BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

STEVE R. TENNY, Claimant, v. LOOMIS, ARMORED US, LLC, Employer, and ACE AMERICAN INSURANCE CO., Surety, Defendants.	**IC 2014-032378** **FINDINGS OF FACT, CONCLUSION OF LAW, AND RECOMMENDATION** **Filed 12/10/19**

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Idaho Industrial Commission assigned the above-entitled matter to Referee Michael Powers, who conducted a hearing in Boise, Idaho, on January 16, 2019. Darin Monroe represented Claimant. Mindy Muller represented Defendants. The parties produced oral and documentary evidence at the hearing. Post-hearing depositions were taken. The parties submitted briefs. Thereafter Referee Powers retired. Upon receipt of a stipulation filed by the parties on July 19, 2019, indicating a willingness to allow the Commission to re-assign the matter to a new Referee to issue a written decision without the need to re-hear the case, the matter was assigned to Referee Brian Harper. The case came under advisement on August 20, 2019.

ISSUE

Based upon the statements of parties at hearing and in briefing, the sole issue to be decided is whether the Claimant's condition for which he seeks benefits was causally related to his accepted industrial accident of December 2, 2014. All other issues were reserved.

CONTENTIONS OF THE PARTIES

Claimant contends that during and after a steroid injection treatment for his accepted right-sided L3-4 disc herniation injury he developed intractable left-sided hip/groin pain. His most recent treatment for this condition includes a pain pump. While initially accepting the left-sided injury and pain pump treatment, Defendants denied further treatment after receiving a favorable IME report.

Defendants claim Claimant's left groin pain is due to iliopsoas bursitis unrelated to his accepted low back injury. There is no objective evidence of nerve damage; there is objective evidence of iliopsoas bursitis. A bevy of physicians have opined that Claimant's ongoing condition is not causally related to medical treatment related to his industrial accident.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. The testimony of Claimant and witnesses Kristi Tenny and Sherry Henslee, taken at hearing;

2. Claimant's Exhibit A (listed under tab 40 in the Joint Exhibits), and Joint Exhibits (JE) 1 through 39, admitted at hearing.

All objections preserved through the depositions are overruled with the following exception – the objection to the introduction of deposition exhibit 1 to Dr. Thompson's

deposition is sustained as being untimely produced. While the article is not admitted, counsel's general questions regarding Dr. Thompson's knowledge or lack of knowledge concerning the interaction of cannabis consumption and perceived pain was appropriate.

FINDINGS OF FACT

1. Claimant was working for Employer on December 2, 2014 when he injured his low back, suffering radicular pain down his right leg to his toes. Notice and acceptance of the claim are not issues.

2. In the weeks after the accident Claimant was treated by Michael Gibson, M.D., at St. Alphonsus Occupational Medicine in Boise. Diagnostic films showed Claimant had multilevel degenerative spondylosis and a right asymmetric disc extrusion at L3-4. He also had moderate to severe right and severe left foraminal stenosis.

3. On December 22, 2014, Claimant received his first steroid injection at L3-4. It lessened but did not eliminate Claimant's right lower back and right leg pain.

4. On January 8, 2015, Claimant underwent his second fluoroscopic guided translaminar epidural injection (ESI) to treat his right-sided low back and leg complaints. There are discrepancies surrounding this event, which is central to the conflict at hand. Specifically, Claimant and his wife testified that Claimant first felt left hip/groin pain during the procedure, while a notation on a "block sheet" filled out by Claimant indicates that "a few hours" after the injection Claimant's left groin and/or hip area became "very uncomfortable." JE 35, p. 2055.

5. Due to Claimant's unrelenting left lower extremity pain complaints, he was sent to Michael Hajjar, M.D., a neurological surgeon on January 21, 2015. Dr. Hajjar noted Claimant's right sided pain had "completely abated" but immediately after his second injection,

Claimant developed left lower extremity pain which made it difficult for Claimant to stand, walk, and carry out daily living activities. Dr. Hajjar noted Claimant had undergone a left hip replacement in early 2014. Examination showed diminished strength in Claimant's left lower extremity as compared to his right. A lumbar MRI was ordered. It was consistent with previous MRI studies.

6. Dr. Hajjar felt Claimant's left-sided pain was "probably consistent with an L3 issue" (JE 25, p. 1605) and ordered a bilateral lower extremity nerve conduction study, which came back normal.

7. On January 22, 2015, Claimant was seen for his annual check up by Roman Schwartsman, M.D., the surgeon who had performed Claimant's left hip replacement in January 2014. Dr. Schwartsman noted Claimant's ongoing issues "with his back" which compromised Dr. Schwartsman's examination. Dr. Schwartsman scheduled a follow up appointment for three months with hip and pelvis x-rays to be conducted in the interim.

