BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. G604726

GENITA MCKNIGHT, EMPLOYEE	**CLAIMANT**
ARKANSAS DEPARTMENT OF HEALTH, EMPLOYER	**RESPONDENT #1**
PUBLIC EMPLOYEE CLAIMS DIVISION, CARRIER/TPA	**RESPONDENT #1**
DEATH & PERMANENT TOTAL DISABILITY TRUST FUND	**RESPONDENT #2**

OPINION FILED JULY 28, 2021

A hearing was held before ADMINISTRATIVE LAW JUDGE KATIE ANDERSON, in Little Rock, Pulaski County, Arkansas.

Claimant was represented by Mr. Andy L. Caldwell, Attorney at Law, Little Rock, Arkansas.

Respondents #1 were represented by Mr. Charles McLemore, Attorney at Law, Little Rock, Arkansas.

Respondent #2 was represented by Ms. Christy L. King, Attorney at Law, Little Rock, Arkansas. Ms. King waived her appearance at the hearing.

STATEMENT OF THE CASE

A previous hearing was held in this case on September 18, 2020, in Little Rock, Arkansas, where a determination was made that an Independent Medical Evaluation (IME) was not reasonable or necessary at the time. Claimant appealed the decision by the Administrative Law Judge (ALJ); however, Claimant withdrew the appeal from the Full Commission and no decision on the appeal was rendered.

A second hearing, and the subject of this Opinion, was held in the above-captioned claim on April 29, 2021, in Little Rock, Arkansas. A Prehearing Order was previously entered in this case on March 10, 2021. The Prehearing Order has been marked as Commission's Exhibit #1 and was made a part of the record without any objection from the parties.

Stipulations:

During the prehearing telephone conference, the parties agreed to the following stipulations:

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

2. An employer-employee relationship existed on June 29, 2016.

3. Claimant's average weekly wage on June 29, 2016, was $312.12, with resulting compensation rates of $208.00/$156.00.

4. Claimant sustained compensable work-related injuries to her left shoulder, left hand, and left upper extremity.

5. Respondents initially accepted this claim of the left shoulder, left hand, and left upper extremity as compensable and paid certain medical and indemnity benefits. Respondents paid a fifty-five percent (55%) impairment rating by Dr. Norton to Claimant's left hand.

6. This claim has been the subject of a previous hearing, with a resulting decision of the ALJ on October 19, 2020, which Claimant appealed, then chose to withdraw her appeal making that decision final, *res judicata* and the law of the case.

7. The last date of maximum medical improvement (MMI) was September 5, 2019.

8. All issues not litigated herein are reserved under the Arkansas Workers' Compensation Act.

Issues:

The parties agreed to litigate the following issues, which were modified[1] at the hearing:

1. Claimant's entitlement to additional permanent partial disability (PPD) for the left hand due to RSD.

2. PPD for the left shoulder.

3. Permanent total disability (PTD) benefits, or the alternative wage loss.

[1] At the hearing, the parties agreed to remove the issue of compensability of Claimant's neck injury, as well as the issue of whether Respondents #1 shall reimburse the reporting cost of the depositions of Claimant's treating physicians.

4. Controversion/attorney's fees.

Contentions:

The following contentions were submitted by the parties:

Claimant contends that she sustained injuries to her left shoulder, left hand, and left upper extremity on or about June 29, 2016, in the course and scope of her employment. Respondents initially accepted the claim as compensable and paid certain medical and indemnity benefits. Claimant contends that she is entitled to additional impairment concerning her left shoulder and left hand due to RSD. Claimant contends that she is permanently and totally disabled, or in the alternative, is entitled to wage loss and attorney's fees. All other issues are reserved.

Respondents #1 contend that Claimant did sustain a compensable injury to her left arm and hand when she lost control of her vehicle on June 29, 2016, and this injury has been accepted and appropriate treatment and benefits have been or are being provided, including medical treatment reasonable and necessary for the compensable injury, temporary total disability (TTD) benefits while Claimant was in a healing period, and permanent partial disability (PPD) benefits for the permanent anatomical impairment rating assigned by Claimant's treating physicians.

Respondents #1 have provided medical treatment reasonable and necessary for Claimant's injury, including treatment with Dr. Kirk Reynolds, who treated Claimant's shoulder conservatively; Dr. Carlos Roman, who has provided pain management treatment; and Dr. Brian Norton, who has performed four (4) surgeries on Claimant's left hand on: July 11, 2016; September 1, 2016; May 30, 2018; and July 22, 2019.

Claimant was released by Dr. Reynolds on September 13, 2017, after he found she had reached maximum medical improvement (MMI) with regard to her left shoulder, that her adhesive

capsulitis has resolved, and that she had zero percent (0%) permanent impairment to the body as a whole and was released to return to work at full, unrestricted duty with regard to the left shoulder.

Dr. Norton released Claimant at maximum medical improvement (MMI) on January 24, 2017, with a fifty-five percent (55%) permanent impairment rating to the hand, which was accepted by Respondents #1 and has been paid to Claimant. Dr. Norton has not assigned Claimant any greater impairment than the fifty-five percent (55%) he already assigned.

Claimant was paid TTD benefits from June 30, 2016, to September 13, 2017, when she was released at maximum medical improvement (MMI) for her left shoulder by Dr. Reynolds. Claimant was then paid PPD benefits for the fifty-five percent (55%) impairment rating that had been assigned to her hand beginning September 14, 2017. Claimant was paid TTD benefits again when she re-entered healing periods, from May 30, 2018, until November 1, 2018, and again from July 22, 2019, until September 5, 2019, her last release at maximum medical improvement (MMI) by Dr. Norton, at which point PPD benefits were paid to her again for the remainder of the fifty-five percent (55%) impairment rating. Claimant tested reliably in the light classification at a Functional Capacity Evaluation (FCE) on December 10, 2018. Claimant was provided vocational rehabilitation, and she was approved for Social Security Disability benefits on October 5, 2018.

Dr. Roman continues to treat Claimant for the compensable left arm, which Respondents #1 provide for Claimant, and separately Dr. Roman treats Claimant for her non-work related back and neck symptoms, which pre-exist the date of compensable injury.

Claimant had a hearing on September 18, 2020, on her demand for an Independent Medical Examination (IME) with another physician besides her treating physicians, for the sole purpose of obtaining new impairment ratings not for any treatment and not to change her treating physicians. The ALJ issued an Opinion October 19, 2020, finding, among other things, the IME was not

reasonable and necessary. Claimant appealed this decision to the Full Commission, then moved to withdraw her appeal, making the decision of the ALJ a final one, and *res judicata* and law of the case.

Respondents #1 have accepted and paid to Claimant the permanent anatomical impairment assigned by her treating physician. Respondents #1 contend that the impairment ratings assigned by Claimant's treating physicians are correct. Respondents #1 have and continue to provide appropriate benefits to or on behalf of Claimant for her compensable injury. Respondents #1 contend that Claimant cannot meet her burden of establishing her entitlement to permanent disability benefits she demands as she is not permanently and totally disabled, she has no greater anatomical impairment than what her treating physicians have assigned her, and she cannot be entitled to wage loss disability benefits for her scheduled injury.

