BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

WCC NO. H101762

RICHARD HORN, Employee	CLAIMANT
HARRIS CO. OF FORT SMITH, Employer	RESPONDENT
TRAVELERS INDEMNITY CO., Carrier	RESPONDENT

OPINION FILED MAY 25, 2023

Hearing before ADMINISTRATIVE LAW JUDGE ERIC PAUL WELLS in Fort Smith, Sebastian County, Arkansas.

Claimant represented by EDDIE H. WALKER, JR., Attorney at Law, Fort Smith, Arkansas.

Respondents represented by GUY ALTON WADE, Attorney at Law, Little Rock, Arkansas.

STATEMENT OF THE CASE

On March 2, 2023, the above captioned claim came on for a hearing at Fort Smith, Arkansas. A pre-hearing conference was conducted on January 9, 2023, and a Pre-hearing Order was filed on January 10, 2023. A copy of the Pre-hearing Order has been marked Commission's Exhibit No. 1 and made a part of the record without objection.

At the pre-hearing conference the parties agreed to the following stipulations:

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

2. The relationship of employee-employer-carrier existed between the parties on February 3, 2021.

3. The claimant sustained a compensable injury to his left hand on or about February 3, 2021.

4. The claimant was earning sufficient wages to entitle him to compensation at the weekly rates of $411.00 for temporary total disability benefits.

5. The claimant is entitled to temporary total disability benefits currently and through the undisputed surgical portion of the surgery recommended by Dr. Kelly and its reasonable and necessary aftercare or the claimant's return to employment.

By agreement of the parties the issues to litigate are limited to the following:

1. Whether Claimant is entitled to additional medical treatment for his compensable left-hand injury in the form of surgery as recommended by Dr. Kelly.

Claimant's contentions are:

> "Claimant contends that the Respondents have failed and refused to authorize surgery recommended by Dr. Kelly and that the Commission should order the Respondents to authorize said surgery since it is reasonably necessary treatment in regard to the Claimant's admittedly compensable injury."

Respondents' contentions are:

> "Respondents have approved the surgical recommendation as modified for related condition to the work injury. Claimant has not undergone the approved surgery as modified. The unrelated treatment for other conditions is not reasonable, necessary or related to the work injury."

The claimant in this matter is a 41-year-old male who sustained a compensable injury to his left hand on February 3, 2021. The claimant testified on direct examination that his hand was crushed between two pieces of metal pipe and that he began to see Dr. Robert Taylor. The claimant underwent three surgeries at the hands of Dr. Taylor. His first surgical intervention was February 4, 2021, the day after the claimant's crush injury. The operative report found at Claimant's Exhibit 1, page 1, states in part as follows.

> PREOPERATIVE DIAGNOSIS: Left middle finger middle phalanx fracture, displaced, comminuted and open.
>
> POSTOPERATIVE DIAGNOSIS: Left middle finger middle phalanx fracture, displaced, comminuted and open.
>
> PROCEDURE: Open reduction and K-wire fixation of left middle finger middle phalanx fracture.

The claimant gave direct examination testimony about the results of his first surgery as follows.

> Q So how did that work out?
>
> A Man, after he - - well, after he took the wire out and my finger - - he had my finger done up. It was just a stiff finger, you know. And he had it together, but it was a stiff finger. It hurt. It was numb all the time, you know.
>
> Q So your finger was just stuck straight out?
>
> A Yes.
>
> Q And you couldn't bend it or anything?
>
> A Correct. It was stuck straight out like this. (indicating).

On April 1, 2021, the claimant underwent a second surgical intervention at the hands of Dr. Taylor. Following is a portion of that operative report found at Claimant's Exhibit 1, page 10.

> PREOPERTIVE DIAGNOSIS: Stiff, painful left middle finger, status post previous crush injury.
>
> POSTOPERATIVE DIAGNOSIS: Same.
>
> OPERATION: Ray amputation of left middle ray.

At the hearing in this matter the claimant gave direct examination testimony about his second surgery in which his middle finger was amputated as follows.

