conclusion requires three factual premises: that the facet arthropathy predated the injury, that obesity is a contributing factor, and that symptom magnification distorts the clinical picture. None of these premises is established by the submission.

The June 2003 imaging report describes "mild facet arthrosis at L4-5 and L5-S1" as an incidental finding on a hip study. The radiologist made no temporal determination about when this developed and offered no characterization suggesting it was longstanding or clinically significant prior to the reported injury. The IME physician converts "mild facet arthrosis" into "preexistent (mild) facet arthropathy" and treats this as causally sufficient to explain the low back pain. This is assumption presented as fact. The imaging report does not support a conclusion that the arthropathy predated December 1985, and the record contains no documentation of low back complaints prior to the plaintiff's report in June 2004 that symptoms began eighteen months earlier. That timeline places onset in late 2002 or early 2003, seventeen years post-injury. The IME physician does not address this timeline or explain how facet changes visible in 2003 establish preexistence relative to an injury in 1985.

Dr. Kinko documented in June 2004 that the low back pain was "most likely compensatory given the prolonged leg length discrepancy and altered gait mechanics" and stated this was "a recognized complication of untreated or undertreated leg length inequality." He identified facet arthrosis as "a structural substrate for this pain" but explicitly stated it did not "fully account for the severity of symptoms in the context of the patient's gait abnormality." This is direct clinical correlation between the documented leg length discrepancy, the documented gait abnormality, and the low back symptoms. The IME physician does not acknowledge this documented opinion, does not address the clinical reasoning Dr. Kinko provided, and does not explain why compensatory gait mechanics should be dismissed as causally relevant. The IME simply reassigns causation to preexisting degeneration without engaging the treating physician's documented analysis.

The obesity attribution is similarly unsupported. The IME documents height as 5 feet 7 inches and weight as 160 pounds "as reported by the examinee." This produces a BMI of approximately 25, which falls at the threshold between normal weight and overweight but does not meet clinical thresholds for obesity as a contributory factor in orthopedic pain conditions. The IME physician labels this "obesity" without calculation or justification and treats it as causally significant without citing any clinical literature or standard supporting that characterization at this BMI level. The attribution cannot be defended on the documented facts.

The combination creates negotiation leverage because the defense must either produce evidence that the facet changes predated the injury and were symptomatic, withdraw the obesity characterization, or concede that the causation opinion for low back pain rests on undocumented assumptions. The treating physician's documented compensatory mechanics explanation is clinically coherent, supported by the leg length measurements, and consistent with the timeline of symptom onset. The IME physician offers no explanation for why this should be rejected in favor of preexisting degeneration that is not demonstrated as preexisting.

The appropriateness-of-care opinion mischaracterizes the treating physician's clinical documentation and applies standards the IME physician does not demonstrate. The IME concludes that use of Avinza is "inappropriate given the lack of objective reason for the examinee's pain complaints and the ineffectiveness of the medication." This conclusion is contradicted by Dr. Kinko's February 2003 documentation, which shows Avinza was initiated after failed trials of celecoxib,

tramadol, and two courses of physical therapy. Dr. Kinko documented "careful consideration of risks and benefits given patient's chronic pain presentation, documented objective findings, and functional limitations" and noted the plaintiff "demonstrated stable use without dose escalation over fourteen months." The clinical rationale is explicit in the treating record. The IME physician does not address this documented decision-making process and does not explain what additional objective findings would have been required to justify opioid therapy under the applicable standard of care.

The assertion that Avinza was "ineffective" is not supported by documentation in the submission. The plaintiff's pain ratings at the IME in September 2004 were 2/10 current, 2/10 average over the past month, with a high of 4/10 and low of 1/10. Dr. Kinko's June 2004 note documents pain rated 3-4/10 on average, worsening to 5-6/10 with prolonged activity. These ratings show the medication was producing meaningful analgesia compared to the 8/10 pain documented on initial presentation in December 1985 and the 7/10 pain documented at discharge in January 1986. The IME physician characterizes this as ineffective without defining what threshold of pain reduction would constitute effectiveness or citing any clinical standard for that determination.