8. Dr. Schwartsman's review of hip x-rays showed no issues with Claimant's hip prosthetics. Dr. Schwartsman diagnosed L3-L4 dermatomal distribution pain secondary to left L4 radiculopathy with stable left hip arthroplasty. The doctor felt Claimant's left-sided pain was due to his back.

9. On April 6, 2015, Dr. Hajjar performed bilateral L3-4 hemilaminotomy and foraminotomy surgery with right microdiscectomy and decompression for Claimant's continuing back complaints. One month post surgery, Dr. Hajjar noted Claimant's hip pain was "essentially gone" and he was ready for physical therapy. However, Claimant continued to complain of left hip area pain to his nurse case manager, Sherry Henslee. Additional testing was ordered.

10. An otherwise normal nerve conduction study performed on May 29, 2015 demonstrated a focal finding in Claimant's left gluteus muscle, and Dr. Hajjar believed that was the source of Claimant's ongoing complaints. He prescribed Claimant muscle relaxers and physical therapy. Claimant also had a hip/pelvis CT scan performed which showed no pathological findings, including iliopsoas bursitis.

11. Claimant was sent to Christian Gussner, M.D., a physical medicine and pain management specialist for evaluation of Claimant's ongoing severe left inguinal pain. After his initial examination, Dr. Gussner diagnosed a hernia and possible left hip bursitis in spite of the negative CT scan. Dr. Gussner did not feel Claimant's pain complaints were related to his back. He referred Claimant to Thomas Huntington, M.D., for evaluation of a suspected hernia.

12. Dr. Huntington found no left-sided hernia. Claimant returned to Dr. Gussner for treatment.

13. Dr. Gussner could not explain Claimant's unrelenting left hip pain and questioned if Claimant might have opioid-induced hyperalgesia due to his chronic opioid pain medication usage and his past history of drug abuse. Dr. Gussner felt it was appropriate to taper Claimant off opiate medication. He also felt Claimant was suffering from left hip bursitis. Dr. Gussner injected Claimant's left trochanteric and iliopsoas bursae. The procedure did not provide Claimant any relief.

14. Given Claimant's lack of relief from the injections, Dr. Gussner concluded Claimant did not have bursitis. He sent Claimant back to Dr. Schwartsman for a bone scan.

15. On September 22, 2015, Dr. Schwartsman again examined Claimant. Dr. Schwartsman again opined that Claimant's ongoing left hip pain was related to his left L3-4

nerve root. Claimant was not "exquisitely tender" over his iliopsoas or rectus on direct palpation, but pain was reproducible down Claimant's left leg with flexion. Claimant's professed left leg weakness and extensive left L3-4 stenosis supported Dr. Schwartsman's opinion that Claimant's problem was neurologic.[1] Dr. Schwartsman ordered an MRI and referred Claimant to Tyler Frizzell, M.D., a local neurosurgeon, for further treatment.

16. Dr. Frizzell ordered a lumbar CT scan with intrathecal contrast. It showed bilateral L5 pars defects with grade 1 anterolisthesis L5 over S1 with degenerative changes greatest at L4-5 and L5-S1, but no structural lesions. Given those findings, Dr. Frizzell referred Claimant to a pain management specialist, Sandra Thompson, M.D.

17. After again ruling out a hernia, Dr. Thompson began a pain management program. Different drug modalities proved ineffective. Dr. Thompson felt Claimant's ongoing left groin pain was "neuropathic in nature" despite the fact there was "no clear underlying objective testing to support [such] diagnosis." JE 30, p. 1768.

18. Dr. Thompson eventually suggested an intrathecal pain pump. After a successful trial, on May 13, 2016, Claimant underwent a permanent implantation. Dr. Thompson continued to treat Claimant with adjustments to and medication refills of the pain pump as of the time of hearing. The pain pump has not eliminated Claimant's pain, although it has subjectively moderated it.

19. Defendants sent Claimant to Rodde Cox, M.D., for an independent medical examination on December 12, 2016. He sent Claimant for another MRI, which showed small to moderate left-sided iliopsoas bursitis. Dr. Cox felt some of Claimant's complaints could be related to this bursitis. The bursitis itself was not causally related to Claimant's work injury.

[1] As discussed below, Drs. Gussner and Schwartsman changed their minds subsequently.

Subsequently Dr. Cox also opined that Claimant's groin pain was not causally related to the injection of January 8, 2014.

20. Claimant returned to Dr. Frizzell in February 2018. Dr. Frizzell ordered a third nerve conduction study and EMG by a neurologist to assess for neurological deficit in Claimant's left lower extremity. The testing was done by Heidi Orme, M.D., on May 7, 2018.