Respondents #1 reserve the right to raise additional contentions, or to modify those stated herein, pending the completion of discovery.

Respondent #2 contends that if Claimant is found to be permanently and totally disabled, they stand ready to commence weekly benefits in compliance with Ark. Code Ann. § 11-9-502. Therefore, the Fund has not controverted Claimant's entitlement to benefits.

Summary of Evidence:

The record consists of the hearing transcript of April 29, 2021, and the exhibits contained therein. Specifically, the following exhibits have been made a part of the record: Commission's Exhibit #1 included the Prehearing Order entered on March 10, 2021; Claimant's Exhibit #1 was 125 pages in length and consisted of medical records; Claimant's Exhibit #2 consisted of a documentary exhibit comprising of a fifty (50) page deposition by Dr. Brian Norton. Respondents' #1 Exhibit #1 was forty-two (42) pages in length and consisted of medical records; Respondents'

#1 Exhibit #2[2] was a documentary exhibit consisting of Forms from Claimant's claim file, communication between Claimant and Respondents #1, vocational rehabilitation reports and letters to Claimant, the Social Security Administration Opinion, and the Functional Capacity Evaluation (FCE); Respondents' #1 Exhibit #3 consisted of one (1) medical record from Dr. Roman; and Respondents' #1 Exhibit #4 was a copy of the transcript from the previous hearing on September 18, 2020, and was retained in the Commission's file. Respondent's #2 Exhibit #1 consisted of the Trust Fund's evidence letter.

Witnesses:

During the hearing, Genita McKnight (Claimant, used interchangeably herein), was the only witness to testify.

Briefs:

After the hearing, the parties submitted briefs on the issues litigated. The briefs were blue-backed and were made a part of the record subsequent to the hearing.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

After reviewing the evidence and other matters properly before the Commission, and after having had an opportunity to hear the Claimant's testimony and observe her demeanor, I hereby make the following findings of fact and conclusions of law in accordance with Ark. Code Ann. § 11-9-704 (Repl. 2012).

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

2. The stipulations set forth above are hereby accepted.

[2] The following documents were admitted over Claimant's objection: correspondence from Respondents #1 to Claimant found on pages 5-8 and pages 10-12, and vocational rehabilitation records found on pages 13-37. It was noted that at the time the evidence was considered the appropriate weight would be given to the documents.

3. Claimant failed to prove by a preponderance of the evidence her entitlement to an additional impairment rating (over the 55% rating assigned by Dr. Norton) for her left hand injuries.

4. Claimant failed to prove by a preponderance of the evidence her entitlement to permanent partial disability benefits for her left shoulder injury.

5. Claimant failed to prove by a preponderance of the evidence that she has been rendered permanently and totally disabled as a result of her compensable left hand injuries.

CASE IN CHIEF

Hearing Testimony:

Claimant was fifty-seven (57) years old at the time of the hearing. She left high school in the eleventh grade and obtained her GED in 1995. Claimant's first job outside the home was in 2005 or 2006, when she worked for approximately six (6) months at the Mad Butcher deli. Soon thereafter, she obtained her CNA certificate began and working for Respondent-Employer in 2006 or 2007 as a home-health nursing assistant. She has worked as a CNA since that time. Claimant's job duties involved traveling to clients' homes and assisting them with daily living and personal care, such as bathing, cooking, and dressing them. Caring for the patients also involved lifting them. For example, she would lift a wheelchair-bound patient from the bed into the chair.

Claimant testified that on June 29, 2016, while driving her car to a patient's home, she was involved in a significant one-car accident where Claimant's vehicle suddenly went off the road and rolled several times. Claimant was then taken to a hospital in Pine Bluff before being transported to the Bradley County Memorial Hospital in Warren, Arkansas, for treatment of her injuries to her left arm, hand, fingers, and shoulder. Thereafter, she was referred to Arkansas Specialty Orthopedics, where she saw Dr. Brian Norton for her left hand injury and Dr. Kirk

Reynolds for her left shoulder injury. She testified that at the time of the hearing, she was still treating with Drs. Brian Norton, Kirk Reynolds, and Carlos Roman.

Claimant ultimately underwent multiple surgeries on her left index, middle, ring, and small fingers. She was diagnosed with a fractured distal ulna and had a scar on the outside of her left wrist. Claimant's most recent surgery at the time of the hearing was on July 22, 2019, with a possibility of another fusion surgery suggested by Dr. Norton. However, Claimant was trying to avoid that surgery so as not to aggravate her reflex sympathetic dystrophy (RSD). Claimant confirmed that she also had a limited amount of skin left due to the surgeries on her fingers and would like to avoid skin grafts. She further explained that, before each surgery, she gets a ganglion block injection in her neck, from which she has experienced a side effect of paralysis in her face.

Claimant was prescribed Lyrica, which she had taken daily for three (3) years, by Dr. Roman to treat her RSD. However, she explained that the side effects include memory loss, so Dr. Roman attempted to decrease her usage before the RSD flared up again. Afterward, Claimant took Lyrica only as needed for pain. She also took Tylenol #3 for pain, which made her drowsy, and she used a nerve pain cream on her hand.

Claimant testified that Dr. Reynolds treated her for left shoulder issues and diagnosed her with adhesive capsulitis. She explained that she had no strength in her left arm and experienced a sensation of "pins and needles" in her left hand and fingers. She further explained that her left index finger is permanently bent, for which Dr. Norton has suggested another surgery. In discussing Claimant's limitations from her hand and finger pains, Claimant testified that she has trouble performing all daily activities requiring her thumb to grip, including folding clothes, tying shoes, and opening things. She testified that she experiences pain like needles when anything bumps or touches her fingers. Because her hand stayed cold, Claimant wore a mitten or a sock

with a hole for her thumb to prevent air from reaching her fingers. In discussing problems arising from her left shoulder pain, Claimant testified that she has a limited range of motion and difficulty lifting her arm above her shoulder.

Claimant testified that she was not able to perform her previous job at the deli, as she would not be able to hold a mop or broom, lift a five-gallon bucket, or tolerate cold air from the freezer on her hands. She further explained that, although she could use a broom at her house, she maneuvered it with only one hand and took periodic breaks. She also denied being able to perform her CNA duties, as, "I wouldn't be able to hold a person up with my right hand and give them a bath with my left hand […] I wouldn't be able to wear a glove at work either, and that's mandatory." She also admitted that she would not be able to work with the side effects of the Tylenol #3 or Lyrica.

Claimant testified that she was approved for Social Security Disability after her left upper extremity injury (and a new diagnosis of emphysema). However, she admitted that she had previously been able to work with her older diagnoses of fibromyalgia, a previous neck injury, degenerative disc disease, and osteoporosis (which were also a basis for her disability determination). She testified that she loved her job as a CNA and wanted to continue working, but she did not feel as though she could work with her left arm conditions. As for her skillset, she stated that she could use applications on her home computer and her cellular phone. Claimant could drive a vehicle, but with her right hand only, and she is able to live alone. She was fortunate that she had family living nearby that could help her around her home.