Q Was it your hope that you would get more function out of your hand if you went ahead and followed the doctor's advice?

A Yes, sir.

Q And as a result of that surgery, that entire finger was amputated?

A Yes, sir.

Q Now, if a person looks at their hand, they actually have knuckles in their fingers.

A Correct.

Q Now, on that third finger, that long finger that you got amputated, was it actually amputated at the knuckle or past the knuckle?

A In my hand?

Q Now, when you say in your hand, if you bend your hand and you've got knuckles across the top of your hand.

A Yes.

Q How far back behind where those knuckles are would you say that amputation was?

A Over halfway.

Q Over halfway up the back of your hand?

A Yes, sir. Right there (indicating). Do you want to see?

Q No, I don't want to see it. You can tell me.

A Okay.

Q So if you put your finger where that amputation occurred on the back of your hand.

A Yes.

Q And you turn it over and look in the front of your hand,

where in the front of your hand would that be? If you drilled a hole through there, where would the hole come out?

A (Indicating), right there.

Q Now, when you say right there, you are pointing to the palm of your hand?

A Yes, (indicating).

Q Okay. So how did that work out for you?

A It didn't. It was worse for me. I got numbness and it - - I have pressure on my hand. It gets numb all the time. And my hand cramps up all the time. I can't hold nothing. I can't grip nothing.

Q Did you have any problems like that before you got hurt?

A No, sir. No, sir.

On September 28, 2021, the claimant underwent a third surgery at the hands of Dr. Taylor. Following is a portion of the report of that operation found at Claimant's Exhibit 1, page 20.

PREOPEATIVE DIAGNOSIS: Status post left third ray amputation and hand pain.

POSTOPERATIVE DIAGNOSIS: Same plus relaxation of deep transverse metacarpal ligament repair.

OPERATION: Left third ray transverse metacarpal ligament repair.

The claimant was questioned on direct examination about this third surgical intervention as follows.

Q What did they do on that surgery?

A His surgery didn't work, so he opted to open me back up again.

Q Opened your hand back up?

A Yes.

Q And what did he do?

A He put a permanent suture in there to hold my hand together.

Q Well, when you were showing your hand a few minutes ago, it didn't look like it was together.

A No, sir.

Q So what happened after the third surgery?

A It didn't work and he released me and said, "That is all I could no." I had to find somebody else.

On November 10, 2021, Dr. Taylor released the claimant from care. A medical record from Dr. Taylor regarding the claimant found at Respondent's Exhibit 1, page 15, states in part "Status post six weeks out from repair of his deep intermetacarpal volar ligament. He is doing well. It is healing up and looks good. He has good range of motion. I am going to probably turn him loose today and I will see him back if he has a problem."

The claimant sought and received a Change of Physician from the Commission in this matter from Dr. Taylor to Dr. James Kelly. The claimant has been seen by Dr. Kelly on two occasions, April 25, 2022, and June 1, 2022. Dr. Kelly authored a letter to the respondent regarding his April 25, 2022, visit with the claimant. The body of that letter follows.

> Thank you very much for referring Richard Horn for consultation. As you are aware, he is a 40-year-old construction employee who worked for Harris Company at Fort Smith. He had a crushing injury to his left middle finger on 02/02/2021. He had fractures of the 3rd finger. He was taken to the operating room by Dr. Robert Taylor in Rogers Arkansas on 02/04/2021. He had debridement and pinning of a left D3 P2 fracture. He also had an A4 pulley repair. Once this healed, he had stiffness in the finger. For