21. Dr. Orme noted Claimant was complaining of persistent daily pain in spite of a successful decompression surgery. Dr. Orme classified Claimant's pain as "well localized" groin pain with no left leg radicular pain, and no numbness or tingling. During the examination the doctor found "giveaway weakness in all manually motor tested groups outside of a specific peripheral nerve or myotomal distribution." Claimant also reported hypoesthesia to pinprick in all dermatomal distributions of his left lower leg. JE 34, p. 2034.

22. Dr. Orme found Claimant's nerve conduction study and EMG to be normal.

DISCUSSION AND FURTHER FINDINGS

23. The question for resolution is whether Claimant's ongoing left-sided hip/groin pain is causally related to his industrial accident, including whether it is a compensable consequence of medical treatment provided to him for his accepted work injury. Claimant must prove that the injury was the result of an accident arising out of and in the course of employment. *Seamans v. Maaco Auto Painting*, 128 Idaho 747, 751, 918 P.2d 1192, 1196 (1996). Temporal association alone does not establish causation. Claimant must provide medical testimony that supports his claim for compensation to a reasonable degree of medical probability. *Langley v. State, Industrial Special Indemnity Fund*, 126 Idaho 781, 785, 890 P.2d 732, 736 (1995).

24. Claimant may establish the requisite causal relationship between the accident and his current condition by demonstrating with persuasive medical testimony that his left hip/groin condition "flowed" from the subject accident. "The basic rule is that a subsequent injury,

whether an aggravation of the original injury or a new and distinct injury, is compensable if it is the direct and natural result of a compensable primary injury." *Castaneda v. Idaho Home Health, Inc.*, IIC 96-029370 (July 27, 1999). Claimant's argument is that if his current left hip/groin condition is not directly caused by the subject accident it is nevertheless a compensable consequence of the subject accident, because the subject accident led to the spinal injection treatment of January 8, 2014, which, in turn, caused nerve damage to Claimant's upper left lower extremity.

25. Several physicians have opined on causation through reports and testimony.

PHYSICIANS FAVORABLE TO CLAIMANT

Dr. Frizzell

26. Dr. Frizzell first treated Claimant in the fall of 2015. In response to a request from Claimant, he authored a letter dated September 19, 2018. Therein he noted he had reviewed medical literature discussing the relationship between L3 and L4 nerve root dysfunction and groin pain. Specifically, he cited to an article from *Journal of Spine* (Sasaki and Colleagues, 2014, 3:3) which found that while the L1 and L2 nerves typically innervate the groin area, some people with L3 or L4 radiculopathy can experience nerve pain in the groin area. Dr. Frizzell attached a copy of the article to his 2018 letter. *See* JE 29 pp. 1750 to 1753. He also cited to two other articles he claimed confirmed the findings of Sasaki *et al.* Relying on these articles and the findings therein, Dr. Frizzell stated that the cause of Claimant's ongoing left lower extremity pain was "his January 2015 epidural injection at L3-L4 on the left side. This led to L3 and L4 nerve root dysfunction resulting in pain into the groin region." JE 29, p. 1748.

27. Dr. Frizzell was deposed post hearing. Therein he reiterated his opinion on causation. While maintaining his position he did make several admissions. The first

significant admission was that nerve conduction studies look for nerve dysfunction, and all of Claimant's nerve conduction studies came back normal, indicating no such dysfunction. Such an admission goes against the doctor's opinion that Claimant suffered "nerve root dysfunction resulting in pain into the groin region." Dr. Frizzell testified that nerve tests do not assess for pain, which is a separate issue from nerve function.

28. In cross examination Dr. Frizzell acknowledged that the Sasaki *et al.* article indicated that while the researchers found a small percentage of individuals can experience groin pain associated with nerve compression at L3 or L4, *all* such patients reviewed in the study experienced groin pain relief with decompression surgery at the affected lumbar level. Dr. Frizzell admitted Claimant's experience was different than the subjects in the study he cited, since Claimant had bilateral decompression surgery at L3-4 with no relief from his groin pain.[2]

Dr. Thompson

29. Dr. Thompson was deposed post hearing. She opined at that time her disagreement with the physicians who felt Claimant's pain complaints were due to iliopsoas bursitis.[3] She explained that bursitis is effectively treated with conservative measures and medications such as anti-inflammatories which proved ineffective in Claimant's case. While Claimant may have bursitis, it was not the primary cause of his ongoing intractable pain which required a pain pump to treat.

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[2] However, Claimant notes the doctor's point was that Claimant's groin pain could be explained by damage to his L3 or L4 nerves as a general proposition, not that Claimant's pain was due to nerve compression. In fact, Claimant argues his groin pain was due to damage inflicted during his second ESI. Several experts in this case indicated that Claimant's groin pain would be associated with nerve damage at L1 or L2 if his pain was neurologic in nature, which they also dispute. They argue damage to L3 or L4 would not produce groin pain.