During cross examination, Claimant testified that she had seen her family doctor, Dr. Kerry Pennington, as early as 2015 when she "went through a cancer scare." I had several female problems, and the hormonal imbalance was messing me up too. I had a hysterectomy in 2015."

She stated that Dr. Pennington had prescribed some medications for fibromyalgia during that time that caused side effects with her memory.

As for her more current treatment for her work injury, Claimant testified that Dr. Roman continued to provide pain management prescriptions for her left hand injuries, as well as treatment for non-work-related issues. Claimant stated that she managed her pain by taking the Lyrica as needed for pain, as well as Tylenol #3 daily for pain. She testified that she did not take those medications if she had to drive.

She stated that she had not seen Dr. Norton since her last visit when she decided not to go through with yet an additional surgery. Dr. Norton prescribed her a brace to wear on her hand. She also confirmed that she had not seen Dr. Reynolds for her shoulder in the past year.

Upon further cross examination, Claimant explained that her CNA certification had lapsed as she had not returned to work. She had not attempted recertification because she believed that she was no longer able to work as a CNA.

With regard to other work opportunities, Claimant testified that she had not looked for work since her work injury, but she did indicate to Ms. Heather Taylor, a Vocational Rehabilitation Consultant, at one time that if a suitable job were available, she would attempt the job. Claimant admitted that Ms. Taylor informed her of job opportunities, including a truck-driving position with Frito-Lay. Claimant indicated that she would have been unable to perform required job duties, such as lifting crates of chips with the Frito-Lay job. She admitted that she did not attend the computer training class that Ms. Taylor suggested, despite living only 35-45 minutes away from the training location.

Claimant confirmed that she had collected social security benefits since October 5, 2018, and that she was pursuing these benefits while Ms. Taylor was working to find suitable job options

for her. Claimant testified that her neck and back problems, which were unrelated to her work injury, also limited her ability to work. When she was asked to explain why she told Ms. Taylor that she had some "personal matters" that were keeping her from returning to work, Claimant explained that she suffered from depression after the deaths of two family members.

On cross examination, Claimant further described her daily activities. She had been forced to rehome some of her many pets, but she also was to keep her guard dogs. She was able to bathe the smaller pets on her own without assistance. She also explained that she had a computer in her home and was able to use it after her grandson helped her turn it on.

Upon redirect examination, Claimant clarified that she had scissors in every room to help her open items, and she was able to use scissors with her right, dominant hand. She further clarified when she was having issues with memory loss back in 2015, those resolved some when Dr. Pennington adjusted her medications. Upon redirect, Claimant further clarified that while Ms. Taylor was assisting her with her job search, she continued to have pain and stiffness in her left hand, and as a result, she did not believe that she would be able to perform some of the job duties for those jobs, including the use of a keyboard. She also mentioned another example of her limitations from her left-hand injury, which was that she was not able to button her clothing or tie her shoes.

Upon recross examination, Claimant testified that her last appointment with Dr. Roman was on March 10, 2021, and her last appointment with Dr. Norton was on August 12, 2020. She testified that the medical records from those two (2) visits with Drs. Roman and Norton reflect her most recent status with her left hand injuries, including the current condition, the current treatment, and any problems she may have had with her hand. She admitted to having had treatment for some

mental health issues, which was not reflected in those medical records, but some of that was a result of losing her husband.

During the hearing, I was given the opportunity to observe Claimant's left hand. My observation of her left hand revealed some appearance of a deformity in her index, middle, ring and small fingers. Claimant appeared to carry her left hand close to her body in a manner as to shield it from exposure.

Medical Exhibits:

Claimant's medical records showed that beginning in December of 2014, Claimant saw Dr. Kerry Pennington at Baptist Health Family Clinic in Warren, Arkansas. From December of 2014 until June of 2016, Dr. Pennington's clinic notes indicated that Claimant was treated for many chronic and acute conditions, such as: myalgia, myositis, heart palpitations, reflux, fibromyalgia, arthralgia, fatigue, dysphagia, hyperlipidemia, osteoporosis, insomnia, neck pain, swelling of the right side of the face, headaches on the left side, vitamin D deficiency, folate deficiency, hypertension, left arm numbness, and smoking cessation. She was also assessed for memory loss, for which Dr. Pennington took Claimant off of her Ambien prescription.

On July 1, 2016, three (3) days after her June 29, 2016, single motor vehicle accident, Claimant returned to Bradley County Medical Center for additional treatment to her left hand. Records indicated a left fractured distal ulna (wrist) and fractures to the left middle and ring fingers. She was treated for cellulitis, and her hand was splinted and elevated. She was admitted for further evaluation. She was released from the hospital once her hand improved.

Claimant underwent surgery by Dr. Brian Norton on July 11, 2016. Dr. Norton performed the following procedures: irrigation and debridement of the left long open middle phalanx fracture; open reduction and internal fixation of the left long finger middle phalanx fracture; closed

reduction and percutaneous pinning of the ring finger middle phalanx fracture; and closed treatment of the left distal ulna fracture.

Dr. Kirk Reynolds at Arkansas Specialty Orthopaedics saw Claimant for complaints from her left shoulder injury. An August 23, 2016, MRI of Claimant's left shoulder showed inferior glenohumeral joint capsulitis, small joint effusion, and mild subacromial subdeltoid bursitis. On August 24, 2016, Dr. Reynolds opined that Claimant could resume normal activity, but she could not use the left upper extremity. If she was better in six (6) weeks, he would start her in physical therapy then.

Also on August 23, 2016, Claimant underwent a bone scan revealing complex regional pain syndrome[3] in the left hand and wrist.

Claimant underwent a second surgery on September 1, 2016, where the hardware was removed from her left ring and long finger, and the long finger scar tissue was released and tendons were repaired.

[3] Complex Regional Pain Syndrome (CRPS) and Reflex Sympathetic Dystrophy (RSD) are used interchangeably throughout the medical records in this case. For clarification purposes, CRPS is defined as a form of chronic pain that usually affects an arm or a leg. CRPS typically develops after an injury, a surgery, a stroke, or a heart attack. CRPS occurs in two (2) types, with similar signs and symptoms, but different causes:

- Type 1. Also known as reflex sympathetic dystrophy (RSD), this type occurs after an illness or injury that did not directly damage the nerves in your affected limb. About ninety percent (90%) of people with CRPS have type 1.

See Complex Regional Pain Syndrome, at https://mayoclinic.org/diseases-conditions/crps-complex-regional-pain-syndrome/symptoms-causes (Last Accessed July 20, 2021).

Claimant first saw Dr. Carlos Roman on September 15, 2016. Dr. Roman noted her reflex sympathetic dystrophy ("RSD") of the left upper extremity. He prescribed Lyrica and suggested she continue physical therapy. A series of ganglion blocks on the left side were set up.

Claimant returned to Dr. Reynolds on October 5, 2016, for her left shoulder pain. She reported an overall improvement. However, due to persistent left shoulder pain associated with the adhesive capsulitis, Dr. Reynolds recommended a guided glenohumeral injection in the left side.

Between October 24, 2016, and November 1, 2016, Claimant underwent three (3) left-sided ganglion nerve blocks performed by Dr. Roman.

