BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

STEVE TENNY, Claimant, v. LOOMIS ARMORED US, LLC, Employer, and ACE AMERICAN INSURANCE CO., Surety, Defendants.	**IC 2014-032378** **ORDER DENYING RECONSIDERATION** **Filed April 24, 2020**

On December 27, 2019, Defendants filed a timely motion for reconsideration with supporting brief. Defendants argue that the Commission erred by relying, in large part, on Dr. Thompson's testimony, without considering any of the reasons why Dr. Thompson's testimony should not be given any weight. Defendants contend that the Commission failed to follow appropriate legal standards. Therefore, the Commission's order finding that Claimant met his burden of proving that his groin and leg pain is a causally related compensable consequence of the treatment he received for his low back injury should be reversed.

On January 21, 2020[1], Claimant filed a response to the motion for reconsideration. Claimant argues that the Commission's December 10, 2019 decision is based on substantial and competent evidence, and that the Commission applied the correct legal standard. Claimant also contends that the Commission incorrectly found Dr. Thompson never reviewed any documentation

[1] The Commission granted Claimant's request for an extension of time to respond to the motion for reconsideration, per the parties' stipulation.

prior to reaching her conclusions, when Dr. Thompson reviewed the Diagnostic Block Sheet, and medical records from Drs. Hajjar, Schwartzman, and Krafft.

Defendants filed a reply brief. Defendants urge the Commission to examine medical expert testimony and rely only on credible expert opinions and evidence and correct its factual conclusions.

DISCUSSION

Under Idaho Code § 72-718, a decision of the Commission, in the absence of fraud, shall be final and conclusive as to all matters adjudicated; provided, within twenty (20) days from the date of filing the decision any party may move for reconsideration or rehearing of the decision. J.R.P. 3(f) states that a motion to reconsider "shall be supported by a brief filed with the motion." Generally, greater leniency is afforded to *pro se* claimants. However, "it is axiomatic that a claimant must present to the Commission new reasons factually and legally to support a hearing on her Motion for Rehearing/Reconsideration rather than rehashing evidence previously presented." Curtis v. M.H. King Co., 142 Idaho 383, 388, 128 P.3d 920 (2005). On reconsideration, the Commission will examine the evidence in the case, and determine whether the evidence presented supports the legal conclusions. The Commission is not compelled to make findings on the facts of the case during a reconsideration. Davison v. H.H. Keim Co., Ltd., 110 Idaho 758, 718 P.2d 1196. The Commission may reverse its decision upon a motion for reconsideration, or rehearing of the decision in question, based on the arguments presented, or upon its own motion, provided that it acts within the time frame established in Idaho Code § 72-718. *See*, Dennis v. School District No. 91, 135 Idaho 94, 15 P.3d 329 (2000) (citing Kindred v. Amalgamated Sugar Co., 114 Idaho 284, 756 P.2d 410 (1988)).

A motion for reconsideration must be properly supported by a recitation of the factual findings and/or legal conclusions with which the moving party takes issue. However, the Commission is not inclined to re-weigh evidence and arguments during reconsideration simply because the case was not resolved in a party's favor.

Defendants question whether Claimant adduced sufficient proof to meet the burden of proof on medical causation and assert that the Referee strained the expert testimony to approximate the legal standard. A claimant must provide medical testimony that supports a 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). "probable" is defined as "having more evidence for than against." Fisher v. Bunker Hill Company, 96 Idaho 341, 344, 528 P2d 903, 906 (1974). Magic words are not necessary to show a doctor's opinion is held to a reasonable degree of medical probability, only his or her plain and unequivocal testimony conveying a conviction that events are causally related. See Jensen v. City of Pocatello, 135 Idaho 406, 412-413, 18 P.3d 211, 217-218 (2001). When causation is at issue, the Commission's role is "to determine the weight and credibility of testimony and to resolve conflicting interpretations of testimony." Jordan v. Dean Foods, 160 Idaho 794, 799, 379 P.3d 1064, 1069 (2016) (citing Henderson v. McCain Foods, Inc., 142 Idaho 559, 565, 130 P.3d 1097, 1103 (2006)).