[3] Defendants objected to her giving this opinion on the grounds she had not provided an opinion letter or report on that subject before her deposition. The objection was not renewed in briefing nor was there a Motion to Strike made, either at the time of hearing or subsequently. Claimant's supplemental answer to interrogatories (JE 6) indicated the doctor would opine on her disagreement with physicians who claim Claimant's pain is due to bursitis. As Claimant points out, there is no requirement that an expert provide a written report. The objection is overruled.

30. Dr. Thompson's testimony on causation came down to her opinion that "something happened" at Claimant's second injection to cause his ongoing left groin pain. She testified that "[i]t's not normal to have this [second] injection and have a persistent headache for a week and pain immediately after. That's just not normal." Thompson Depo. p. 13. Dr. Thompson agreed that there is no objective evidence showing the root of Claimant's pain complaints, but she nevertheless opined that "something happened here" with "here" being at the second injection. *Id.* Later in her deposition, Dr. Thompson reiterated her position that Claimant suffered a "complication of some sort there [at the second injection], and that's what started the whole chronic groin pain." Thompson Depo. p. 19. She held her opinions to a "highly likely" degree.

PHYSICIANS FAVORABLE TO DEFENDANTS

Dr. Schwartsman

31. On April 4, 2017, in response to a letter from Defendants' counsel with attached medical records generated after the time he last saw Claimant, Dr. Schwartsman authored a causation opinion letter. Therein he wrote;

> I do concur with Dr. Cox that the iliopsoas bursitis is a potential cause of left hip pain and is the likely cause of [Claimant's] symptoms. *** I would be of the opinion that left groin pain complaints are attributable to the iliopsoas bursitis barring any other physical exam findings. *** I do agree with Dr. Cox that iliopsoas bursitis would be at this point the cause of [Claimant's] current symptoms.

JE 22, p. 677. Dr. Schwartsman was not deposed.

Dr. Krafft

32. Kevin Krafft, M.D., performed Claimant's first two electrodiagnostic nerve tests in the first six months after Claimant's second epidural steroid injection. In September 2018, in response to a letter from Defendants' counsel in which she summarized selected

medical records and opinions of other physicians, Dr. Krafft authored a causation opinion letter. Therein he wrote;

> There is no objective evidence that the epidural steroid injection that [Claimant] received on January 8, 2015 damaged [his] nerves or caused his current left groin pain.
>
> The doctor who performed the January 8, 2015 injection intended to inject at the L3-4 level. He would have had to miss by two levels to hit a nerve that would impact the groin because the groin is not in the nerve distribution for the L3-4 level. The images taken during the injection … show that the doctor did not miss. The needle was injected into the sheath surrounding the nerves at the L3-4 level.
>
> My testing shows no nerve damage from the L3-4 level. Also, Dr. Orme's testing shows no nerve damage from the L1-2 level.
>
> Based on a reasonable degree of medical certainty, [Claimant's] current groin pain was not caused by the epidural steroid injection he received on January 8, 2015. Bursitis is a better explanation for Claimant's ongoing left groin pain complaints.

JE 27, p. 1651. Dr. Krafft was not deposed.

Dr. Hajjar

33. On December 21, 2018, Dr. Hajjar responded to a letter from Defendants' counsel requesting a causation opinion letter. Previously, on December 15, 2017, Dr. Hajjar had authored an opinion on causation to an unknown recipient. Both opinion letters were consistent in denying any connection between Claimant's second injection and his current hip/groin complaints.

34. Dr. Hajjar was deposed on March 14, 2019. Therein he admitted that the L3 nerve can innervate the groin area, and sometimes overlaps with the L2 nerve in that area. He further admitted that the area of Claimant's pain complaints would be consistent with an L3 nerve issue. However, he noted there are many conditions which can mimic nerve pain in the groin region which are not nerve issues.

35. Given the facts that, (1) there were multiple normal nerve conduction studies, (2) decompression surgery did not help Claimant's pain, (3) Claimant's pain did not "exactly mimic classic nerve pain, and that is was more a spot of pain, versus a distribution that is similar to the nerve diagram where nerves go," and (4) Claimant had a pre-existing hip issue which led to a hip replacement surgery, Dr. Hajjar came to the conclusion that Claimant's groin pain was not a "nerve issue." Hajjar Depo. p. 20; *see also* p. 35. Instead, Dr. Hajjar felt Claimant's complaints were "more likely than not related to [his] hip condition, and pre-existing in nature, and far less likely related to the work-related injury, or any pathology in [Claimant's] low back." *Id.* at 21.

36. Dr. Hajjar observed that where the second epidural injection was made from the right side, it would be difficult to damage the nerves on Claimant's left side. Also, when a nerve is inadvertently injected the pain is immediate, which is inconsistent with Claimant's handwritten note that his left groin pain became "very uncomfortable a few hours after injection." Dr. Hajjar admitted that while developing pain a few hours after injection does not indicate injection-caused nerve damage, if overwhelming pain occurred during the injection it would be much more likely that the injection caused nerve damage.