The Neurontin critique follows the same pattern. The IME states Neurontin use was "inappropriate given the lack of evidence of neuropathic pain." Dr. Kinko documented in August 2003 that the plaintiff described "burning, lancinating pain in a distribution consistent with the lateral femoral cutaneous nerve, which is at risk during the lateral surgical approach used in his 1985 ORIF procedure" and that Neurontin "produced approximately 40 percent reduction in this specific pain component per patient report." This is documented clinical rationale with symptom characterization, anatomic correlation to the surgical approach, and documented treatment response. The IME physician does not address this documented evidence of neuropathic pain or explain why symptom description and nerve distribution are insufficient to support a neuropathic pain diagnosis. He simply asserts lack of evidence without engaging the evidence Dr. Kinko documented.

The failure to address depression critique is the only appropriateness finding that aligns with the documented record. Dr. Kinko's June 2004 note explicitly documents PHQ-9 screening with a score of 7, acknowledgment of mild depression, and placement of a behavioral health referral with documented patient receptiveness. The IME physician states "the failure to address the examinee's probable significant depression has been

inappropriate." Dr. Kinko addressed depression directly in the final documented visit before the IME, which undercuts the assertion of treatment failure. The IME physician either did not review this portion of the June 2004 note or reviewed it and concluded the intervention was inadequate, but he does not explain what additional intervention would have met the standard of care or why referral to behavioral health was insufficient.

This creates negotiation leverage because the appropriateness-of-care conclusions cannot be defended without either ignoring the documented clinical rationale in the treating record or applying unstated standards the IME physician does not articulate. The defense must either withdraw these conclusions or produce the clinical standards and evidence the IME physician relied upon to reach them. The treating record documents thoughtful, progressive care with documented failures of conservative treatment, documented rationale for medication selection, and documented treatment response. The IME dismisses this without engaging it, which makes the appropriateness opinion vulnerable to exclusion or significant discounting in any fact-finder evaluation.

The impairment rating ignores the documented progression of leg length discrepancy and functional decline. The IME assigns 3 percent whole person impairment based solely on the 2.5 cm limb length discrepancy measured at examination. This rating does not account for the documented progression from 8mm in 2001 to 11mm radiographically in 2003 to 2.8 cm clinically in June 2004. The IME physician measured leg length "from the lateral pelvic rim to the lateral tibial plateau" and documented a 2.5 cm deficit, which is less than the 2.8 cm Dr. Kinko measured clinically two months earlier using the block method. The IME does not address this discrepancy in measurement technique or explain why the clinical measurement should be disregarded in favor of the skeletal measurement when the functional impact of leg length inequality depends on the clinical discrepancy the patient experiences during weight-bearing and ambulation.

The AMA Guides rating also does not account for the progressive restriction in hip range of motion documented by both the IME and Dr. Kinko, the documented hip abductor weakness producing a positive Trendelenburg sign, or the documented antalgic gait pattern. These are objective functional limitations that contribute to overall impairment but are not captured in the rating provided. The IME physician does not explain why range of motion restriction, abductor weakness, and gait abnormality do not warrant additional impairment rating under the Guides methodology.

This creates negotiation leverage because the impairment rating is demonstrably incomplete on the documented findings and uses a measurement technique that produces a lower value than the clinically relevant measurement documented by the treating physician. The defense cannot simultaneously rely on the IME's physical examination findings of restricted motion and abductor weakness while arguing that impairment is limited to leg length discrepancy alone. The rating methodology is internally inconsistent with the documented findings and understates the functional impact the IME's own examination revealed.

SECTION 5: CLARIFICATION PROMPTS AND PRACTICAL LANGUAGE

Clarification Questions

1. The report concludes that low back symptoms are "more likely than not" caused by "pre-existent (mild) facet arthropathy, obesity and symptom magnification" rather than biomechanical compensation from the leg length discrepancy. What clinical findings support the attribution to pre-existing facet arthropathy rather than compensatory loading, given that Dr. Kinko documented positive Patrick's testing, left paraspinal tenderness, and clinical correlation between the gait abnormality and lumbar symptom onset?

2. The report states that "more diffuse low back symptoms are of uncertain origin, given the degree of symptom magnification present." What specific pain drawing findings constitute "degree of symptom magnification," and how was this determination made when the total Pain Disability Index score was 13 percent and the CES-D score was 10, both of which the report characterizes as mild or non-significant?

