

**NOT DESIGNATED FOR PUBLICATION**

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F303399

CARL SYKES, EMPLOYEE	CLAIMANT
GNB TECHNOLOGIES, EMPLOYER	RESPONDENT
AMERICAN ZURICH INS., INSURANCE CARRIER	RESPONDENT

OPINION FILED SEPTEMBER 19, 2006

Upon review before the FULL COMMISSION in Little Rock,  
Pulaski County, Arkansas.

Claimant represented by the HONORABLE R. GUNNER DELAY,  
Attorney at Law, Fort Smith, Arkansas.

Respondents represented by the HONORABLE NEAL HART, Attorney  
at Law, Little Rock, Arkansas.

Decision of Administrative Law Judge: Affirmed and Adopted.

OPINION AND ORDER

Respondents appeal an opinion and order of the  
Administrative Law Judge filed October 24, 2005. In said  
order, the Administrative Law Judge made the following  
findings of fact and conclusions of law:

1. The Arkansas Workers' Compensation  
Commission has jurisdiction of this claim.

2. On February 21, 2003, the relationship of employee-employer-carrier existed between the parties.
3. The claimant sustained a compensable injury to his right hand on February 21, 2003.
4. Medical expenses and temporary total disability have been paid.
5. The claimant is entitled to the maximum compensation rate for 2003.
6. The claimant is entitled to additional medical treatment for his forth (sic) or ring finger of his right hand [,] whether it be a fusion or any other treatment as recommended by his treating physician, either Dr. Kelly or Dr. Moore.
7. The claimant has proven by a preponderance of the evidence that he is entitled to a prosthetic multicolor faux pinky finger prosthesis for the loss of his fifth finger.

We have carefully conducted a de novo review of the entire record herein and it is our opinion that the Administrative Law Judge's decision is supported by a preponderance of the credible evidence, correctly applies the law, and should be affirmed. Specifically, we find from a preponderance of the evidence that the findings made by the Administrative Law Judge are correct and they are, therefore, adopted by the Full Commission.

We therefore affirm the October 24, 2005, decision of the Administrative Law Judge, including all

findings of fact and conclusions of law therein, and adopt the opinion as the decision of the Full Commission on appeal.

All accrued benefits shall be paid in a lump sum without discount and with interest thereon at the lawful rate from the date of the Administrative Law Judge's decision in accordance with Ark. Code Ann. §11-9-809 (Repl. 2002).

Since the claimant's injury occurred after July 1, 2001, the claimant's attorney's fee is governed by the provisions of Ark. Code Ann. §11-9-715 as amended by Act 1281 of 2001. Compare Ark. Code Ann. §11-9-715 (Repl. 1996) with Ark. Code Ann. §11-9-715 (Repl. 2002). For prevailing on this appeal before the Full Commission, claimant's attorney is hereby awarded an additional attorney's fee in the amount of \$500.00 in accordance with Ark. Code Ann. §11-9-715(b) (Repl. 2002).

IT IS SO ORDERED.

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OLAN W. REEVES, Chairman

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SHELBY W. TURNER, Commissioner

Commissioner McKinney dissents.

DISSENTING OPINION

I must respectfully dissent from the majority opinion finding that the claimant has proven by a preponderance of the evidence that he is entitled to additional medical treatment, including a fusion of his right 4<sup>th</sup> (or ring) finger, and to a multi-colored prosthesis for his right 5<sup>th</sup> (pinky) finger. It was stipulated by the parties that the claimant sustained a compensable injury on February 21, 2003, and that medical and temporary total disability benefits have been paid. On appeal, the respondent contends that additional medical treatment in the form of a right 4<sup>th</sup> finger fusion and right pinky finger prosthesis is not reasonable and necessary to the treatment of the claimant's compensable injury.

My carefully conducted de novo review of this claim in its entirety reveals that the claimant has failed to prove by a preponderance of the evidence that the above described additional medical treatment is reasonable and necessary for the treatment of his compensable injury. Therefore, I find that the decision of the Administrative Law Judge should be reversed.