On November 22, 2016, Claimant reported to Dr. Norton that she had stiffness in her fingers but that her RSD was improving. Occupational therapy was prescribed for the stiffness noted in her ring and small fingers with flexion. Also noted was her index finger pseudo-boutonniere deformity.

On November 28, 2016, Claimant returned to Dr. Roman. His clinic notes indicated Claimant had seen some improvement of the burning pain with her left hand, but noted her significant restricted range of motion with that hand. Dr. Roman was also treating Claimant for low back pain unrelated to her work injury.

When Claimant returned to Dr. Reynolds on December 7, 2016, Dr. Reynolds noted that her shoulder pain and stiffness had improved with underlying adhesive capsulitis. Claimant would start physical therapy for gentle range of motion. Claimant remained on modified duty at work with current restrictions.

Claimant reported to Dr. Norton on December 27, 2016, that her index finger deformity had not improved. Due to continued stiffness in left hand fingers, she was to continue participation

in occupational therapy for finger motion and remain on the same work restriction of no use of the left hand.

On January 18, 2017, Claimant saw Dr. Reynolds and reported that her shoulder had not improved. Dr. Reynolds prescribed a steroid and continued physical therapy. She remained on modified duty with no lifting, pushing, or pulling, and no work above shoulder level.

On January 24, 2017, Dr. Norton noted Claimant's significant stiffness in the fingers, and that she was undergoing treatment and therapy for CRPS, including stellate ganglion blocks. She was progressing with treatment, and Dr. Norton opined that she had reached maximum medical improvement (MMI). He assigned Claimant an impairment rating of the left index finger of ninety-one percent (91%), the long finger of ninety-seven (97%) percent, the ring finger of one hundred percent (100%), and small finger of eighty-four percent (84%), including a hand rating of fifty-five percent (55%), upper extremity impairment of fifty percent (50%) and whole person impairment of thirty-three percent (33%) based on the AMA Guides to the Evaluation of Permanent Impairment, Fourth Edition. The statement was made with a reasonable degree of medical certainty.

When Claimant returned to Dr. Roman on February 23, 2017, Dr. Roman noted that Claimant's hand was still a bit "off color;" that she had little swelling; that she was not overly sensitive to touch on the left hand; that the Lyrica was working well for her; that she had decreased mobility in her fingers and contracture in the index finger; that she had undergone seven (7) ganglion blocks; and that she did not have the type of diffuse swelling typically seen with RSD. He opined that she was at the point of medical management.

In March of 2017, Claimant reported to Dr. Reynolds that her left shoulder range of motion had improved with the steroid treatment. She was to continue physical therapy, take another round of steroid medication, and remain on the current work restrictions.

In June of 2017, Claimant returned to Dr. Reynolds. Claimant reported that her left shoulder pain and range of motion with adhesive capsulitis had improved with physical therapy. She was to remain on the current work restrictions.

On July 10, 2017, Dr. Roman administered an epidural steroid injection at C6-C7, which was unrelated to Claimant's work-related injury.

Claimant saw Dr. Norton on July 25, 2017, and he noted a "piece of glass" in Claimant's left elbow and small finger during examination. He also noted the continued pain in her left hand and stiffness in her index, middle, ring and small fingers. They discussed surgical options to remove the glass; however, Claimant elected to proceed with observation at that time.

On August 17, 2017, Dr. Norton wrote that after sustaining multiple fractures in Claimant's ring and long fingers and undergoing surgery to address the fractures, Claimant developed CRPS. Claimant was left with significant stiffness and pain in her left hand. He opined that Claimant had a "very significant disability involving the left hand," which was likely a primary disability, making it difficult for her to use the left hand in any type of job activity.

On August 24, 2017, Dr. Roman noted that Claimant continued to have contractures, "some discoloration," and gross swelling (which had improved with the seven (7) ganglion blocks that Claimant had received). He opined that her RSD was stable. He noted the main issue for Claimant was the mechanical obstruction from arthrofibrosis on those joints, but noted that there were no changes with that.

On September 13, 2017, Dr. Reynolds noted Claimant's report that her adhesive capsulitis had improved and that Claimant felt that she was doing better. At that time, Dr. Reynolds opined that Claimant had reached maximum medical improvement (MMI) with regard to her left shoulder injury and could return to work without restrictions on her shoulder. Dr. Reynolds assigned Claimant a zero percent (0%) impairment rating to the shoulder pursuant to the AMA Guides to the Evaluation of Permanent Impairment, Fourth Edition, and noted it was within a reasonable degree of medical certainty.

On September 14, 2017, Claimant underwent a cervical epidural steroid injection at C6-C7 by Dr. Roman.

On September 22, 2017, Claimant saw Dr. Roman. Dr. Roman opined that Claimant's RSD had resolved, but the contractures from the injury to her left hand remained unchanged.

On May 30, 2018, Claimant underwent an additional (third) surgery on her left hand by Dr. Norton. He performed a left index finger scar tissue release with tendon release for improved movement and a PIP joint fusion, as well as ring finger and small finger PIP releases with removal of tendon adhesions. At her June 15, 2018, checkup, she was doing well. Her index finger infection had improved. Clinic notes indicated that she would begin therapy for range of motion for her ring and small fingers as well as the index finger joint. She had to refrain from use of her left hand. Claimant reported that she felt that her CRPS was returning based on increased pain in her left hand, and therefore, Dr. Norton suggested she see Dr. Roman for possible reoccurrence of her RSD.

In July of 2018, Dr. Norton wrote that Claimant was "doing relatively well" and was instructed to move forward with additional physical therapy to continue the improvement seen to

her range of motion in her index, ring, and small fingers and to wean her out of the long finger splint. She was still placed on a restriction of no use of the left hand.

In September of 2018, Dr. Norton noted Claimant's wound on the dorsal aspect of the ring finger at the PIP joint, which he attributed to the fact that there was not much soft tissue in that area. As such, he recommended a silicone sleeve to avoid surgery on that finger and continued therapy of the ring and small fingers.

In October of 2018, Dr. Roman continued to treat Claimant's CRPS in the left upper extremity with medication, including Lyrica, as well as her low back pain, which was unrelated to her 2016 work injury.

In November of 2018, Dr. Norton reported that Claimant was doing relatively well. She continued to have some pain; some flexion of the ring and small fingers; improvement of the boutonniere deformity of the index finger; and no sign of infection. He opined that overall, her symptoms were unchanged, and there did not appear to be any signs of worsening or active CRPS.

Claimant underwent a Functional Capacity Evaluation (FCE) on December 10, 2018, where she had reliable results and demonstrated the ability to perform work in the light classification of work with the following limitations on the left side, reaching immediate – constant; reach overhead – occasional; reaching with five (5) pound weight – occasional; handling – occasional; and fingering - occasional. On the right side, Claimant's limitations included: reaching immediate – frequent; reaching overhead – occasional; reach with five (5) pound weight – frequent; handing – constant; fingering – constant.

On December 18, 2018, Dr. Roman noted the hardware in her long finger and the weakness and minimal grip or strength in her index, ring, and small fingers; however, he found no signs of

active RSD at that time. He also treated her for back pain and continued her on Lyrica and pain medication.

In April of 2019, Dr. Roman opined that there were no signs of RSD. He also noted Claimant's scar tissue at her PIP and DIP joints in her left hand.