37. Dr. Hajjar found Dr. Orme's nerve conduction study to be telling in that it was done years after Claimant's original complaint. There was no denervation which one would expect to see if Claimant had suffered nerve damage years previously.

38. Dr. Hajjar opined that Claimant's symptoms are consistent with iliopsoas bursitis. The doctor admitted that while bursitis can be discovered using three tests, CT scan, ultrasound, or MRI, the CT scan he ordered on June 4, 2015 did not show any indication of iliopsoas

bursitis. He was not specifically asked to explain why the CT scan failed to show the bursitis if it was present from the time of Claimant's second ESI.

Dr. Gussner

39. In November 2017, in response to a letter from Defendants' counsel in which she summarized selected medical records outlining Claimant's medical progression since his industrial accident as well as physician opinions, and provided selected medical records and deposition testimony, Dr. Gussner authored a causation opinion letter. Therein he opined that Claimant's left lower extremity symptoms were not related to his work accident, but instead the most likely cause of Claimant's subject complaints was his iliopsoas bursitis, as found on a January 4, 2017 MRI. Further elaborating, Dr. Gussner felt that Claimant could have had tight hip flexors as a result of his total hip replacement and lying in a prone position might have stretched the hip flexors, which may have contributed to the bursitis.

40. Dr. Gussner also opined the epidural injection did not contribute to Claimant's complaints. Dr. Gussner noted the needle did not come close to Claimant's left L1 or L2 nerve roots, and it is those nerve roots which innervate the groin and medial thigh. Finally, there was no objective evidence of left lumbar radiculopathy on EMG testing.

41. Dr. Gussner was deposed on March 11, 2019. He testified that although he ruled out bursitis when he was treating Claimant in 2015 based on the fact his diagnostic injections for bursitis provided no relief, in reality he might have missed hitting the bursae with his two shots. He did not use an ultrasound guided injection process but rather simply palpated Claimant and injected his most tender spots.

42. Dr. Gussner questioned why Claimant's pain was severe enough to warrant a fentanyl pain pump when no objective testing showed any rationale for such pain level. Dr. Gussner does not believe Claimant should be on a long-term narcotic treatment plan.

43. Dr. Gussner does not feel Claimant's ongoing groin pain was caused by the January 8, 2015, injection. In the first place, Claimant's groin pain was "very localized," "reproducible with direct palpation of the anterior hip, reproducible with hip flexion," and not the diffuse pain associated with L3 nerve damage which would radiate "down the anterior thigh to the inside part of the knee." Gussner Depo. p. 21. L4 nerve damage would likewise produce a pain pattern different than Claimant's complaints. Furthermore, an interlaminar epidural injection such as Claimant received is posterior to the sac that contains the nerves and does not come close to the L3 or L4 nerve roots. This is in contrast to a transforaminal injection which is done right next to the nerves. While at times a transforaminal injection may hit a nerve, causing immediate shooting pain down the patient's leg, such did not happen here. Images taken during the injection do not show the needle tip anywhere near the L3 nerve, which was above the injection site.

44. After reviewing the January 4, 2017 MRI of Claimant's pelvis showing the iliopsoas bursitis, Dr. Gussner testified that the MRI was the only objective test imaging study that explains the location of Claimant's pain. The doctor had no explanation for the severity of Claimant's complaints, although after reading Dr. Calhoun's notes from psychological testing, he noted Claimant's psychological factors, including his somatoform tendencies, anger, depression, and anxiety, can all increase a pain response.

45. Dr. Gussner noted nerve conduction studies find "significant" nerve damage, and one can have pain or irritation of the nerve and still have a normal nerve conduction study. Gussner Depo. p. 32.

46. Dr. Gussner testified that in his opinion one "can certainly have immediate pain during an injection. Having lifelong pain after an injection without any objective findings is improbable." Gussner Depo. pp. 49, 50.

Dr. Cox

47. In Dr. Cox's opinion report dated June 23, 2017, he stated the most likely cause of Claimant's left lower extremity symptoms was, in his opinion, the iliopsoas bursa, to the exclusion of all other potential factors such as Claimant's original work accident, his lumbar steroid injections, his lumbar surgery, or even his hip replacement.

48. On December 19, 2018, in response to an inquiry from Defendants' attorney, Dr. Cox again opined that Claimant's pathology was not consistent with permanent nerve injury affecting the groin as a result of the January 8, 2015 injection. He further disagreed with Dr. Frizzell's opinion, since electrodiagnostic testing failed to show any evidence of L3 or L4 radiculopathy.