On February 21, 2003, the claimant sustained a circumferential crushing-type compensable injury to his right hand when his glove got caught in a gear mechanism. More particularly, the claimant's right pinky finger was traumatically amputated and his 4<sup>th</sup> finger was severely crushed as a result of this incident. Consequently, the claimant underwent numerous surgical procedures and extensive physical therapy over the course of his medical treatment, primarily involving his 4<sup>th</sup> finger. The claimant's primary treating physician for this injury was Dr. James Kelley, who released the claimant on August 9, 2004, with permanent restrictions. As of that date, Dr. Kelley had not scheduled the claimant for further surgery due to his opinion that further surgery held a high risk of failure, it would not help alleviate the claimant's pain, nor would it improve the claimant's mobility and function.

In an evidentiary deposition taken on April 8, 2005, Dr. Kelley described with particularity the course of the claimant's medical treatment and the basis for his belief that further surgery would not be beneficial. Dr. Kelley explained that the claimant initially underwent plating of the 4<sup>th</sup> finger, with repairs to the tendons,

nerves, and arteries of that finger. The claimant's right pinky finger was revised at the level of the amputation sight, which was just proximal to the proximal interphalangeal, or first joint. As of the claimant's follow-up examination a week after his first surgery, Dr. Kelly opined that the pinky finger was healing properly and that the claimant should begin physical therapy for the 4<sup>th</sup> finger. Dr. Kelley released the claimant on that date, February 28, 2003, to return to one-handed work duty. The claimant next saw Dr. Kelley on March 12, 2003, at which time there were no signs of infection at the claimant's surgical sight. Therefore, the claimant's sutures were removed and he was continued on physical therapy and one-handed work restriction.

As of the claimant's March 31, 2003, follow-up appointment, there were signs of skin breakdown over the back area of the claimant's 4<sup>th</sup> finger wound. The claimant was also displaying stiffness of his right proximal interphalangeal joint, which Dr. Kelley said was not surprising considering the type of injury that he had sustained. Therefore, on April 3, 2003, Dr. Kelley performed a capsulotomy on the proximal interphalangeal joint, and a small skin graft at the sight of the breakdown. Following

this surgery, Dr. Kelley released the claimant back to one-handed duty. Explaining why he allowed the claimant to return to work so quickly, Dr. Kelly stated:

Again, you know, my typical routine is to always let people go back to one-handed duties as long as it is not going to endanger them ... .

As of his follow-up appointment with Dr. Kelley on April 9, 2003, the claimant was reportedly healing as expected. As part of his physical therapy, Dr. Kelley started the claimant on whirlpool therapy in order to help cleanse the claimant's wound site and promote healing. The claimant's wound responded well to this therapy, with the exception of a tiny area of skin over the 4<sup>th</sup> finger joint. In his deposition, Dr. Kelley explained that he is very aggressive with trying to get closure of an open wound because continued inflammation or swelling in a joint can limit motion. Therefore, Dr. Kelly decided to place a tiny stamp graft over the area of the claimant's wound that was still open. Although the claimant was approximately three months post-injury at that time, Dr. Kelley explained that the problems the claimant was experiencing with closure were not unusual considering the type and degree of injury that the claimant had sustained. With regard to the claimant's

continuing joint stiffness, Dr. Kelley explained that the claimant was compliant with his instructions, but that the claimant has a low pain threshold which made it difficult for him to bend his finger as was required by his therapy.

More specifically, Dr. Kelley stated:

Carl [the claimant] I think was compliant, but Carl has a low pain tolerance, and that comes into factor when dealing with any patient because if you're not willing to bend the finger, it is hard to make the finger bend. And ... at this point, it started to become an issue.

Stiffness is something that I can't get rid of alone. ... I can surgically close. I can surgically tenolyse, free up tendons, capsules or whatever. But ultimately the work, the real work, is on the patient's back, and unfortunately it's painful.

And as I said, Carl had a tendency, even in the office like for dressing changes and things - - he just had a low pain threshold. That's no fault of his. I mean, we're all wired differently. ... [B]ut, that certainly made the recovery more difficult.

