ARKANSAS COURT OF APPEALS
NOT DESIGNATED FOR PUBLICATION
SARAH J. HEFFLEY, JUDGE

DIVISION I

CA 07-563

December 19, 2007

RITTER COMMUNICATIONS
APPELLANT

APPEAL FROM THE ARKANSAS WORKERS' COMPENSATION COMMISSION [NO. F601584]

V.

ROGER RHEA
APPELLEE

AFFIRMED

The appellant, Ritter Communications, appeals a finding of the Workers' Compensation Commission that a second surgery is reasonable and necessary for the treatment of appellee's compensable injury. Appellant argues that substantial evidence does not support the Commission's decision. We affirm.

Appellee, Roger Rhea, is employed by appellant as a telecommunications technician. On January 20, 2006, appellee was installing wire from inside a cage that was perched atop a forklift, six feet off the ground, when the cage fell off the forklift. Appellee, who is right-hand dominant, sustained lacerations to the first, second, and third fingers of his left hand.[1] He was taken to the emergency room and received stitches in all three fingers.

[1] Appellee also injured his right shoulder, but this litigation does not involve that injury.

Most prominent was the laceration to appellee's left middle finger. Within days of the accident, he was seen by his family physician, who referred him to Dr. Henry Stroope, an orthopedic surgeon. Dr. Stroope reported in regards to the left middle finger an obvious transection of the flexor digitorum profundus tendon in Zone 2 with intact flexor digitorum superficialis function. He referred appellee to Dr. Michael Moore, a hand specialist, for consideration of the repair of the flexor digitorum profundus tendon.

On February 1, 2006, Dr. Moore performed surgery to repair the left long finger FDP tendon. Dr. Moore wrote the following in his operative report.

> Mr. Rhea is a pleasant gentleman who sustained a laceration over the volar aspect of the left long finger approximately 1 ½ weeks ago. Since this incident, he has not been able to flex the DIP joint. The sensation in his finger is intact. There is a transverse wound just proximal to the PIP joint flexion crease. The wound is clean and without evidence of infection. Mr. Rhea is admitted for repair of the left long finger FDP tendon. The indications, risk and potential complications of surgical treatment were discussed. The complications include but are not limited to neurovascular injury, infection, finger stiffness and reflex sympathetic dystrophy. In addition, Mr. Rhea understands that there is a chance that he may require a flexor tenolysis following healing of the flexor tendon.

Appellee was seen by Dr. Moore for follow-up care on February 6, 2006. Dr. Moore sent appellee to occupational therapy for PROM exercises as per the Duran protocol, which appellee attended three times a week from February 13 to February 24, and from April 5 to April 26.

Appellee was seen by Dr. Moore on February 16 and again on March 30. In a letter to appellant's plan administrator on March 30, Dr. Moore noted that it had been two months since appellee's surgery and that although his pain had subsided he still had residual stiffness in his fingers and limited active motion of the left long finger DIP joint. In another letter dated April 26, Dr. Moore wrote that appellee had regained full passive motion of the left long finger but that he

continued to have limited active motion in that finger. He discussed treatment options with appellee, which included accepting the final result of stiffness and limited active motion, or proceeding with a left long finger flexor tenolysis. Dr. Moore reported that appellee had chosen to undergo surgery which was planned for June.

At the request of appellant's plan administrator, appellee was seen by Dr. David M. Rhodes on June 5. Dr. Rhodes noted that appellee had an active range of motion of the left long finger of 0 to 82 degrees at the PIP joint with a passive range of motion there of 0 to 98 degrees. At the DIP joint, appellee had no active range of motion with a passive range of motion of 0 to 60 degrees. In terms of a plan, Dr. Rhodes stated in his report:

> I told the patient that there is a possibility of adhesion formation versus a possible failure of repair of the FDP tendon. I would recommend that the patient continue with therapy to possibly increase his range of motion. If after a few more months of therapy, he still lacks range of motion then he may opt for a tenolysis at that time.