49. Dr. Cox was deposed on March 12, 2019. He testified that Claimant's complaints of increased pain with sneezing and/or coughing, sharp constant pain, and feelings similar to an abscessed tooth are all consistent with iliopsoas bursitis. It is possible for the bursitis to persist indefinitely due to tightness in surrounding muscles and tendons which continuously irritate the bursa. Without correction of the underlying mechanical problem even steroid injections might not resolve the bursitis. Pain medication will not heal the underlying bursitis, or make it less inflamed or irritated.

50. Dr. Cox felt that if Claimant had suffered nerve damage from the injection, Claimant's pain would improve over time, which did not happen; instead his pain continued to worsen with time. Dr. Cox highlighted medical records in the days following Claimant's second ESI, and noted Claimant was not complaining of exquisite pain in those first few visits. Nerve damage pain would be immediate, not build with time.

51. Dr. Calhoun's records showing Claimant suffered from somatic system disorder with predominant pain was consistent with Dr. Cox's findings that Claimant exhibited symptomology that was not well explained by anatomical findings. When asked for Dr. Cox's opinion of the cause of Claimant's ongoing groin pain, he responded, "I think certainly a contribution could be the iliopsoas bursitis. But his pain levels are fairly high. He does have a number of nonphysiologic findings that have been noted by myself, but also noted by other practitioners. And that would be consistent with a somatic system disorder." Cox Depo. p. 36. Secondary gain was also considered.

Analysis

52. Although the parties spend considerable time dueling over numerous point-by-point "micro arguments," the resolution of the issue comes down to two competing "macro analyses." Claimant's arguments sound, in one form or another, in the notion that Claimant experienced pain from the moment of his second injection which pain has been consistent and unrelenting, and is not rooted in his iliopsoas bursitis. While his theory does not solely rely on a temporal relationship between the onset of Claimant's left groin pain and the second steroid injection, that relationship is the foundation for it. Defendants' argument relies heavily on a lack of objective testing for nerve damage, which makes the prospect that Claimant suffered severe permanent nerve damage from his injection treatment highly unlikely.

Defendants can also point to an objective pain causing condition, iliopsoas bursitis, as the more likely cause of Claimant's ongoing complaints.

53. Claimant argues the following points establish the proof he needs to support his claim;

- Claimant's second injection was at the L3-4 level, and medical testimony and studies prove that the L3 and/or L4 nerve roots can innervate the groin area in some individuals.
- Claimant's complaints have been consistent since they began in January 2015, and Claimant's experts opined such complaints are consistent with permanent nerve damage.
- A CT scan taken on June 4, 2015 did not show evidence of iliopsoas bursitis in Claimant's left hip.
- The ESI injections performed by Dr. Gussner into the iliopsoas bursae on September 4, 2015 did not have any effect on Claimant's groin pain.
- Dr. Gussner originally ruled out iliopsoas bursitis based on his findings and testing.
- It was not until an MRI done on January 4, 2017 nearly two years after Claimant began having groin pain revealed a small to moderate left-sided iliopsoas bursitis that Defendants denied Claimant's claim and took the position Claimant's ongoing complaints since January 2015 was related to this bursitis.
- Claimant and his wife both testified that his left groin pain began during his January 8, 2015 injection, and he mentioned that pain at the time of the injection; his "block sheet" notation that his left groin pain "became very uncomfortable a few hours after injection" is not an inconsistent statement to his testimony.

54. Defendants argue the following points rule out Claimant's claim that the January 8, 2015, steroid injection caused or contributed to Claimant's ongoing left groin pain;

- No objective evidence of nerve damage exists in spite of three nerve conduction studies performed to try and establish some explanation for Claimant's ongoing pain complaints.
- Objective evidence which would account for Claimant's pain does exist in the form of an MRI showing left-sided iliopsoas bursitis in Claimant's hip.
- Five physicians have opined that Claimant's ongoing left hip/groin pain is caused by his iliopsoas bursitis.
- Claimant's pain complaints do not correspond with an L3 or L4 nerve distribution, as the groin area is innervated by L1 and L2 nerve roots, which were two levels away from where the injection was performed.
- X-ray evidence showing the actual injection establishes that the needle was nowhere near any of Claimant's nerve roots.
- The only contemporaneously-produced evidence, the "block sheet" indicates Claimant's pain did not begin during the injection, but rather became uncomfortable several hours after the injection.
- Claimant exhibited symptom magnification, and nonanatomic symptoms, consistent with his diagnosed somatoform tendencies, or possible opiod induced hyperalgesia, making his severe pain complaints disproportional to any objective evidence.
- Neuropathic medicines did nothing to relieve Claimant's subjective complaints of pain.
- A temporal relationship standing alone does not establish causation.[4]

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[4] Not all of the "micro arguments", such as parsing words like "uncomfortable" vs. "painful," and choices of words a physician used in a particular medical record, are included in this analysis because they were not material to the decision. Not every fact, or every argument advanced by a party must be disclosed and considered in the decision, only those which are material to the fact finder and which are considered when deciding the matter. *Accord, Davaz v. Priest River Glass Co,* 125 Idaho 333, 870 P. 2d 1292 (1994); *Swanson v. Kraft, Inc.,* 116 Idaho 315, 319, 775 P.2d 629, 633 (1989); *Madron v. Green Giant Co.,* 94 Idaho 747, 751, 497 P.2d 1048, 1052 (1972).