Dr. Kelley added that he believed the claimant's reports of pain to be legitimate. Dr. Kelley further stated that he believed that the claimant was suffering from some degree of post-traumatic stress syndrome as a result of his

injury, which, according to Dr. Kelley, is a "common event in major hand injuries".

Ultimately, the claimant's skin graft of May 12, 2003, "took well" according to Dr. Kelley. Therefore, Dr. Kelley placed the claimant back on one-handed duty with the intent of trying to increase his level of work activity. On June 9, 2003, Dr. Kelley released the claimant to light duty with a 20 pound lifting restriction, and frequent lifting of no more than 10 pounds. Dr. Kelley explained that he wanted the claimant to start using his right hand again for two reasons. First, Dr. Kelley wanted to start "streaming the claimant back into a more normal lifestyle". Second, Dr. Kelley stated that he firmly believes that work activity is good hand therapy.

I try to explain that to the patients as well. Sometimes they think that I'm, you know, pushing them harder than what they need to be, but, I mean, it's - - day-to-day activities and motion is very important when it comes to hand rehab[ilitation]. And if you're doing that eight hours in a day, obviously you're going to get more motion than you are with an hour session in therapy once or three times a week or whatever number you pick.

On his June 20, 2003, appointment, the claimant informed Dr. Kelley that he could not work due to his pain.

Dr. Kelley stated that he tried to explain to the claimant that his type of injury is painful, and that he was "quite a bit slower at being pushed back to a ... work environment" than were many of his other patients. Dr. Kelley further stated that he told the claimant that he needed to "push through" some of his pain in order to achieve increased motion. Dr. Kelley explained to the claimant that if he did not do this, he could potentially end up with more stiffness and immobility than he would have otherwise. Dr. Kelley further stated:

And the plan would be to allow everything to settle, for the scarring to mature, and that you have to allow a break, I guess is the best way of putting it, to allow wounds to mature, for scars to settle and to soften. And then once that took place, then we would probably look at doing some other procedures on him to try to get his motion going, you know, things like removing hardware once the bone is healed, capsulotomies again, things like that. But it just wasn't - - it wasn't time to do that.

Reportedly due to the claimant's insistence that he do so, on June 20, 2003, Dr. Kelley proceeded to schedule the claimant for surgery to remove his hardware, and to perform another capsulotomy and a tenolysis. Concerning this, Dr. Kelley stated:

Yeah. That's just what I had talked about because - - well, when he came in, he wanted me to do this, you know, like that day. And that's why I was saying that he ... just couldn't keep pushing it and that the reason why we had not done that before - - because one of the things that he wanted to know is why ... we couldn't keep him off work and just get all the work done. And that's what I tried to explain to him, that it's done in stages, it takes time, that you can't press through these things.

At that point in the claimant's recovery, the doctor felt that his bone had healed sufficiently for the hardware to be removed, thus freeing the claimant's finger for increased mobility. This procedure was performed on June 26, 2003. By July 9, 2003, the claimant appeared to be making a good recovery from this procedure. Therefore, Dr. Kelley started him back in "fairly aggressive" therapy, and placed him back on light-duty work restrictions. On August 4, 2003, Dr. Kelley again examined the claimant and found "no signs of any problems" with the claimant's wound, and no signs of bone infection. The claimant was still experiencing a significant amount of stiffness. Therefore, Dr. Kelley requested that he continue with his stretching and motion therapy, thus allowing the claimant's scars to continue to mature. If the claimant was not able to tolerate

his stretching exercises due to his pain, Dr. Kelley recommended that they would try manipulation, which, as he explained, is simply numbing the finger and manipulating the joint. Dr. Kelley further described manipulation as a simple procedure designed to try to help a patient maintain motion or get more motion back when they have been unsuccessful in physically pulling capsular adhesions through themselves. According to Dr. Kelley, "[S]ometimes you [the doctor] just need to break those adhesions loose yourself for them [the patients]." Dr. Kelley admitted that he broached the possibility of amputation with the claimant at that point in his recovery due to the claimant's low pain tolerance level.