Claimant returned to Dr. Norton in May of 2019. Dr. Norton's records indicated that Claimant had recurrent boutonniere deformity to the left index and long fingers, for which he recommended surgery to fuse the index and long fingers. Dr. Norton also referred Claimant back to Dr. Roman for her complaints of left shoulder pain and upper arm pain.

In July of 2019, Claimant underwent a left cervical sympathetic (stellate ganglion) nerve block administered by Dr. Stephen Paulus.

Also in July of 2019, Claimant underwent a fourth surgical procedure of her left hand involving removal of the hardware of the left long finger and joint fusion of the left index and long finger performed by Dr. Norton. At a post-op appointment with Dr. Norton in September of 2019, Claimant was doing relatively well after fusing her DIP joints of the index and long fingers and while she continued to have pain, overall, her functionality and pain were improved. She was released to return to work under the guidelines of the Functional Capacity Evaluation (FCE). She was placed at maximum medical improvement (MMI), with no change in her impairment rating.

Claimant saw Dr. Reynolds in June of 2019, when she reported left shoulder pain after playing with her grandchildren and hitting her left shoulder. Dr. Reynolds assessed her with left shoulder pain. The physical examination of her left shoulder was normal with no atrophy, tenderness to palpation at the AC joint or posterior joint line, and well-maintained motion. She remained at maximum medical improvement (MMI) and could continue work at full duty.

Claimant returned to Dr. Roman in September of 2019. At that time, Dr. Roman noted the contracture of Claimant's left hand fingers, arthrofibrosis of the DIP and PIP joints particularly involving the long and ring fingers, and the recent surgical procedure by Dr. Norton to insert pins in her fingers to align them and prevent further distortion with boutonniere's deformity. Upon examination, Dr. Roman noted that the PIP and the DIP joints are flexed approximately fifteen (15) degrees so that there was a slight curvature to allow her to maintain some grip; that her range of motion in her wrist was still maintained; that her range of motion in her hand overall was significantly limited; that she could only make fifty percent (50%) of a fist; and that her thumb had better mobility. Lastly, Dr. Roman noted that, per the Budapest criteria, there were no signs of reoccurrence of her CRPS or RSD. Dr. Roman did not recommend any interventional procedures and continued with the current protocol.

In March of 2020, Dr. Roman noted Claimant's left index finger had some rotation at the PIP joint toward the long finger since the surgery, for which he recommended a splint. He also noted some pain in the back of her hand and the fact that her PIP joints were "pretty much frozen with very limited motion." However, she had better motion at the MCP joints.

In June of 2020, Dr. Roman continued providing pain management for Claimant's left extremity and her back. Dr. Roman noted her severe stiffening of the joints in the hand and the contractures of her fingers (except for the thumb). He also noted the thin skin and a prominent knot around the joint of her left index finger, for which he referred her back to Dr. Norton for evaluation.

In August of 2020, Dr. Norton saw Claimant for complaints of recent increased pain in her left long finger. Dr. Norton noted Claimant's continued stiffness in her four fingers; the lack of motion at the long finger PIP joints; no motion at the index finger PIP joint; minimal motion in the

remaining joints of the hand. However, he noted that Claimant was doing relatively well, other than the issues with the long finger. He noted that the protrusion of the long finger was likely a bony abnormality and not hardware. A joint fusion was the only option for Claimant's long finger, but she elected not to proceed with surgery at that time. Claimant remained on the same work restriction, and there was no change in her impairment rating.

Upon return to Dr. Roman in September of 2020, Dr. Roman noted that Claimant had some contractures of the ring and small fingers and significant contractures, particularly of the proximal interphalangeal joints of the index and middle fingers. The thumb, however, maintained a reasonably good range of motion. However, she had no signs of RSD on the left hand.

Dr. Roman noted on December 9, 2020, that the color, tone, and temperature was symmetric between Claimant's two hands, and thus, there was no sign of RSD. Claimant's physical examination showed the contractures in all digits except for the thumb and her inability to make a complete fist with her left hand. Claimant's medication protocol was continued.

In March of 2021, Dr. Roman noted in the history of present illness that Claimant's CRPS had been resolved. Upon physical examination, Dr. Roman noted the contractures in the PIP joints of Claimant's left index, middle, ring, and small fingers; however, the MCP joints moved fairly well. He also noted that Claimant could not make a complete fist due to the contractures. No changes were made to her medication, and no additional treatment was recommended.

Documentary Exhibits:

Claimant submitted the deposition testimony of Dr. Brian Norton, taken on December 28, 2020.[4] Dr. Norton is an orthopedic hand surgeon, who saw Claimant after her motor vehicle accident on June 29, 2016. He initially treated her for a fractured wrist and fingers. After her first

[4] At the time of the deposition, Dr. Norton was still treating Claimant for her left hand injury.

surgery, Claimant was diagnosed with RSD following a triple bone scan. Her symptoms included hypersensitivity, changing in coloration, and contracture. Claimant was treated with Lyrica, which was prescribed by Dr. Carlos Roman for her nerve pain. A second surgery was performed on Claimant on September 1, 2016, where the hardware in her fingers was removed and the scar tissue around the hardware was released. He stated that this procedure was fairly common. Dr. Norton placed Claimant at maximum medical improvement (MMI) on January 24, 2017. Claimant was still treating with Dr. Roman at that time. Dr. Norton gave Claimant a ninety-one percent (91%) rating to the left index finger, a ninety-seven percent (97%) rating to the long or middle finger, a one hundred percent (100%) rating to the ring finger, and an eighty-four percent (84%) rating to the little finger, which pursuant to the combined value chart, equated to a hand impairment rating of fifty-five percent (55%). That rating did not include Claimant's wrist, as her wrist had normal range of motion, and her fractured ulna was treated with a splint only. Moreover, Claimant's thumb was spared from injury, for the most part. He described Claimant's injured hand as a "helper" hand, in that Claimant still had use of the hand, but could not grip or lift with the hand.

Dr. Norton also stated that he had never given a rating for RSD because it is both subjective and objective and difficult to rate. Hence, he did not evaluate her RSD as it pertained to the impairment rating. He explained that if there had been a nerve injury, he could quantify that objectively with two point discrimination, but that is different from Claimant's complaints about sensibility, which he could not quantify. He could objectively measure motion by using passive range of motion, but he does not rate a patient for RSD. He stated that Claimant did not appear to have any motor deficit of her peripheral nerve as there was no nerve laceration, but rather just motor deficit from loss of motion.

Dr. Norton explained that after she was given the rating for her left hand, she had two (2) additional surgeries, one of which was a fusion surgery. Once a fusion is performed, there is no mobility of the joint. Dr. Norton explained that Claimant had some loss of mobility from the fusion surgery on her index finger and long finger joints. However, Claimant did have some use of the index finger, which was important for pinching. He added that the RSD impacted the entire hand, and as a result, she also lost mobility in her small finger and to some extent, her thumb. After the injury, Claimant had limited use of her left arm, wrist, and hand, which could be for the remainder of her life.