55. Several doctors and a medical journal article establish that it is possible for the L3 nerve root to innervate the area of Claimant's left-sided groin complaints. As such, the argument that it is not possible to damage the nerves in Claimant's groin with an L3-4 injection is rejected. The Referee finds that as a foundational matter there does exist a potential that the L3-4 injection could have inadvertently damaged Claimant's left-sided L3 nerve, and that nerve could innervate Claimant's groin area. As noted by Dr. Hajjar, "not everybody is wired the same way." Hajjar Depo. p. 31.

56. The evidence is clear that Claimant's complaints are unusual, no matter what is causing them. If Claimant's pain originated from an iliopsoas bursitis, it is not clear why the bursitis did not show up on CT scan, did not respond to steroid injections,[5] and did not respond to other conservative treatment short of a fentanyl pain pump, which all experts agree is generally considered "overkill" for treatment of bursitis. Likewise, it is highly unusual to have the January 8, 2015 right-sided ESI cause nerve damage in Claimant's left L3 nerve sufficient enough to cause "lifelong" pain necessitating use of a pain pump but with no detectable evidence of such damage on three separate nerve conduction studies. Dr. Gussner called it "improbable."

57. Prior to the nerve conduction studies, several physicians felt Claimant's complaints were consistent with nerve damage. Drs. Frizzell and Thompson continue to opine that Claimant suffered nerve damage as the result of the January 8, 2015 ESI, in spite of the lack of demonstrable evidence of such. Neither of them provided any detailed testimony on the mechanics of *how* the injection caused the damage in rebuttal to Dr. Gussner's testimony that the needle did not come close to Claimant's L3 nerves. Dr. Frizzell also acknowledged

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[5] Dr. Gussner testified that he performed the injection with palpation only, and might have "missed" injecting the bursae with his two injections. He did not feel that way at the time he performed the process, and used the results of the injections to rule out bursitis.

in his deposition that there is no objective evidence that Claimant's groin pain is caused by nerve damage. Frizzell Depo. p. 23. While it is implied in Drs. Frizzell and Thompson's opinions that somehow the injection on January 8, 2014 impacted the left-sided nerves innervating Claimant's left groin, neither physician expressly stated as much.

58. Dr. Frizzell noted Claimant's complaints were in an L3 nerve distribution. Dr. Thompson testified that "something happened" during the injection, although she never reviewed any documentation prior to reaching that conclusion. Instead she based her opinion on Claimant's history and her examination. Standing alone, there is sparse authority for their opinions other than Claimant's consistent testimony that his left groin pain began during the injection procedure.

59. By far the most compelling evidence in favor of causation is the temporal relationship between the ESI and the onset of Claimant's complaints, coupled with Claimant's detailed testimony of the contemporaneous conversation he had with the anesthesiologist performing the January 8, 2014 ESI. Claimant testified that he felt initial pain during the treatment and told his wife and personnel at the facility of the pain. Claimant's testimony on this point is detailed in that he recalled not only mentioning the pain to the provider, but remembers the provider's explanation for discounting the complaint. His testimony is persuasive on this point. Claimant's wife's testimony is corroborative.

60. Several doctors opined that Claimant's notation of his groin area growing increasingly "uncomfortable" in the hours following the injection is immaterial to causation. No expert was asked whether the effect of the lidocaine, which was administered in the injection and is a numbing agent, could account for Claimant's testimony that he felt pain during the procedure and then several hours later the pain increased with time to the point of

being excruciating, where it more-or-less plateaued until the time of his pain pump implantation. However there is evidence in the record, including Dr. Cox's testimony at page 17 of his deposition, that steroid injections temporarily numb the injected area and it is the patient's pain reduction after the anesthetic wears off that determines the effectiveness of the treatment.

61. The fact that nerve conduction studies showed no significant abnormalities when coupled with significant other evidence in the record, including Claimant's psychological profile, his reaction to EMG testing (describing it as the most painful experience he ever had, and excruciating, TR. p. 34), and his various nonanatomical findings at his third nerve testing and his IME, all suggest that Claimant's perceived pain is disproportional to his injury. As Dr. Gussner noted, it is difficult to correlate Claimant's injury, either bursitis or mild nerve damage to his subjective complaints. But the severity of Claimant's disability is not currently at issue, only causation of his groin injury.

62. Dr. Hajjar admitted that if there was evidence to support the fact that Claimant's left-sided groin pain began at the time of the injection (and not several hours later), such a fact would "imply potentially a nerve injury." Hajjar Depo. p. 33.