... I was concerned that he would not be capable - - of going through the therapy based on his track record more or less, you know, what had happened in the past, that he might want to consider amputation rather than continuing with ... procedures. But obviously that's something only he can decide.

Dr. Kelley explained that amputation can sometimes improve function in those instances where a patient's finger is permanently flexed in an awkward position. When asked to explain in more detail why he left the decision about amputation to the claimant, Dr. Kelley explained as follows:

And the reason is because when I get somebody that has been through these kinds of procedures, this number of procedures in this ... period of time, it gets to the point where you have to look and say, Are we winning here? Are we gaining function versus just spinning our wheels?

You have to accept what you have if it is reasonable; or if what you have isn't reasonable that you can't attain any better, you have to consider different ways of trying to improve it, and amputation is one of those options.

The second alternative that Dr. Kelley proposed to the claimant was a fusion. According to Dr. Kelley, a fusion allows the damaged finger to be permanently placed in a more functional position. Dr. Kelley categorized the claimant's degree of contracture as "moderate" because of the claimant's limited motion at the PIP joint. Dr. Kelley testified that the claimant had good motion at the proximal or base of the finger, but no motion at the distal phalanx, which he stated was "not as critical". Dr. Kelley further stated that the proximal phalanx is "a little more important" because it allows you to grip and to get your hand into tight places.

Dr. Kelley eventually opined that the more reasonable course of treatment for the claimant's joint

stiffness was manipulation because it is a fairly minor procedure which would allow him to ascertain such things as joint stability, range of motion, and ultimately, whether a joint fusion or joint replacement was necessary. Dr. Kelley performed this procedure on September 11, 2003, from which he was able to determine that the claimant had fair range of motion. In addition, Dr. Kelley was able to flex the claimant's finger to his palm, which was approximately 80 to 90 degrees of flexion, with 100 to 110 degrees of flexion of the proximal phalanx being normal. However, Dr. Kelley pointed out that he achieved this result using passive range of motion. He added that the claimant's tendon would not necessarily allow him to "pull that through", and that his pain tolerance level might not allow him to maintain that level of motion.

At the claimant's next appointment, Dr. Kelley described his passive range of hand motion as "fairly good". However, he stated that the claimant's active flexion was still limited due to scarring of the tendons. Therefore, and because the claimant was not interested in amputation, Dr. Kelley scheduled him for another capsulotomy. "At that point," stated Dr. Kelley, "the only thing I could come up with to try to improve his motion was to lyse some of those

scar adhesions on the tendon and hope that he could keep it moving once he'd done that." According to Dr. Kelly, this procedure, which was performed on September 16, 2003, was of no benefit to the claimant.

I mean, when I - - when we came through and did the actual procedure, we freed up the tendon, I was able to fully flex the finger and fully extend [the] finger. ... I was able to get the finger to flex and move.

So, because of that, the tendons were functional I guess is the best way of putting it. ... In other words, if you pulled on the tendon, they would flex. Now, keeping in mind, ... anytime you have a raw surface or an injured surface of the body, the body wants to heal it. Well, one of the things it is going to do is want to lay down adhesions on it.

So that's where the therapy and gut fortitude come in. If you've got a tendon that's raw like that, if you don't keep it moving, it won't take long before you're going to lose it again because it just gets stuck.

Dr. Kelley testified that after this procedure he had been blunt with the claimant concerning his role in his own recovery, telling him, in part, that "his outcome was in his hands so that he needed to keep this thing moving". In December of 2003, Dr. Kelley reported being pleased with the claimant's outcome, mainly because the claimant had reached

the doctor's goal for him of being able to flex his proximal phalanx 90 degrees. "If you can get 90 degrees or anything close to 90 degrees on a bad PIP injury at any joint, that's an excellent outcome," explained Dr. Kelly, "because essentially ... you're approaching a normal range." At that time, Dr. Kelley advised the claimant that he needed to continue advancing and improving. Therefore, the doctor continued the claimant's physical therapy.