Here, the Referee found that Claimant has proven that his left-sided groin condition is a causally related compensable consequence of treatment he received for injuries sustained as a result of his December 2, 2014 industrial accident. The matter was hotly contested, and the Referee acknowledged that Claimant's evidence only prevailed by a small margin. The Referee explained that there was no doctor whose opinion carried the most weight, although the totality of testimony and evidence supported the position of Dr. Thompson that "something" happened at Claimant's

January 8, 2015 injection causing the left-sided groin condition. (FOF 22 ¶ 65-66). Defendants are incorrect in their assertion that the Referee did not weigh the reasons why Dr. Thompson's opinion should not be adopted, or the reasons why Defendants' experts should have prevailed. While Defendants are correct that the expert testimony from Claimant had various shortcomings, criticism of the Claimant's case does not remedy the shortcomings in their own expert testimony on causation. On the other hand, Claimant argued that the Referee essentially shortchanged the strengths of Dr. Thompson's testimony by failing to acknowledge the other evidence she considered in developing her opinion. This was a difficult and close case, and the Commission does not intend to use this reconsideration as a vehicle to re-weigh the facts and opinions offered below. Witnesses and experts are not expected to be infallible in order to present credible testimony before the Commission. The Referee found that the facts of this case, and the medical testimony, supported a finding of medical causation for the groin pain.

Before the Referee, and again on reconsideration, it was asserted that the interlaminar injection performed on January 8, 2015 at L3-4 could not have caused pain in Claimant's left groin, since discomfort at that level is mediated by nerve roots which exit at the L1-2. From the testimony of Drs. Frizzell, Gussner, and Hajjar, it is clear that it is indeed possible for L3-4 nerve roots to innervate the groin, the situs of Claimant's persistent pain. Therefore, the fact that the injection was accomplished at L3-4 lends no particular support to the proposition that the injection cannot be responsible for Claimant's left-sided groin pain. After all, and as Dr. Hajjar observed, everybody is wired slightly differently.

Dr. Frizzell testified that he believes the injection of January 8, 2015 is causally related to the onset of Claimant's left groin pain because he accepted Claimant's testimony that Claimant's left-sided groin pain started immediately following the injection. He rejected the differential

diagnosis of iliopsoas bursitis precisely because Claimant's discomfort began immediately at the time of the interlaminar injection. Dr. Gussner testified that if Claimant experienced the immediate onset of pain during the injection, that would be consistent with the needle hitting an exiting nerve root. Dr. Hajjar, too, recognized that if Claimant experienced the immediate onset of pain at the time of the injection, it would be much more likely that the Claimant's symptoms were causally related to the injection. However, it is difficult to tie the onset of pain to the injection if the pain did not start until a few hours after the injection.

Accordingly, it is important to the resolution of the causation question to have some understanding of when and how Claimant's symptoms developed. If Claimant experienced the immediate onset of severe pain at the time the injection was being accomplished, it is more likely that his pain complaints are causally related to the injection than if Claimant did not begin to experience left groin pain until some hours or days following the injection of January 8, 2015. Here, there has been considerable testimony concerning the "block sheet" which Claimant filled out in the hours and days following the January 8, 2015 injection. *See* Joint Exhibit 2055. Defendants urge the Commission to conclude that the block sheet cannot be reconciled with Claimant's testimony concerning the onset of his left hip discomfort.

Turning to Claimant's testimony, it is first notable that Claimant denies any left-sided groin pain prior to the injection of January 8, 2015. He testified that he noted the onset of left groin pain as the injection was being accomplished by the anesthesiologist. As soon as the injection commenced Claimant reported to the anesthesiologist that he was experiencing left-sided groin pain, to which the anesthesiologist purportedly retorted that such symptoms were impossible, due to the location of the injection. Claimant Depo., 58-59; Hrg. Tr., 26-27. Claimant's testimony concerning the severity and progression of his left groin difficulty following the injection is a little

bit harder to make sense of. For example, when asked whether his pain complaints had changed since the injection, Claimant testified: "It's – no. It's just gotten — it's been progressively worse. I have been in the same condition when I left that day that I am in now." Claimant Depo. at 60.

At hearing, too, Claimant was asked to comment on the progression of his discomfort following the injection:

> I mean by that time — right now, to be honest, at that time I was feeling very uncomfortable, so he continued it and by the time I got out of there my leg was very uncomfortable and it was difficult for me to walk. It's that simple, I was not in pain when I got there. I was in that pain when I left. Simple as that.

Hrg. Tr. at 27.