3. The causation analysis states that low back symptoms are attributed to symptom magnification and obesity. What is the clinical basis for introducing obesity as a causal factor when body weight is documented as 160 pounds at 5 feet 7 inches (BMI approximately 25), and neither the treating record nor the IME physical findings identify obesity as a documented condition?

4. The work capacity section states the examinee "assumes that he is unable to sit, but I can find no objective reason why that should be the case." What treating record entry documents that Mr. Sample stated he is unable to sit, given that the IME's own functional status section reports he "can sit for up to two hours"?

5. The appropriateness of care analysis concludes that Neurontin use has been "inappropriate given the lack of evidence of neuropathic pain." How does this conclusion address Dr. Kinko's documentation of "burning, lancinating pain" in the lateral femoral cutaneous nerve distribution and the surgical approach risk to that nerve structure during the 1985 ORIF procedure?

6. The report concludes that Avinza use is "inappropriate given the lack of objective reason for the examinee's pain complaints and the ineffectiveness of the

medication." What clinical findings establish that the medication has been ineffective when Dr. Kinko documented a stable dose without escalation over fourteen months and the IME examination occurred during ongoing medication use?

7. The IME physical examination documents external rotation at 15 degrees bilaterally. Dr. Kinko's June 2004 examination documented external rotation at 20 degrees on the left. How was symmetrically decreased external rotation determined when the treating physician documented asymmetric limitation favoring the injured side?

8. The leg length measurement in the IME examination reveals "a 2.5 cm deficit on the left" measured from lateral pelvic rim to lateral tibial plateau. The June 2003 imaging report documents 1.1 cm femoral shortening, and Dr. Kinko's clinical measurement using blocks documents 2.8 cm without lift compensation. What accounts for the discrepancy between the IME's 2.5 cm measurement and Dr. Kinko's 2.8 cm clinical measurement, and which measurement method was used during the IME examination?

9. The causation section states "there is a causal relationship between the examinee's current left hip complaints and the reported injury" but attributes low back symptoms to other causes. What clinical reasoning distinguishes hip-related symptoms caused by the 1985 injury from lumbar symptoms caused by compensatory biomechanics resulting from the same injury, given that both symptom groups arise from documented structural changes?

10. The report states that prior to "his July 2004 hip surgery" the examinee would have had "essentially the same work restrictions." No hip surgery in July 2004 is documented in the materials provided. What records establish this surgical event, and how does the presence or absence of this surgery affect the work capacity analysis?

11. The appropriateness of care section states that "the failure to address the examinee's probable significant depression has been inappropriate." The IME's own CES-D administration produced a score of 10, which the report characterizes as "not consistent with a depressed mood." How are these two conclusions reconciled?

12. The maximum medical improvement determination states that MMI has been achieved. Dr. Kinko's June 2004 note states explicitly that "Patient is not currently at maximum medical improvement in my clinical opinion as further treatment trials remain available and have not been exhausted." What clinical findings support the conclusion that no further recovery or restoration of function can be anticipated when the treating physician documented ongoing treatment planning and incomplete therapeutic intervention trials?

Practical Language for Mediation and Correspondence

The IME physician concludes that low back symptoms are attributable to pre-existing facet arthropathy, obesity, and symptom magnification rather than biomechanical compensation from documented leg length discrepancy and altered gait mechanics. This conclusion is not supported by the treating record. Dr. Kinko documented progressive lumbar symptoms beginning eighteen months prior to the June 2004 examination, positive Patrick's testing indicating sacroiliac involvement, and clinical correlation between the gait abnormality and symptom onset. The facet arthropathy identified on imaging was characterized as mild and was present bilaterally, not in a distribution that accounts for the progressive left-sided symptoms Dr. Kinko documented.

The IME introduces obesity as a causal factor for lumbar symptoms without documentation. Mr. Sample's recorded weight is 160 pounds at 5 feet 7 inches, producing a BMI of approximately 25, which does not meet clinical thresholds for obesity. Neither the treating record nor the IME's own examination identifies obesity as a clinical finding. The attribution to obesity is unsupported by the documented facts.