The claimant continued to make progress in his recovery, and on February 26, 2004, Dr. Kelley proceeded with another tenolysis with the hopes of achieving a 90 degree arc. The claimant was seen in follow-up from this procedure on April 2, 2004, at which time Dr. Kelley observed improved range of motion and joint stability. Dr. Kelley continued the claimant with physical therapy and kept him on light duty. As of his next appointment on May 3, 2004, Dr. Kelley discontinued the claimant's physical therapy, but he postponed declaring the claimant to be at maximum medical improvement in order to make sure that he was not going to show more flexion deformity.

On June 21, 2004, the claimant underwent a functional capacity evaluation study which placed him in the medium work category. On August 9, 2004, Dr. Kelley opined

that the claimant had reached maximum medical improvement, and he assigned him with a 23% permanent physical impairment rating. Further, the claimant was permanently restricted from lifting over 50 pounds, and from frequently lifting over 25 pounds using both hands. Finally, the claimant was instructed to avoid constant, repetitive pinching and gripping with his right hand.

On January 4, 2005, the claimant was seen for an independent medical evaluation by hand specialist, Dr. Michael Moore. In his concluding remarks of the report of that examination, Dr. Moore states the following:

It is my opinion Mr. Sykes sustained a significant injury to the right ring and small fingers. I had a long discussion with him regarding his medical condition and treatment options. It is my opinion further surgery or therapy to improve the motion in the ring finger is not indicated. As stated above, Mr. Sykes has undergone several surgical treatments to improve the ring finger motion. Each treatment has been unsuccessful. It is my strong opinion that further surgical treatment would be unpredictable and would not significantly improve the motion or function in the right finger. This opinion is based on the fact that Mr. Sykes sustained a significant soft tissue injury. In addition, the recent x-rays revealed post-traumatic degenerative arthritis of the PIP joint. If he should have persistent pain symptoms in the right finger or a

progressive contracture, it is my opinion that the most appropriate treatment would be a right finger PIP joint arthrodesis and possibly DIP joint arthrodesis. I reviewed this treatment option with Mr. Sykes [and] all his questions were answered.

For purposes of this claim, Dr. Kelley was again deposed on June 27, 2005. At the commencement of his depositional testimony, Dr. Kelley acknowledged that he had not seen the claimant since his last appointment of August 9, 2004. Further, Dr. Kelly agreed that he had exhausted all forms of reasonable and necessary medical treatment for the claimant at that time. Dr. Kelley testified in this regard as follows:

Q. Okay, so when you released him in August 2004, you weren't recommending any additional treatment for the ring finger?

A. When I saw him last, and actually if you go back to ... June 21, 2004, which was the day that I saw him and he stated to me that his hand was bothering him.

And since I had placed him on his regular job, I told him that if that was the case, if he wasn't able to work on his regular job, that there wasn't anything I could do for him other than get permanent restrictions.

After discussing his decision to obtain the functional capacity evaluation study, Dr. Kelley continued ...

That way, we could place him on permanent restrictions based on the results of the FCE, and then also provide him a deficit rating because I felt ... that we had exhausted all avenues at that point.

Dr. Kelley added to these statements that there was nothing surgically that could be done for the claimant at that time.

With regard to his prognosis for the claimant at the time of his second deposition, essentially, Dr. Kelley opined that the claimant had plateaued as far as certain aspects of his condition were concerned. For example, with regard to range of motion, Dr. Kelley stated, "At this point in time, it's, I think, all that we can expect to accomplish." Dr. Kelly continued that he was not pleased with what he had been able to accomplish for the clamant in this respect. Dr. Kelly attributed failure to achieve a reasonable outcome, in part, to the claimant's low "pain tolerance or activity", and to the severity of the claimant's injury. When asked if he had ever considered fusion surgery as a viable treatment option for the claimant, Dr. Kelley responded:

He had mentioned or he had asked, I think, at one time if there was anything else. And I said, "Well, with the stiffness you have, I mean, if the only other thing you could consider would be fusion.

But, if you've got a stiff finger, I don't really think that the fusion, to be honest with you, is going to relieve his pain. It certainly isn't going to change his function.