Finally, on cross-examination, he testified as follows concerning the progression of his discomfort following the injection:

> Q. You testified earlier that you felt an onset of pain at the time of the second injection on January 8th 2015?
>
> A. Yes.
>
> Q. What level was that pain?
>
> A. At first I want to say it was probably a four or a five, if I remember correctly. Maybe even three. It wasn't an immediate pain that started out. It was a progressive pain that started and ended up getting worse.
>
> Q. Okay. Well, help me understand these, because you said that during the injection you told the doctor that you were having pain.
>
> A. I was feeling pain in my hip. I didn't say excruciating pain – excruciating pain. I told him I was feeling pain in my hip as he was injecting me and it was not normal, because he told me he was injecting my right side. It was for my right side.
>
> Q. Okay. So at what point did the pain worsen?
>
> A. When I filled out that report for IMI, from that point on it progressively got worse. It never got any better. It just got to a point where it was excruciating and, then, it never changed.

Q. At what point did become excruciating?

A. As time went on I would say within the — within the first month after having that injection I was as I am now.

Q. Did the pain worsen after our back surgery?

A. The pain worsened after my injection. There was no excruciating pain as a result of my back as far as I felt.

Q. I'm just — I'm trying to understand your progression of symptoms.

A. No. I understand that.

Q. So, to your back surgery did the pain in your groin or hip – what you have been talking about today, did that worsen?

A. It stayed the same as it was when I got the injection. It was excruciating pain.

Q. Okay. Well, you're giving me conflicting testimony here. You're saying that it stayed the same and just a minute ago you said that it worsened during the first month.

A. And I also said that it hasn't gotten better or changed since. It's been that same intensity after the first month after the injection.

Q. Your answer is it didn't worsen after the back surgery?

A. No, it did not. Then I — excuse me. I didn't understand what you were saying.

Q. What's the difference between something being uncomfortable and something being in pain?

A. Something being in pain? It's uncomfortable. So, right now in this chair, because I'm not comfortable sitting here and that's no disrespect. Pain, when I feel like I'm — if I sneeze or I cough or I — I turn my leg wrong, it's like getting kicked in the groin. That's the only way I can describe it. It's that painful. I — I don't know how else to describe it.

…

Q. So, scale of zero to ten — it's going to be a pain scale. Zero is no pain, ten is the worst pain imaginable, you're in tears crying. Okay? To you is "uncomfortable" on that scale? Is uncomfortable like a zero or one or is it right before you hit that scale?

> A. Uncomfortable is about a five, to be honest with you. About a five. Four or five. It never goes below that. It never has since I have gotten my pain pump to where it's at now.
>
> Q. So, "uncomfortable" to you is the same thing as pain then?
>
> A. Not necessarily, no, because pain to me is when it goes beyond that four and five range and gets up to the seven, eight range, which is unbearable and I am in severe pain.
>
> Q. But I'm saying a pain scale of zero to ten. I want to make sure we are speaking the same language here. So, something that's a three to you is not pain, it's uncomfortable?
>
> A. Yes. Reason being, given my past history, I have had to deal with pain. I have had to live with it, so something that is uncomfortable for me, just as sitting and whatnot, a four or five, that's comfortable, because it doesn't hurt as bad as when I'm walking or doing something physical and I have the sharp pain that shoots me up to seven, eight, possible nine. That's the difference for me. Being comfortable. Being comfortable to be able to tolerate it and put it out of my mind to where it doesn't affect my day — day-to-day living.

Hrg. Tr. at 59:18 – 64:3.

Again, Claimant's description of the progression of his discomfort is potentially contradictory since he seems to acknowledge, on the one hand, that his discomfort progressively worsened over a period of approximately 30 days following the injection, and on the other hand, that it was immediately excruciating and did not change. It is not clear whether this represents an internal inconsistency, versus an inability of Claimant to express himself clearly. Because these statements concerning the progression of Claimant's difficulty following the injection are contained in the same section of testimony, it is hard to accept that Claimant made these potentially conflicting statements with any intention to deceive. It seems more likely that he was attempting to explain, albeit imperfectly, how he experienced the new onset of left groin pain at the time of his injection, and that he has never been without this new area of discomfort in the years since. The possibility that his testimony contains inconsistencies about the manner in which his

symptoms progressed following the injection does not denigrate the central point of his testimony; he never had groin pain prior to the January 8, 2015 injection, he experienced an immediate onset of that discomfort at the time the injection was commenced, and has been with him in some fashion, ever since.