63. While there are films showing the injection site during Claimant's January 8, 2015 steroid injection, those images are "point in time" and do not show the entire process from start to finish.

64. Dr. Thompson admitted the neuropathic medication she prescribed Claimant did not provide relief, but noted Claimant did not take a full course of the medication because of unwanted side effects. She was not asked why she did not try alternative neuropathic medications.

65. There is no one doctor whose opinion carries the most weight; rather, when the evidence is pieced together from various statements and admissions of the experts, the totality of the testimony and evidence supports the position of Dr. Thompson that "something happened" at Claimant's January 8, 2015 injection. This conclusion is supported by Claimant's consistent testimony, as well as the observations and opinions of the treating physicians during the course of Claimant's treatment. Only after the 2017 MRI showed iliopsoas bursitis did at least two of the physicians who originally felt that Claimant's complaints were consistent with nerve damage change their opinions. No expert gave a persuasive explanation for why, if Claimant had suffered from iliopsoas bursitis from the date of his second injection, it was not discovered for two years thereafter.

66. While there is evidence to support the theory that Claimant's condition is not nearly as debilitating or significant as he makes it out to be, and the bursitis was contributing to Claimant's complaints by the time of hearing, nevertheless the weight of the evidence establishes that at least some of Claimant's left-sided groin condition is causally related to treatment he received for his accepted industrial accident of December 2, 2014.

67. The Referee recognizes that this decision is not wholly satisfying in that the weight of the decision rests primarily on a temporal relationship between Claimant's unusual claim that he felt left groin pain at the time of the injection into his right L3-4 epidural space, which pain has not resolved years later. The Commission has held that a temporal connection alone will not support a causation finding. *See, e.g. Chapman v. Trinity Health Crop.* IIC 2011-012506 (June 19, 2013). However, any persuasive medical evidence in addition to a temporal relationship may tip the scale in favor of causation, even when such opinion does not provide for the exact nature of the injury. *See, e.g. Boswell v. Edgewood*

Vista, IIC 2015-033326, (March 15, 2019); *Kobrock v. The Franklin Group,* IC 2015-009878 (January 25, 2019). In the present case, Dr. Hajjar's acknowledgment that significant pain directly at the time of the injection could support a causal connection, coupled with Dr. Gussner's opinion that some level of nerve damage might not be picked up on nerve studies, in addition to the opinions of Drs. Frizzell and Thompson, and more importantly Claimant's course of treatment over the intervening years provides the slight weight needed to tip the scale ever so minutely in Claimant's favor.

CONCLUSION OF LAW

Claimant has proven by a preponderance of the evidence that his left-sided groin condition is a causally related compensable consequence of treatment he received for injuries sustained as a result of his accepted industrial accident of December 2, 2014.

RECOMMENDATION

Based upon the foregoing Findings of Fact and Conclusions of Law, the Referee recommends that the Commission adopt such findings and conclusion as its own and issue an appropriate final order.

DATED this 25th day of October, 2019.

INDUSTRIAL COMMISSION

/s/
Brian Harper, Referee

CERTIFICATE OF SERVICE

I hereby certify that on the 10th day of December, 2019, a true and correct copy of the foregoing **FINDINGS OF FACT, CONCLUSION OF LAW, AND RECOMMENDATION** was served by regular United States Mail upon each of the following:

DARIN MONROE
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MINDY MULLER
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/s/

jsk

BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

CONNIE LOPEZ, Claimant, v. PERSONNEL PLUS, INC., Employer, and IDAHO STATE INSURANCE FUND, Surety, Defendants.	**IC 2014-028197** **ORDER** December 12, 2019

Pursuant to Idaho Code § 72-717, Referee John C. Hummel submitted the record in the above-entitled matter, together with his recommended findings of fact and conclusions of law, to the members of the Idaho Industrial Commission for their review. Each of the undersigned Commissioners has reviewed the record and the recommendations of the Referee. The Commission concurs with these recommendations. Therefore, the Commission approves, confirms, and adopts the Referee's proposed findings of fact and conclusions of law as its own.

Based upon the foregoing reasons, IT IS HEREBY ORDERED that:

1. Claimant has no permanent impairment.

2. Claimant has no disability.

3. Pursuant to Idaho Code § 72-718, this decision is final and conclusive as to all matters adjudicated.

DATED this __12th____ day of __December_____, 2019.

INDUSTRIAL COMMISSION

__/s/_____
Thomas P. Baskin, Chairman

__/s/_____
Aaron White, Commissioner

__/s/_____
Thomas E. Limbaugh, Commissioner

ATTEST:

__/s/_____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the __12th__ day of __December_____, 2019, a true and correct copy of the foregoing **ORDER** was served by regular United States Mail upon each of the following:

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