I had debated fusing it, I think, the time before that I did the last capsulotomy. The physical joint itself, you know, there's some injury there, but I really think it wouldn't improve Carl's long-term outcome. That's the reason why his last visit I didn't offer it to him.

When asked if he thought that a fusion in this particular case would be a reasonably necessary form of medical treatment, Dr. Kelley reiterated the above, stating, "I don't think it would add anything to Carl's functional hand." Dr. Kelley agreed that the claimant's degree of contracture of his ring finger could continue to worsen due to lack of stretching and a desire not to use this finger. Further, Dr. Kelley explained that a fusion is typically recommended in cases where the finger has contracted to the point that it will not clear the palm. Dr. Kelley warned, however, that noncompliance after such a fusion

carries the risk of leaving a patient in a worse condition than before the fusion. As far as such a procedure helping him in the workplace, Dr. Kelley testified that, depending on the type of work that the claimant does, a fusion would be potentially of no benefit to him. To this Dr. Kelley added:

If he gets into that workforce or job position and he finds there's no benefit whatsoever about having the finger fused or whatever, then why do it.

Pointing out that the claimant has already undergone numerous surgical procedures, Dr. Kelley stated, "I mean, I just don't know why or what the benefit would be of having the eighth or ninth [surgery] if it's not going to improve his ability to work or change his outcome." Dr. Kelley further stated that he would only consider a fusion to be beneficial to the claimant if his contracture was more than 60 to 70 degrees. In conclusion, based upon the claimant's past failures, Dr. Kelley was, at best, skeptical that a fusion would improve the claimant's condition. Further, Dr. Kelley admitted that in the claimant's case, he would probably recommend amputation rather than a fusion "just because of the compliance issue".

With regard to the claimant's proposed pinky finger prosthesis, Dr. Kelley testified that it would be for cosmetic purposes only, and that it is not medically necessary that he have one. More specifically, Dr. Kelley stated:

These are strictly - - on the fingers like this, strictly for looks. They're not functional. In other words, these are not put on, you know, to be able to grip and to hold and to add to the functional use of the hand. They're strictly so that it doesn't look like you have a finger missing.

Further, Dr. Kelley agreed that a prosthetic finger can sometimes be "more of a hindrance than a help", especially in a work environment. Dr. Kelley further explained as follows:

It's not something that you would wear to work. It's not something you would be able to put on 24/7. It's not something that you would utilize to improve the work use of the hand.

If you were to try and wear this thing during the daytime when you're working around machinery and things like this, that's what I'm getting at. It's not something that you would do like that. It would be a hindrance. In fact, it would be a danger.

Although not reasonable and necessary from a work perspective, Dr. Kelley added that in some cases, such as when a patient has been psychologically traumatized, prostheses are beneficial in helping with the recovery process. Moreover, Dr. Kelley acknowledged that he had referred the claimant for psychological treatment due to what he perceived to be post-traumatic stress syndrome, which he added he was trained to recognize as a hand Fellow. The record reveals that the claimant did not pursue ongoing psychological treatment following his referral. In fact, the claimant attended counseling sessions on a couple of occasions, then discontinued this treatment. Dr. Kelley agreed that this behavior would indicate that a patient is not damaged enough by their loss to feel that they need such intervention. Dr. Kelley acknowledged that he had prescribed a set of prosthetic fingers to the claimant, explaining that they typically come in a set that offers color variations to accommodate seasonal changes in skin coloration. However, when asked if he was still recommending that the claimant get a prosthetic finger, Dr. Kelley replied:

You know, it's a situation that when ever I get a person that's an amputation, if they request it I tell them all the reasons, the good, the bad, and the ugly about them.

In other words, you can't wear them 24/7. You get skin maceration. You have to make sure that they're taken off regularly. All these sorts of reasons. You can't work in them. And then if they understand all that and they still would like to have one, I have no qualms in writing a script for one.

Finally, Dr. Kelley agreed that finger prostheses are always elective.