Next, the Commission is invited to compare Claimant's deposition and hearing testimony with the information recorded by Claimant on the Block Sheet. First, Claimant confirmed that he filled out the block sheet as he had been asked to do. In other words, he reported his symptoms as they occurred, not at one sitting. The notation on Joint Exhibit 2055 that has attracted the most attention is the notation associated with the arrow pointing to the left groin of one of the two anatomical figures on the exhibit. The notation reads:

"It became very uncomfortable a few hours after injection."

It is argued that this notation is inconsistent with Claimant's deposition and hearing testimony that he noted the onset of discomfort as the injection was taking place. However, it should be clear that for Claimant to say that he became "very uncomfortable" some hours after the injection is not inconsistent with Claimant noting the sudden onset of a lesser degree of discomfort contemporaneous with the performance of the injection. Next, it is argued that Claimant's self-report of his level of pain is somehow inconsistent with his handwritten notation, or his deposition/hearing testimony. It is true that Claimant reported that his level of discomfort prior to the procedure was between level 6-7 on a scale of 1-10. He reported the same level of discomfort immediately after the injection, but thereafter reported that his discomfort went down to a level of 3 out of 10 after about an hour, and stayed at that level for another two hours before dropping down to a level of 2 out of 10. However, at about 4:00 p.m. on January 8, 2015, Claimant reported that his pain went back up to a level of 5 out of 10. Twenty-four hours after the injection he was

experiencing pain at a level of 4 out of 10. Thereafter, for the next six days or so, his pain remained at a level of 3 out of 10.

Claimant did not have left groin pain prior to the injection, so it must be assumed that the pre-injection pain he referenced was from his back or right lower extremity. Claimant's pain diagram reflects that following the injection he had, in addition to left groin discomfort, a headache, right hip pain and lower back discomfort. Exhibit 2055 does not reflect to what extent Claimant's post injection reports of his level of pain were mediated by one or more of the aforementioned pain centers.

It is also important to recall that the epidural steroid injection also included a local anesthetic intended to ameliorate the localized discomfort at the injection site caused by the needle. The potential masking effect of this local anesthetic is revealed in Dr. Cox's testimony. Dr. Cox testified that if Claimant's groin pain was in fact caused by hitting a nerve root during the injection, one would expect to see an immediate spike in Claimant's pain, which would be expected to persist. However, Dr. Cox then recognized that this expected course would be impacted, for at least 24 hours, by the local anesthetic used in the injection. Therefore, even if the injection did hit a nerve root, the local anesthetic might significantly diminish Claimant's discomfort until it wore off. However, per Dr. Cox, Claimant did not experience a corresponding increase to discomfort as the local anesthetic wore off. In fact, Dr. Cox testified that one week after the injection, Claimant's pain was still less than it had been prior to the injection. To Dr. Cox this meant that the nerve innervating Claimant's left groin was not hit during the injection. Cox Depo., 16:13 – 17:12. However, Dr. Cox's opinion appears to be based on the assumption that all of the pain complaints referenced by Claimant on Exhibit 2055 relate solely to the left groin pain. Taking into account the unchallenged fact that Claimant's pre-injection pain related to something other than left groin

pain, Dr. Cox's judgment about how Claimant's left groin pain responded to the injection is called into question; if Claimant had left groin pain of zero immediately prior to the injection, and left groin pain of a 4 or a 5 out of 10 a few hours after the injection, then that history seems entirely consistent with a new onset of left groin pain which may have been masked, to some extent, by the local anesthetic used to minimize discomfort associated with the needle. Dr. Cox's testimony does not denigrate Claimant's deposition and hearing testimony that Claimant developed a *new* discomfort in his left groin contemporaneous with the January 8, 2015 injection.

On balance, we agree with the Referee that Exhibit 2055 is not inherently at odds with Claimant's deposition and hearing testimony. It is sufficient to say that both Claimant's testimony and Exhibit 2055 are consistent with the proposition that Claimant developed a new onset of left groin pain contemporaneous with the January 8, 2015 injection, a symptom complex from which he did not suffer prior to the injection, but from which he has continued to suffer in the years since. It is also worth noting that this would be a strange thing for Claimant to decide to make-up just for the purpose of advancing his worker's compensation claim. If contrived, it seems an unnecessary charade to have maintained these several years, when it probably would have served Claimant just as well to insist that he simply suffered intractable low back pain following his accident and surgery. Indeed, it is such an unlikely thing to think up that it paradoxically has the ring of truth.