Dr. Norton testified that he last saw Claimant on August 12, 2020. At that time, Claimant had a bony prominence on her left index finger, but Claimant and Dr. Norton decided against fusion surgery so as to not put Claimant at risk of a flareup of her RSD (which occurred after the first two surgeries). As for the left deviation of her index finger, it was stable, and Dr. Norton did not think it would get much worse. At that time, her RSD was under fairly good control, and her symptoms were better than they had been previously. Claimant was not going to regain mobility in any of the joints that were fused, and she likely would not have any better mobility with additional surgery. At that time, he told Claimant to return as needed.

Dr. Norton testified that Claimant could perform work activities that only required the use of her right hand but could not say to what capacity she could use her right hand without her left hand. However, she could not do work that required two hands.

Dr. Norton stated that Claimant's impairment rating did not change after third and fourth surgeries, as Claimant did not have much mobility in those joints prior to the procedure. His impairment rating included the motion of each joint, and he followed the AMA Guides when measuring the motion of each joint and in calculating the impairment to the hand as a whole. Dr.

Norton had not recommended any additional treatment for Claimant, unless Claimant decided to proceed with additional fusion surgery for her index finger. As for her RSD, Dr. Norton stated that it was pretty typical for a patient with RSD to have flareups from time to time that would need to be treated with medication or nerve blocks.

On cross examination, Dr. Norton clarified that Claimant's initial surgery on her wrist was splinting only, and Claimant did not currently need any additional surgery on her wrist. Dr. Norton also confirmed that the fifty-five percent (55%) impairment rating to the hand was calculated using Table 1, Figures 19, 21, and 23 of the AMA Guides to the Evaluation of Permanent Impairment and was based on what he had actually treated.

Dr. Norton stated that he referred Claimant to Dr. Roman for treatment of her RSD. Dr. Norton also agreed that Dr. Roman had opined on September 2, 2017, that Claimant's RSD had resolved. When Dr. Norton examined Claimant after September 2, 2017, he had not observed any glaring symptoms of active RSD. Dr. Norton also referred Claimant for a Functional Capacity Evaluation (FCE) where Claimant's results were reliable, and she tested in the light category for work. Dr. Norton also clarified that he only treated Claimant's left hand. She is right-hand dominant.

After Claimant's two (2) additional surgeries, Dr. Norton noted in a September 5, 2019, clinic record that her functionality and pain had improved. He released her to return to work within the guidelines of the Functional Capacity Evaluation (FCE), placed her at maximum medical improvement (MMI), and noted there was no change in her impairment rating. As of the date of the deposition, he still agreed that there was no change in Claimant's impairment rating.

On redirect examination, Dr. Norton verified that Dr. Roman's notes indicated that on June 15, 2018, Claimant was having a flareup of her RSD, which is typical for RSD patients. Dr. Norton

testified that even if a patient's RSD is not considered active, the patient may still have pain from the RSD. Claimant also had contracture, which also could be caused by RSD. Even if the RSD went into remission, the patient could still have contracture or stiffness

On recross examination, Dr. Norton confirmed that the contracture and stiffness in Claimant's case were related to motion, which had already been considered in the impairment rating he assigned. He also testified that on a November 1, 2018, surgical report, Dr. Norton wrote, "There does not appear to be any signs of worsening or active complex regional pain syndrome." He believed that to be true at the time.

Documentary records also showed that Claimant underwent vocational rehabilitation between September of 2017 and February of 2018 with Heather Taylor, MRC, CRC, a Vocational Rehabilitation Consultant. In the initial evaluation, Ms. Taylor noted that Claimant had sustained significant injury to her left arm and could only use the left arm for assistance. She also noted that Claimant had not acquired any significant transferable skills from her work history (as she had entered the job force at forty-three (43) years of age for the first time) and had performed only one (1) occupation since that time; therefore, if she was able to resume employment in the future, it would be of an unskilled or semi-skilled nature. Some examples of minimum wage jobs that Claimant could perform in the unskilled or semi-skilled area with her left hand restrictions included host/hostess, greeter, desk clerk, and mail clerk, among others. Ms. Taylor noted that some of the jobs listed could require computer skills that Claimant did not currently possess. Between September of 2017 and February of 2018, Ms. Taylor continued to notify Claimant of job openings that could accommodate Claimant's skills and restrictions; however, Claimant reported that there were other issues (which she did not disclose) that prevented her from returning to work.

On October 5, 2018, Claimant was awarded social security disability benefits by the Social Security Administration. Administrative Law Judge David Knowles determined that Claimant had been under a disability as defined in the Social Security Act since June 24, 2016.

On April 16, 2021, Respondent #2 sent a letter to the Commission indicating that Respondent #2 deferred to the outcome of litigation on the following issues: compensability of Claimant's neck injury; Claimant's entitlement to additional permanent partial disability (PPD) for the left hand due to RSD; PPD for the left shoulder; permanent and total benefits or in the alternative, wage loss; and whether Respondents shall reimburse the reporting cost of the depositions of Claimant's treating physicians. Respondent #2 also informed the Commission that they would not attend the hearing and would like notice of any changes to the stipulations or issues.

ADJUDICATION

A. Additional Permanent Anatomical Impairment/PPD for Claimant's Left Hand Injury and Shoulder:

An injured worker must prove by a preponderance of the evidence that she is entitled to an award for a permanent physical impairment. Weber v. Best Western of Arkadelphia, Workers' Compensation Commission F100472 (Nov. 20, 2003). Any determination of the existence or extent of physical impairment shall be supported by objective and measurable findings. Ark. Code Ann. § 11-9-704(c)(1).

"Objective findings" are defined as those findings which cannot come under the voluntary control of the patient. Ark. Code Ann. § 11-9-102(16)(A)(i).

Pursuant to Ark. Code Ann. § 11-9-522(g) and our Rule 099.34, the Commission has adopted the Guides to the Evaluation of Permanent Impairment (4th Ed. 1993) to be used to assess anatomical impairment. Permanent benefits shall be awarded only upon a determination that the

compensable injury was the major cause of the disability or impairment. Ark. Code Ann. § 11-9-102(4)(F)(ii)(a).

1. Claimant's left hand injuries-Additional impairment rating:

In the present matter, it is undisputed that Claimant sustained an admittedly compensable injury to her left shoulder, left hand, and left upper extremity, on June 29, 2016, when she was involved in a single car motor vehicle accident while performing her job duties for Respondent-Employer. Claimant soon thereafter came under the care of Dr. Norton for her compensable left hand injury. She underwent a total of four (4) surgeries on one or more of her left fingers on July 11, 2016; September 1, 2016; May 30, 2018; and July 22, 2018, and underwent a bone scan on August 23, 2016, revealing CRPS in the left hand and wrist.

After months of treatment (including two surgeries and a bone scan revealing CRPS), Dr. Norton assigned Claimant a fifty-five percent (55%) permanent impairment rating to the left hand on January 24, 2017 (which was accepted and paid by Respondents #1). Dr. Norton released Claimant at maximum medical improvement (MMI) with regard to her left hand and noted that his assessment was based on the AMA Guides to the Evaluation of Permanent Impairment, Fourth Edition.