Employers must promptly provide medical services, including artificial limbs, which are reasonably necessary for treatment of compensable injuries. Ark. Code Ann. § 11-9-508(a). However, injured employees have the burden of proving by a preponderance of the evidence that the medical treatment is reasonably necessary for the treatment of the compensable injury. Air Compressor Equipment v. Sword, 69 Ark. App. 162, 11 S.W.3d 1 (2000); See also, Norma Beatty v. Ben Pearson, Inc., Full Workers' Compensation Commission Opinion filed February 17, 1989 (Claim No. D612291); See also, Ark. Code Ann. §11-9-508(a). When assessing whether medical treatment is reasonably necessary for the treatment of a compensable injury, we must analyze both the proposed procedure and the condition it is sought to remedy. Deborah Jones v. Seba, Inc., Full Workers' Compensation Commission Opinion filed December 13, 1989 (Claim No. D512553).

Moreover, whether a medical procedure or device is reasonable and necessary treatment is a question of fact to be decided by the Workers' Compensation Commission. Sword, Supra; Citing, Ark. Dept. of Correction v. Holybee, 46 Ark. App. 166, 725 S.W.2d 420 (1994).

The testimony of the claimant's primary treating physician, namely Dr. Kelley, which is fully supported by the medical records, clearly demonstrates that the claimant has fully received comprehensive and appropriate medical treatment for his compensable injury. This treatment has included numerous surgical procedures and extensive physical therapy. However, due to what Dr. Kelley could only explain as the claimant's low pain tolerance, the claimant has not achieved the mobility in his ring finger that Dr. Kelley had expected him to obtain based upon his course of treatment. Although Dr. Kelley's noted observations of the claimant's low level of pain tolerance appears credible, and no doubt, the claimant's recovery has surely been a painful process, Dr. Kelley's testimony reveals that the claimant has failed to achieve his expected outcome primarily due to his failure to fully participate in his own recovery. The result of this has obviously been that the claimant's numerous surgical procedures were for naught. Therefore, it is unreasonable to

expect that a fusion, which will not add to the claimant's mobility or increase his hand function, is necessary for the treatment of the claimant's compensable injury, for which he reached maximum medical improvement in August of 2004. Further, taking the claimant's history of noncompliance in his own recovery into consideration, in addition to the fact that this procedure will not improve the claimant's long-term outcome, this proposed procedure will potentially put him at risk of more damage. Therefore, this proposed procedure is not only unnecessary, but it is unreasonable, as well.

The question of the reasonableness of a prosthetic device was examined in Air Compressor Equipment v. Sword, Supra, by the Court of Appeals. In that case, the court found that there was substantial evidence to support the Commission's finding that a myoelectric prosthesis, versus a conventional or hook type prosthesis, was reasonably necessary for the treatment of the claimant's compensable injury. The claimant, who had lost all of his fingers and thumb on his right hand when an air compressor misfired, could not return to manual labor after his accident. Therefore, he was planning to pursue a teaching career. In

upholding the Commission's award of the more costly prosthetic device the court reasoned:

Given the testimonies of appellee's plastic surgeon and reconstructive surgeon and the board certified prosthetic orthotist, there was substantial evidence to support the finding that the myoelectric prosthesis was reasonably necessary to restore appellee as far as practicable to his physical condition before his work-related injury. See Crain-Burton Ford Co. v. Rogers, 12 Ark. App. 246, 674 S.W.2d 944 (1984).

The present claim is distinguishable from Sword in several ways. Obviously the claimant in Sword, who was right hand dominant, lost full function and use of his hand in his accident. For this reason alone, it was necessary that he receive a prosthetic device. Further, apparently three medical specialists testified in support of the claimant receiving a myoelectric prosthetic device. Finally, the question was not whether the claimant was entitled to a prosthetic device; even the respondent/appellee agreed that he was. Rather, the issue was which device he was entitled to - the standard prosthesis or a more costly one. In the present claim, the claimant has not lost full function and use of his right hand. Further, the record is devoid of evidence that receiving a prosthesis for his pinky finger

will improve the function of his hand. Rather, the claimant's own treating physician has testified that it will not increase the claimant's hand function or mobility. In fact, in certain situations, Dr. Kelley testified that a prosthesis could present a physical danger to the claimant. Dr. Kelley's testimony clearly reflects that such a device would merely be for aesthetic purposes, and could only be used on a limited basis.