The report criticizes Neurontin prescribing as inappropriate due to lack of evidence of neuropathic pain. Dr. Kinko documented burning, lancinating pain in the lateral femoral cutaneous nerve distribution and noted that this nerve is at risk during the lateral surgical approach used in the 1985 ORIF procedure. The IME does not address this documented neuropathic pain presentation or the surgical risk to the nerve structure. The conclusion that Neurontin prescribing was inappropriate cannot be reconciled with the documented clinical rationale in the treating record.

The appropriateness of care analysis states that Avinza prescribing has been inappropriate given lack of objective findings and medication ineffectiveness. The treating record documents failed trials of celecoxib, tramadol, and physical therapy

prior to opioid initiation. Dr. Kinko documented that Avinza was initiated after careful risk-benefit consideration and that the patient demonstrated stable use without dose escalation over fourteen months. The IME examination occurred while the patient was taking Avinza, yet the report does not explain how medication ineffectiveness was determined during active use or what findings would establish effectiveness in this clinical context.

The IME concludes that Mr. Sample has reached maximum medical improvement. Dr. Kinko's June 2004 note explicitly states that the patient has not reached MMI because further treatment trials remain available and have not been exhausted. The IME does not address this direct conflict or explain what clinical findings support the conclusion that no further recovery can be anticipated when the treating physician documented incomplete therapeutic intervention.

The leg length discrepancy presents a measurement inconsistency across three sources. The June 2003 imaging report documents 1.1 cm femoral shortening by radiographic measurement. Dr. Kinko's clinical measurement using blocks documents 2.8 cm leg length inequality without lift compensation. The IME documents 2.5 cm deficit measured from lateral pelvic rim to lateral tibial plateau. The IME does not explain the variance between these measurements or clarify which measurement was obtained and what clinical significance should be assigned to the difference.

The work capacity section states that the examinee assumes he is unable to sit but the IME can find no objective reason supporting this limitation. The IME's own functional status documentation reports that Mr. Sample can sit for up to two hours. No treating record entry documents a statement from Mr. Sample that he is unable to sit. This portion of the work capacity analysis appears to address a limitation that is not documented in either the IME findings or the treating record.

The causation analysis draws a distinction between hip complaints caused by the 1985 injury and low back symptoms attributed to other causes. Both symptom groups arise from documented structural changes produced by the same injury—the hip fracture, subsequent impaction deformity, progressive leg length discrepancy, and altered gait mechanics. The IME does not explain the clinical reasoning that separates hip symptoms as injury-caused from lumbar symptoms as non-injury-caused when both result from the same documented biomechanical chain.

The report references "his July 2004 hip surgery" in the work capacity section. No hip surgery in July 2004 appears in the materials provided. If this surgery did not occur, the work capacity analysis comparing pre-surgery and post-surgery functional status is based on an incorrect factual premise. If the surgery did occur but was not documented in the materials reviewed, the IME's analysis is incomplete because it does not account for the surgical intervention when assessing causation and maximum medical improvement.

The appropriateness of care section concludes that Dr. Kinko inappropriately failed to address significant depression. The IME's own depression screening using the CES-D produced a score of 10, which the report characterizes as not consistent with depressed mood. Dr. Kinko's June 2004 note documents a PHQ-9 score of 7 consistent with mild depression and documents that behavioral health referral was placed during that visit. The conclusion that depression was not addressed is contradicted by the treating record and by the IME's own screening results.

The pain drawing is cited as revealing findings suggestive of symptom magnification, but the Pain Disability Index total score is 13 percent and the CES-D score is 10, both of which the report characterizes as mild or non-significant. The report does not explain how these three instruments produce findings that support both the presence of symptom magnification sufficient to affect causation conclusions and the absence of significant psychological factors or functional disability. The internal consistency of these characterizations is not demonstrated.

SECTION 6: CONFIDENCE SURFACE

The IME establishes with clarity that Sample sustained a four-part comminuted intertrochanteric femur fracture in December 1985, underwent open reduction and internal fixation with compression hip screw and cerclage wire, and healed the fracture without avascular necrosis or hardware failure. The physician correctly identifies 2.5 cm leg length discrepancy from radiographic measurement and applies the AMA Guides methodology without technical error to arrive at 3% whole person impairment. These conclusions rest on documented imaging, surgical records, and standardized impairment rating tables. They are defensible in any forum.