> whatever reason, at that point, once the hand healed Dr. Taylor had opted to do a ray amputation rather than reconstructing the long finger. I asked the client and there was no discussion of possible joint replacements or tenolysis/capsulotomy. Needless to say he ended up with a ray amputation of the 3rd ray. He did not have a D2 metacarpal transfer. This left with him with the typical gap opening in the palm and scissoring of the fingers when he makes a fist. This is a classic deformity for this type of ray amputation. He is also complaining of some numbness in the hand especially in the exaggerated web space but also in all of his fingertips including the thumb.
>
> In examining him, he has the widening of the palm where he has objects will fall through the between the 2nd and 4th fingers he also had a positive Tinel's, Phalen's and compression test at the wrist. He had blunted sensation in the median distribution of the hand.
>
> I am recommending that we get EMG/NCV studies completed on him. I will see him back once these have been completed. I have discussed briefly with him metacarpal transfer to help with the functional use of his hand as well as probably, carpal tunnel release as well as possible exploration of the common digital nerves which may be also either directly injured or scarred down causing him sensory issues in the hand. I will see him back here in the office once the nerve study has been completed and make appropriate recommendations there afterwards.

On May 16, 2022, the claimant underwent an EMG of his left hand by Dr. Miles Johnson at the recommendation of Dr. Kelly. Following is a portion of that diagnostic report.

> SUMMARY: Left median, radial, and ulnar motor studies are normal. Left median ulnar orthodromic latency difference is normal. Medial and ulnar antidromic sensory responses to the fourth digit were normal. Left radial sensory response to the first digit was normal. Median sensory response of the second digit was normal. EMG examination of the left upper extremity is within normal limits.

On June 1, 2022, the claimant was again seen by Dr. Kelly. Following is a portion of that progress note.

> Mr. Horne presents to the office today, he underwent EMG/NCV study on his left upper extremity. EMG study was essentially

> normal. I think this is compatible with his findings. The numbness he gets is when he is using the hand it is applying pressure to the nerve in the palm as well as the wrist and of course he has had the ray amputation which is his major issue. I explained what I recommend is that he would have a metacarpal transfer of the 2nd to the 3rd spot and we will plate the metacarpal in place. I also would complete an endoscopic carpal tunnel release and I think in doing so this will eliminate the intermittent numbness he is getting in his hand. Metacarpal transfer will also provide better functional use of the finger as currently he drops objects into the widened web space as well as he has weak grip strength because of the scissoring that the ray amputation has caused. I explained that by removal of the widened web space and alignment of the metacarpal this should improve functional use strength and decrease the pain. He wants to think about this so I am going to leave it for him to decide, if he decides he would like to proceed he just needs to contact our office.

The respondent in this matter engaged the services of a company called "genex" to review the surgical recommendations of Dr. Kelly. A "physician advisor report" is found Respondents Exhibit 1, pages 36-40. That report is signed by Dr. Aaron Humphreys, who is licensed both in Texas and Alaska. It appears from my review of the report that Dr. Humphreys agrees with the surgical recommendations of Dr. Kelly except to modify the recommendation as not to perform the carpal tunnel release as part of the surgical intervention. Following is a portion of Dr. Humphrey's report specifically a section subtitled "analysis and clinical basis for conclusion" regarding carpal tunnel release.

> Analysis and Clinic Basis for Conclusion
>
> The ODG supports a carpal tunnel release for non-severe carpal tunnel syndrome when there are corroborating subjective and objective findings, no current pregnancy or other treatable diseases, failure to 3 initial conservative treatments, and a positive left diagnostic test for median nerve entrapment. The ODG does not address a ray transfer or fascial release. The journal of the American academy of orthopedic surgeons states that right resection with or without adjacent ray transfer can be useful for treating vascular insufficiency, tumors, infection, trauma, recurrent

> Dupuytren contracture, and congenital tonalities of the hand. The ODG supports a fascial release for forearm compartment syndrome. The ODG supports surgery following reconstructive hand surgery. In this case, the claimant has an extensive surgical history including a ray amputation of the third ray. There is a persistent deformity and function postoperatively resulting in the gap opening in the palm and scissoring of the fingers when making a fist. The examination is concerning for carpal tunnel syndrome; however, a recent EMG/NCV (electromyogram/nerve conduction velocity) was noted to be negative for peripheral nerve entrapment or neuropathy. The LT D2 ray transfer to D3 would be appropriate to optimize function and prognosis in this case; however, clarification is needed to support the carpal tunnel release and fascial release. Based on the available information, left CTR (carpal tunnel release) (end0) & fascial release forearm CPT-29848, 25020 is not medically necessary and noncertified; however, LT D2 ray transfer to D3 CPT – 29125, 26555 is medically necessary and certified.