Respondents #1 contend that they have accepted the Claimant's injury to her left hand and left shoulder and have paid appropriate benefits, including medical treatment, temporary total (TTD) disability benefits while Claimant was within her healing periods, and permanent partial disability (PPD) benefits for the permanent anatomical impairment rating assigned by Claimant's treating physician, Dr. Norton, of fifty-five percent (55%) to her left hand on January 24, 2017. Respondents #1 contend that the impairment ratings assigned by Claimant's treating physicians

are correct, and Respondents #1 have and continue to provide appropriate benefits to, or on behalf of, Claimant for her compensable injury.

On the other hand, Claimant contends that she is entitled to additional impairment concerning her left shoulder and left hand due to RSD.

I acknowledge that after Dr. Norton assigned the fifty-five percent (55%) impairment rating to her left hand, he performed a third surgery in May of 2018, in the form of scar tissue release along with tendon release for improved movement, and a PIP joint fusion on Claimant's left index finger, and PIP release with removal of tendon adhesions on her ring finger and small finger. Shortly thereafter, Claimant showed overall improvement at the June 15, 2018, post-op appointment, and her index finger infection had improved. Clinic notes indicated that she would begin therapy for improved range of motion on those fingers, and she was placed in an index finger splint. Because Claimant reported experiencing increased pain in her left hand, Dr. Norton recommended she see Dr. Roman.

Also, after Dr. Norton assigned Claimant an impairment rating to her left hand, he performed a fourth surgery in July of 2019, to remove the hardware of the left long finger and to perform a joint fusion of the left long and index finger. At a post-op appointment, Claimant was doing relatively well and was released to return to work under the guidelines of the Functional Capacity Evaluation (FCE). She was placed at maximum medical improvement (MMI), with no change in her impairment rating.

During the period of time that Dr. Norton was treating Claimant, she was still under the care of Dr. Roman for her work-related injury as well as for other health issues (including her low back and neck) that were unrelated to her compensable work injury. On February 23, 2017, Dr. Roman opined that she was at the point of medical management, and while noting the varying

degrees of contractures on her fingers, opined that her RSD had resolved on September 22, 2017. Dr. Roman kept Claimant on Lyrica, although her testimony indicated that due to side effects from the medication, she only took the Lyrica as needed. Dr. Roman noted in November of 2018 Claimant was doing relatively well and that despite some continued pain, there was not much change in her symptoms overall. On December 18, 2018, Dr. Roman examined Claimant, finding no signs of active RSD. Lastly, in September of 2019, Dr. Roman noted that, per the Budapest criteria, there were no signs of reoccurrence of her CRPS or RSD. Dr. Roman did not recommend any interventional procedures and continued with the current protocol.

Dr. Norton continued to see Claimant for her recurrent boutonniere deformity and on an as-needed basis, and Dr. Roman continued to see Claimant for her hand pain and her other unrelated health issues.

In August of 2020, Dr. Norton's notes indicated that Claimant was doing relatively well other than the issues with the lack of motion at the long finger PIP joint and a bony abnormality of the long finger, for which a surgical joint fusion would be the only treatment option. Claimant opted against additional surgery.

Upon return to Dr. Roman in September of 2020, Dr. Roman's clinic notes indicated that Claimant had no signs of RSD in the left hand. Further, he noted the significant contractures of the index and middle finger joints and some contractures of the ring and small fingers. The thumb, however, maintained a reasonably good range of motion.

Again, on December 9, 2020, Dr. Roman opined that Claimant's physical examination did not show signs of RSD. Most notably, the recent medical evidence demonstrates that on March 21, 2021, Dr. Roman opined that the Claimant's CRPS had resolved, and no changes were made to her medication and no additional medical treatment was recommended. In the present matter, I

find that Dr. Roman's opinion is corroborated by the probative evidence and is entitled to significant evidentiary weight.

Moreover, I find that Dr. Norton's expert opinion is corroborated by his deposition testimony, medical records, and physical examination of the Claimant's hand, as such I have assigned significant weight to his opinion. While Dr. Norton testified at his deposition that he did not rate Claimant's RSD because RSD symptoms were both subjective and objective, he testified that the objective symptoms of RSD included mobility, which was, in fact, included in the rating assigned. He testified that Claimant had some use of her hand in that it was functional as essentially a "helper" hand. My review of the Guides and other evidence of record demonstrates that Dr. Norton's assessment of a fifty-five percent (55%) impairment rating to the hand comports with Table 1 at page 3/18 for a hand injury.

Based on the evidence before me, particularly the expert opinions of Drs. Norton and Roman, coupled with my review of the Guides, I find that Claimant has failed to meet her burden of providing objective and measurable findings to support an assessment of a permanent impairment rating to her left hand over and above the fifty-five percent (55%) rating assigned by Dr. Norton on January 24, 2017.

Accordingly, I find that Dr. Norton's fifty-five percent (55%) permanent anatomical impairment rating is consistent with Claimant's injuries to her left hand. Therefore, I find that the preponderance of the credible evidence establishes that Claimant sustained a fifty-five percent (55%) permanent anatomical impairment rating as a result of her left hand injuries.

2. Claimant's left shoulder injury-Impairment rating:

Claimant also sustained an admittedly compensable injury to her left shoulder on June 29, 2016, for which Claimant saw orthopedic specialist, Dr. Kirk Reynolds. After an MRI on August

23, 2016, showed inferior glenohumeral joint capsulitis, small joint effusion, and mild subacromial subdeltoid bursitis, Claimant was restricted to no use of the left shoulder. Claimant underwent physical therapy to improve her range of motion. Dr. Reynolds continued to treat Claimant, and in January of 2017, he placed her on modified duty with no lifting, pushing, or pulling, and no work above shoulder level. From that point on, she reported improvement in her left shoulder, and in September of 2017, Dr. Reynolds noted that Claimant's adhesive capsulitis had improved, and that Claimant felt that she was doing better. As a result, Dr. Reynolds opined that Claimant had reached maximum medical improvement (MMI) with regard to her left shoulder injury and could return to work without restrictions on her shoulder. Dr. Reynolds assigned Claimant a zero percent (0%) impairment rating to the shoulder pursuant to the AMA Guides to the Evaluation of Permanent Impairment, Fourth Edition and noted it was within a reasonable degree of medical certainty.

Claimant did not see Dr. Reynolds again for almost two (2) years. In June of 2019, Claimant reported to Dr. Reynolds that she was having left shoulder pain; however, the pain was occasioned by Claimant striking her left shoulder while playing with her grandchildren. Dr. Reynolds' physical examination of her shoulder was normal, revealing no atrophy, some tenderness to palpation at the AC joint or posterior joint line, and well-maintained motion. With no objective findings revealed, he opined that Claimant remained able to perform regular, full-duty work. No other physician has restricted Claimant from returning to work due to her left shoulder, and Claimant has not returned to Dr. Reynolds for additional treatment since that time. Dr. Reynolds' opinion with regard to Claimant's shoulder is supported by the medical records as a whole, and as such, I give it great weight.

Based on the foregoing, coupled with my review of the Guides, I find that Claimant has failed to meet her burden of providing objective and measurable findings to support an assessment of a permanent impairment rating to her left shoulder, and thus, failed to prove her entitlement to permanent partial disability (PPD) benefits for her left shoulder.