The causation opinion connecting current left hip complaints to the 1985 injury stands on similarly solid ground. Dr. Boucher states to a reasonable degree of medical certainty that the hip complaints relate causally to the fracture. The treating record supports this position through eighteen years of documented follow-up showing persistent pain localized to the surgical site, hardware-related discomfort, progressive impaction, and functional limitation tied directly to the structural consequences of the injury. No alternative causation theory appears in the submission that would undermine this conclusion. The IME's causation statement on the hip itself is defensible and unlikely to shift negotiation position.

The report does not establish with equivalent clarity the basis for the work capacity restrictions it imposes. Dr. Boucher assigns sedentary capacity with ten-pound occasional lift, five-pound frequent lift, fifteen minutes walking per hour, and intermittent sitting and standing with frequent position changes. These restrictions appear in the work capacity section without documented connection to examination findings.

The physical examination shows symmetrically decreased external rotation, 2.5 cm leg length discrepancy, and normal gait with no pain on hip motion. Dr. Boucher states explicitly that Sample had no pain with hip motion during testing and that resisted hip abduction and external rotation were pain free. The record contains no measured strength deficit, no atrophy, and no documented impairment of lower extremity function that would explain a fifteen-minute-per-hour walking restriction for a patient who reports walking two miles daily.

The IME does not explain how a patient with painless hip motion on examination, normal gait, no assistive device use, and self-reported two-mile daily walking capacity becomes restricted to fifteen minutes of walking per hour in a work context.

The gap between examination findings and assigned restrictions remains unbridged by reasoning visible in the report. The work capacity opinion depends on unstated clinical reasoning that the submission does not contain. In mediation, this is where the IME becomes difficult to defend when the treating physician has documented functional walking capacity and daily activity levels that exceed the IME's restrictions by significant margin.

The causation opinion regarding low back symptoms presents a different vulnerability. Dr. Boucher concludes that diffuse low back symptoms are of uncertain origin and attributes them more likely than not to preexisting mild facet arthropathy, obesity, and symptom magnification. This rests on mild facet arthrosis at L4-5 and L5-S1 on the June 2003 imaging report.

Dr. Kinko's June 2004 assessment does not appear anywhere in Dr. Boucher's analysis. Dr. Kinko states that the low back pain is most likely compensatory given the prolonged leg length discrepancy and altered gait mechanics. He explicitly notes that while the facet arthrosis provides a structural substrate, it does not fully account for symptom severity in the context of the documented gait abnormality. The IME frames the back pain as uncertain origin and invokes preexisting arthropathy without engaging the treating orthopedist's documented clinical reasoning.

Dr. Kinko connects the back symptoms to the biomechanical consequences of the injury through leg length inequality and altered gait. The IME does not explain why this reasoning is incorrect or why preexisting mild facet arthropathy presents a more probable cause than compensatory mechanics in a patient with 2.8 cm clinical leg length discrepancy and documented Trendelenburg gait. The causation opinion on the back depends on declining to address the treating record's alternative explanation. The IME's position requires either accepting that compensatory back pain is implausible or explaining why Dr. Kinko's reasoning is wrong. The report does neither.

The symptom magnification finding carries significant weight in the report's overall argument but rests on limited demonstration. Dr. Boucher identifies symptom magnification based on the pain drawing and states that the examinee's diffuse low back

symptoms are of uncertain origin given the degree of symptom magnification present. The pain drawing receives reference but does not appear reproduced in the submission.

The behavioral observations section states that Sample appeared comfortable, sat continuously for twenty minutes, showed no significant pain behavior, and demonstrated no non-physiologic findings. The Pain Disability Index produced a total score of 9 out of 70, which the IME interprets as mild perceived disability. The CES-D depression screening scored 10, which the IME states is not consistent with depressed mood.

The symptom magnification conclusion depends on the pain drawing alone.

The other inventories do not support magnification. The behavioral observations explicitly contradict it. Dr. Boucher does not explain what features of the pain drawing justify the symptom magnification finding or how that finding reconciles with the absence of pain behavior, the low disability index, and the normal affect and cooperation documented throughout the examination.