The claimant testified that he needs the proposed prosthesis in order to boost his self-esteem and make him feel more confident in his business dealings. This brings up the issue of the psychological component of the claimant's recovery. Whereas Dr. Kelley testified that when a patient has been psychologically traumatized, prostheses are sometimes beneficial in helping with the recovery process, he further testified that a patient's lack of participation in counseling signals that a patient is not damaged enough by their loss to feel that they need such intervention. As previously mentioned, the claimant underwent a couple of counseling sessions before he abandoned this treatment. The record shows that the claimant has not received counseling in over two years. During cross examination, the claimant admitted that he has learned to adapt to the loss of his

pinky finger from a "mental" perspective. Therefore, the facts of this case do not substantiate that the claimant, assuming that he did initially, continues to suffer psychological trauma stemming from his work related injury. Further, since the claimant's only justifiable need for such a device might be the psychological component of his injury, and since the claimant has failed to establish that he continues to suffer psychological trauma stemming from his work related injury, he has failed to prove by a preponderance of the evidence that a prosthetic pinky is reasonably necessary to the treatment of his compensable injury. Therefore, this device should be denied and the decision of the Administrative Law Judge reversed in this regard.

Finally, as previously discussed, the preponderance of the evidence fails to support a finding that the claimant's proposed fusion is reasonably necessary to the treatment of his compensable injury. Whether the claimant was noncompliant in his recovery due to his pain threshold, or for some other reason, it is evident that he has not benefitted from the numerous procedures that he has undergone in Dr. Kelley's attempts to help improve the range of motion of his ring finger. Rather, due to the claimant's

failure to successfully push past his discomfort during therapy sessions, the otherwise successful procedures to loosen the claimant's tendons have ultimately failed to improve the claimant's mobility and increase his function. The claimant testified that he wants the fusion procedure, in part, in order to help alleviate the pain associated with bumping, bending, and straightening his finger. In addition, the claimant agreed that he wants a fusion so that he can more fully participate in certain sports and physical exercises. However, as of his last deposition, Dr. Kelley admitted that such a procedure would not improve the claimant's long-term outcome, nor would it help alleviate his pain or improve his function and mobility. According to Dr. Kelley, because such a procedure would most likely be of little to no benefit, he did not offer a fusion to the claimant on his last visit. Moreover, the claimant testified that he has adapted to his condition so that he can perform necessary daily activities such as dressing and grooming himself, driving a car, and performing household chores. The claimant further stated that he is able to participate in gainful "manual labor" employment, such as he was performing at the time of his injury, as long as it does not involve excessive gripping. Dr. Kelley and Dr. Moore both indicated

that under certain circumstances, such as if his contracture was more than 60 to 70 degrees, a fusion might be in order to help permanently place the claimant's finger in a less obtrusive position. However, there is no medical evidence to support a finding that the claimant currently suffers to this degree of contracture. The claimant reached maximum medical improvement for his compensable injury on August 9, 2004, at which time Dr. Kelley assigned him an impairment rating and released him from his care. This was the last time that the claimant sought treatment from Dr. Kelley. Further, Dr. Kelley's has opined that a fusion will not improve the claimant's condition, and, based upon the claimant's history of non-compliance, may even cause worse damage. Therefore, as previously stated, I find that the claimant has failed to prove by a preponderance of the evidence that the proposed fusion is reasonably necessary to the treatment of his compensable injury, and this procedure should be denied.

Based upon the above and foregoing, I find that the claimant has failed to prove that additional medical treatment in the form of a 4<sup>th</sup> finger fusion and pinky finger prosthesis is reasonably necessary to the treatment of his compensable injury. This conclusion is further

supported by the strong opinion of Dr. Michael Moore that further surgical treatment would be unpredictable and would not significantly improve the motion or function of the claimant's finger, and Dr. Kelley's testimony that a prosthesis serves no functional purpose. Therefore, I must respectfully dissent from the majority opinion.

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KAREN H. MCKINNEY, Commissioner