B. Permanent and Total Disability of the Left Hand Injury:

Claimant contends that she has been rendered permanently and totally disabled as a result of her compensable left hand injury of June 29, 2016.

Ark. Code Ann. § 11-9-519(e) provides:

> (1) "Permanent total disability" means inability, because of compensable injury or occupational disease, to earn any meaningful wages in the same or other employment.
>
> (2) The burden of proof shall be on the employee to prove inability to earn any meaningful wages in the same or other employment.

Claimant is fifty-seven (57) years old. She has an eleventh-grade education and has since earned her GED. The evidence shows that Claimant has worked primarily as a CNA for Respondent-Employer. She was out of the workforce for approximately ten (10) years before she obtained her CNA license. Claimant then entered the workforce and began working for Respondent-Employer in approximately 2006 as a CNA, where she worked until she suffered compensable injuries to her left hand, left wrist, left shoulder, and left upper extremity from a single motor vehicle accident on June 29, 2016, while employed by Respondent-Employer.

Claimant received emergency treatment for her injuries and thereafter received subsequent treatment for her left hand injuries by orthopedic hand specialist, Dr. Norton, and pain management specialist, Dr. Roman. Claimant had pain, mobility issues (contractures), recurrent boutonniere deformity, and scar tissue on her left index, middle, ring, and/or small fingers, and Dr. Norton ultimately performed a total of four (4) surgeries on one or more of her left fingers. Claimant also

had physical therapy to increase mobility in her fingers. Ultimately, on January 24, 2017, Dr. Norton assigned Claimant a fifty-five percent (55%) impairment rating for her left hand injury, which has been accepted and paid by Respondents #1. A bone scan also confirmed a diagnosis of CRPS in Claimant's left hand, for which she treated under the care of Dr. Roman. Dr. Roman also treated Claimant's continued complaints of pain in her left hand as well as other health issues unrelated to her work injuries.

During the hearing, Claimant testified that due to her compensable injury to her left hand, she is unable to return to work as a CNA or in any other area of employment. In addition to the pain from her left hand condition, Claimant also testified that the memory loss from the Lyrica impacted her ability to return to work. However, Dr. Roman adjusted her dosage of Lyrica (because it was effective for treating her pain), and Claimant testified that she only took the Lyrica as needed. Claimant took Tylenol #3 for her pain, which she had done for years, including while she was working. Claimant also testified that her depression impacted her ability to return to work; however, the record does not demonstrate that any mental health restrictions have been placed on her by any mental health professional or treating physician.

While Claimant's testimony at the hearing demonstrates that her daily activities have been significantly limited due to her compensable injury, Claimant is right-hand dominant and also testified that she is able to live alone. She is able to drive a vehicle. She is also able to care for her guard dogs and bathe her smaller pets. She is able to do some housework, including using a broom with her right hand. She had good mobility in her thumb and has not required any surgery on the thumb. While she testified that she did not have any computer skills, she admitted that she was able to manipulate certain applications on her computer.

Dr. Norton also testified that even with Claimant's disability of the left hand, she could use the left hand, but more as a "helper" hand. Testimony showed that Claimant still had the ability to pinch her index finger and her thumb together. As of the date of Dr. Norton's deposition, he still agreed that there was no change in Claimant's impairment rating. I note that neither Dr. Norton, nor any other treating physician, has opined that Claimant is permanently and totally disabled, and there is no probative evidence of record demonstrating the same.

While I sympathize with the significant injury Claimant has sustained to her left hand, based on the foregoing, I do not find that her testimony that she is unable to return to any type of work due to her left hand limitations to be corroborated by the evidence of record.

Therefore, after considering all the evidence in this case impartially, without giving the benefit of the doubt to either party, I find that Claimant failed to prove by a preponderance of the credible evidence that she is permanently totally disabled as a result of her compensable left hand injury of June 29, 2016.

As of the date of the hearing, Claimant was drawing Social Security Disability benefits. However, that determination included older diagnoses of fibromyalgia, a previous neck injury, degenerative disc disease, and osteoporosis, and Claimant admitted she had previously been able to work with those conditions, which are unrelated to her compensable injury. Of note, the determination by the Social Security Administration of Claimant being disabled is not binding on the Commission.

Nevertheless, as for returning to work, Claimant has made no effort to pursue any gainful employment since her compensable injury. The evidence shows Claimant is able to perform light work with restrictions on her left hand of occasional handling and fingering. Ms. Taylor stated that from a vocational rehabilitation standpoint, while Claimant had not acquired any transferrable

skills, she could perform unskilled or semi-skilled work. Ms. Taylor sent letters to Claimant about job openings within the light classification of work and within Claimant's restrictions between September of 2017 and February of 2018. From the record, it appears that Claimant did little in the way of responding to Ms. Taylor's communication, and admitted during her testimony that she did not pursue any of the opportunities from Ms. Taylor even though they could be performed with one hand or with an assist hand. Those jobs included host/hostess, switchboard operator, and patient assist representative, among others. Hence, it is clear that she has had opportunities to return to work within her ability, but has simply declined to do so.

I also note that Claimant testified that she had previously done some work caring for an elderly couple in a nursing home, not in the role of a CNA, but more as a companion, where she would sit with them, get them something to drink, and call for nurse assistance when needed.

In summary, although Claimant suffers significant limitations on the use of her left hand after her compensable injury, the evidence before me demonstrates that the primary reason Claimant did not return to work was unrelated to her physical limitations of her compensable hand injury, but due to her problems with depression and her back and neck conditions, which were not a part of her claim for her left hand compensable work injury. Hence, the preponderance of the evidence in this case does not demonstrate that because of her compensable injury of 2016, Claimant has the inability to earn meaningful wages.

Therefore, after considering all the evidence in this case impartially, without giving the benefit of the doubt to either party, I find that the claimant failed to prove by a preponderance of the credible evidence she is permanently totally disabled as a result of her compensable left hand injury of June 29, 2016.

C. Permanent and Total Disability for Left Shoulder:

Regarding Claimant's left shoulder injury, a permanent impairment rating is *not* a prerequisite to consider the effects of a compensable injury or injuries in a claim for permanent total disability. Rutherford v. Mid-Delta Community Services, Inc., 102 Ark. App. 317, 285 S.W.3d 248 (2008).

Here, Claimant does not have any restrictions whatsoever to her left shoulder. In fact, the medical records show that she achieved satisfactory results from her conservative treatment from Drs. Reynolds and Roman. On September 13, 2017, Dr. Reynolds pronounced her to be maximum medical improvement (MMI) for her left shoulder and opined that her adhesive capsulitis had resolved. He released her to return to work at full duty, with no physical work restrictions.

Based on all the foregoing and other probative evidence of record, I find that the Claimant has failed to establish that she is permanently and totally disabled as a result of her compensable injury to her left shoulder.

ORDER

For the reasons discussed herein, this claim for additional anatomical impairment, wage loss disability or permanent and total disability must be, and hereby is, respectfully denied in its entirety and dismissed.

IT IS SO ORDERED.

_____

KATIE ANDERSON
ADMINISTRATIVE LAW JUDGE