The magnification finding is load-bearing for the low back causation opinion but draws support from one inventory while contradicted by observable behavior and other validated instruments. The treating record shows PHQ-9 score of 7, consistent with mild depression, while the IME's CES-D shows 10, not consistent with depression. The discrepancy goes unexplained and weakens the magnification argument further.

The appropriateness of care opinion receives confident statement but depends on clinical assumptions the submission does not demonstrate. Dr. Boucher concludes that Avinza use is inappropriate given the lack of objective reason for pain complaints and the ineffectiveness of the medication. The treating record shows Dr. Kinko initiated Avinza in February 2003 after failed trials of celecoxib, tramadol, and two courses of physical therapy, and documents chronic pain presentation with objective findings including hardware-related tenderness, progressive impaction on imaging, and functional limitation.

The IME examination shows tenderness over the lateral hip hardware site and resisted abduction producing 4/10 pain per Dr. Kinko's note, though Dr. Boucher's own examination states resisted abduction was pain free. The conclusion that there is no objective reason for pain complaints requires ignoring documented hardware tenderness, progressive impaction, heterotopic ossification, and functional range of motion decline.

The conclusion that the medication is ineffective receives statement without support. The treating record does not document ineffectiveness. Dr. Kinko's note states stable use without dose escalation over fourteen months, which is clinically consistent with adequate pain control rather than ineffectiveness. Dr. Boucher does not explain the basis for the ineffectiveness finding. The appropriateness of care opinion becomes defensible only if the documented objective findings receive disregard and if medication ineffectiveness can be asserted without documentation. Neither position is strong in negotiation.

The Neurontin inappropriateness finding depends on the conclusion that there is no evidence of neuropathic pain. Dr. Kinko's August 2003 note documents burning, lancinating pain in the left proximal thigh and lateral hip region in a distribution consistent with lateral femoral cutaneous nerve involvement, which faces recognized risk during lateral surgical approach. The IME does not address this documented clinical finding or explain why the described symptoms do not constitute evidence of neuropathic pain. The conclusion that Neurontin is inappropriate requires either that the treating physician's documented nerve distribution symptoms are clinically incorrect or that burning and lancinating pain in a surgical approach nerve distribution does not meet the standard for neuropathic treatment. The IME does not make either argument explicit.

The maximum medical improvement finding conflicts with the treating record. Dr. Kinko's June 2004 note explicitly states that Sample is not currently at maximum medical improvement because further treatment trials remain available and have not been exhausted. Dr. Boucher does not address this statement or explain why the treating orthopedist's clinical judgment on MMI is incorrect.

The MMI conclusion appears to rest on Dr. Boucher's view that no further treatment is necessary rather than on demonstration that no further recovery or restoration of function can be anticipated. The distinction matters because MMI receives definition in the report as the date after which further recovery and restoration cannot be anticipated based on reasonable medical probability, not the date after which the IME physician would discontinue treatment. The treating record documents ongoing range of motion decline, progressive impaction, and planned interventions including behavioral health referral and possible hardware removal. The MMI opinion depends on treating these as irrelevant to recovery potential. The report does not explain why.

What remains solid is the structural findings, the hardware status, the impairment rating methodology, and the causation opinion as applied to the hip itself. These conclusions are grounded in documented imaging, validated measurement, and longitudinal treating records showing persistent injury-related symptoms without alternative explanation. They will hold across forums.

The work capacity restriction structure presents exposure. So does the low back causation opinion that requires ignoring compensatory mechanics. The symptom magnification finding is contradicted by behavioral observations. The medication appropriateness conclusions depend on disregarding documented objective findings. The MMI determination conflicts directly with the treating physician's explicit statement. These positions depend on reasoning the report does not show or on declining to engage record entries that contradict the conclusions. They create negotiation exposure because they require either accepting gaps in clinical reasoning or defending positions the treating record contradicts directly.

The attorney's leverage sits at these points. The IME's strength sits with the structural findings and the hip causation opinion. The distinction holds across strategy contexts and should guide where pressure is applied and where concessions are anticipated.

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