Still, there is no denying that this is a close case, and one would hope for a better explanation of how the January 8, 2015 interlaminar injection at L3-4 caused the symptoms of which Claimant now complains. While we are persuaded, as was the Referee, that Claimant did experience the new onset of left groin discomfort contemporaneous with the January 8, 2015 injection, our acceptance of these facts leaves us not much closer to understanding the mechanics of what happened. Dr. Gussner has explained that an interlaminar injection would not really get

close to the exiting L3-4 nerve roots. Had Claimant's injection been of the transforaminal variety, it would be easier to understand how such an injection might accidentally hit the exiting nerve root. Per Dr. Gussner, it is much more difficult to understand how the injection that was actually given could cause injury to that particular nerve root. At the end of the day we are left with the fact that the onset of Claimant's left groin discomfort coincides with the administration of the injection. This was enough for Dr. Frizzell and Dr. Thompson, and even led Dr. Hajjar to concede that if Claimant's discomfort came on as he now insists, something unexpected happened to the nerve root innervating Claimant's left groin, even though we are left without a good understanding of precisely how that injury was accomplished. While it is Claimant's burden to prove causation, the fact that other explanations, such as a hernia or orthopedic injury involving Claimant's hips, have been ruled-out, further supports our decision. That Claimant now qualifies for a diagnosis of iliopsoas bursitis is not particularly persuasive. Objective evidence for this condition was first noted in the January 2017 MRI. The condition was not noted in the 2015 CT scan, and Dr. Gussner abandoned the inclusion of this condition in his differential following Claimant's failure to respond to a series of injections intended to treat suspected bursitis. Claimant may indeed suffer from iliopsoas bursitis at the present time. However, the evidence fails to persuade us that this condition was extant in January of 2015 and for some reason became suddenly symptomatic on January 8, 2015, coincidental to his epidural steroid injection.

Finally, we recognize that Claimant has undergone numerous electrodiagnostic studies, all of which have been entirely negative for evidence of nerve damage/dysfunction. However, as Drs. Frizzell and Hajjar have noted, while a negative nerve conduction study may rule-out physical damage to the structure of a nerve, it in no wise rules out the fact that Claimant experiences pain

in the distribution of the nerve. While we accept that there is no evidence of gross damage to the nerve, this does not persuade us that the injection did not do something to cause Claimant's pain.

The Commission notes that Defendants also take issue with what they perceive as improper inferences drawn by the Referee from the "snapshots" of the interlaminar injection of January 8, 2015. The Referee noted that since the images he reviewed were discrete snapshots taken in the course of the procedure, as opposed to a fluoroscopic movie of the entire procedure, the possibility exists that something may have happened before or after the image was taken that might shed some light on the development of Claimant's symptoms. We conclude that it was entirely permissible for the Referee to make this observation and does not amount to the substitution of his own medical opinion for that of a medical expert.

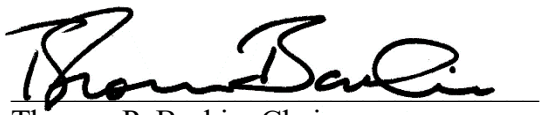
The Commission recognizes that this was a difficult and close case for the Referee. The Referee could not ignore the compelling temporal relationship between the epidural steroid injection and the onset of Claimant's complaints and explained that the case was not solely decided on a temporal relationship. Defendants do not have a persuasive argument denigrating this reasoning. Defendants have not persuaded the Commission to reverse the Referee's findings.

ORDER

Based on the foregoing reasons, the Commission **ORDERS** the following: Defendants request for reconsideration is DENIED. **IT IS SO ORDERED.**

DATED this 24th day of April, 2020.

INDUSTRIAL COMMISSION



Thomas P. Baskin, Chairman

Aaron White, Commissioner

Thomas E. Limbaugh, Commissioner

ATTEST:

Kamerron Monroe
Commission Secretary

INDUSTRIAL COMMISSION SEAL STATE OF IDAHO

CERTIFICATE OF SERVICE

I hereby certify that on the 24th day of April, 2020, a true and correct copy of the foregoing **ORDER DENYING RECONSIDERATION** was served by email upon each of the following:

DARIN MONROE
dmonroe@monroelawoffice.com

MINDY MULLER
mmw@moffatt.com

Emma O. Landers