I know that the report from Dr. Humphreys was requested on September 29, 2022, as found on the report's first page at Respondent's Exhibit 1 page 36; however, the report date is blank on that same page. Page 40 of Respondent's Exhibit 1 indicates a peer-to-peer contact occurred on September 30, 2022, but the actual date of Dr. Humphrey's report is otherwise not known.

On October 3, 2022, Dr. Kelly appears to respond to Dr. Humphreys' report via letter to the respondent. The body of that letter follows.

> Addressing this letter pertaining to our mutual client Richard Horn. He is scheduled to have left D2 metacarpal transfer to the right 3rd as well as Ray amputation of the right 2nd metacarpal base. This is secondary to the crushing injury where he had an amputation of his right 3rd finger. He is also complaining of numbness in the thumb and index finger. This is related to his carpal tunnel syndrome where he had both positive physical findings. As far as his negative conduction studies, I am sure you are aware that 10% of the people can have false negative EMG/NCV studies. His physical findings are much more accurate and predictable of carpal tunnel syndrome. His carpal tunnel syndrome is definitely related to his injuries as he

> had a crushing type injury which is a common outcome for development of carpal tunnel syndrome.
> Postoperative swelling and the two surgical procedures he had there afterwards on his hand all relate to this diagnosis. I hope this letter is self-explanatory. If my staff or myself can be of any further assistance please feel free to contact us.

On February 20, 2023, Dr. Kelly authors a letter to the claimant's attorney acknowledging a clerical error in his note dated October 3, 2022, which indicates left and right hands and should have only stated left hand. That letter is found at Claimant's Exhibit 1, page 35.

After a review of all of the medical evidence and testimony in this matter, I find that the surgical recommendation of Dr. Kelly is reasonable, necessary medical treatment for the claimant's compensable left-hand injury, to include the carpal tunnel release recommended by Dr. Kelly. As Dr. Kelly has examined the claimant on two occasions, I give him more weight than Dr. Humphreys, who has never examined the claimant. I am also persuaded by Dr. Kelly's October 3, 2022, letter which he clearly sets out the need for carpal tunnel release, which includes both the claimant's injury itself and the three types of surgical intervention he has had at the hands of Dr. Taylor since that time.

From a review of the record as a whole, to include medical reports, documents, and other matters properly before the Commission, and having had an opportunity to hear the testimony of the witness and to observe his demeanor, the following findings of fact and conclusions of law are made in accordance with A.C.A. §11-9-704:

FINDINGS OF FACT & CONCLUSIONS OF LAW

1. The stipulations agreed to by the parties at the pre-hearing conference conducted on January 9, 2023, and contained in a Pre-hearing Order filed January 10, 2023, are hereby

accepted as fact. The parties' additional stipulation set forth at the beginning of the hearing is also accepted as fact.

2. The claimant has proven by a preponderance of the evidence that he is entitled to additional medical treatment for his compensable left-hand injury in the form of surgery as recommended by Dr. Kelly which includes carpal tunnel release.

ORDER

The respondents shall pay the costs associated with the recommended surgical treatment of Dr. Kelly, including the carpal tunnel release and costs associated with the surgical aftercare.

Pursuant to A.C.A. §11-9-715(a)(1)(B)(ii), attorney fees are awarded "only on the amount of compensation for indemnity benefits controverted and awarded." Here, no indemnity benefits were controverted and awarded; therefore, no attorney fee has been awarded. Instead, claimant's attorney is free to voluntarily contract with the medical providers pursuant to A.C.A. §11-9-715(a)(4).

If they have not already done so, the respondents are directed to pay the court reporter, Veronica Lane, fees and expenses within thirty (30) days of receipt of the invoice.

IT IS SO ORDERED.

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HONORABLE ERIC PAUL WELLS
ADMINISTRATIVE LAW JUDGE