Appellee returned to Dr. Moore for a check up on July 20, 2006. During this visit, Dr. Moore noted that appellee had completed his therapy program and that he continued to have limited active motion of the left long finger. Dr. Moore further noted that appellee desired to regain more motion in the left long finger and wanted to proceed with a flexor tenolysis. In a September 8 letter to the plan administrator, Dr. Moore wrote:

> Following surgery, he developed residual stiffness at the DIP joint, which is not uncommon following flexor tendon surgery. Mr. Rhea has completed therapy treatments.
>
> The treatment options at this point are to accept the final result or proceed with a left long finger flexor digitorum profundus tenolysis, which may improve the active motion of the finger. The surgery is elective in the sense that Mr. Rhea has the option of accepting the final result or proceeding with treatment that may improve the

> motion of the finger. He felt that the limited motion of the finger did significantly affect the function of his left hand. Therefore, he elected to proceed with the flexor tenloysis, which is a reasonable treatment option. In addition, the tenolysis is necessary in order to improve the motion of the left long finger. Mr. Rhea understands the risks of surgery, which include flexor tendon rupture, neurovascular injury, infection, and residual finger stiffness. Furthermore, he understands that the surgery may not significantly improve the motion in the long finger. Following a discussion of the treatment options and risk of surgery, Mr. Rhea felt the benefit of potentially improving the left long finger motion was worth the risk of surgery. These statements are made within a reasonable degree of medical certainty.

Dr. William C. Collins, who had thirty-five years of experience in hand surgery, reviewed appellee's medical records. In a one-page report written in October 2006, he expressed the following opinions:

> It is my considered opinion that any tendon repair may be offered a tenolysis to improve function, but in a patient with an intact and well functioning sublimis tendon the patient should be sure that he is willing to run the risk of actual decrease in the flexor function of this digit from additional surgery.
>
> If the patient were a guitar picker, violinist, or had other specific DIP joint needs, he might think it worth the risk, otherwise he might best be served by accepting this minimal limitation and substituting for this problem with other adaptive means.

The hearing before the administrative law judge was held on November 3, 2006. Appellee had returned to work, but he testified that the joint was stiff and that he was not able to touch his palm with his left middle finger. In describing his work, he stated:

> Every part of my job requires I use my hands. Manipulating small telephone wires into tight spaces, connect blocks, very small, delicate instruments and screws, connections in tight, very tight spaces, sometimes where you can't get in with your right hand, you have to use your left hand. You have to guarantee use of both left and right hands. I am right handed. I use both hands as a communications specialist. There is delicate work that is required

> in my job using my left hand. ... The dexterity involved with placing wires into connections and putting them into a form and connect box requires the use of all your fingers.

Appellee further testified that the lack of range of motion in his left long finger slowed him down in his work. He also said it was his understanding from the outset that two surgical procedures would be performed. Appellee understood that the tenolysis might not succeed and that the procedure may result in decreased range of motion, but he believed that the benefit of improving the range of motion in his finger would give him the ability to do his job better. Appellee also testified that therapy had helped, and he continued to do exercises at home. He was not aware that Dr. Rhodes had recommended more therapy before proceeding with surgery.

The administrative law judge found that the tenolysis procedure was reasonable and necessary for the treatment of appellee's injury, and the Commission affirmed and adopted that decision. Appellant contends that the Commission's decision is not supported by substantial evidence. Appellant argues that the surgery only has a chance of improving appellee's condition and that it might make his condition worse. Appellant also maintains that the better course of treatment was additional occupational therapy.

Under Arkansas law, the employer must "promptly provide for an injured employee such medical, surgical ... services and medicine as may be reasonably necessary in connection with the injury received by the employee." Ark. Code Ann. § 11-9-508(a) (Supp. 2007). The employee has the burden of proving by a preponderance of the evidence that medical treatment is reasonable and necessary. *Wal-Mart Stores, Inc. v. Brown,* 82 Ark. App. 600, 120 S.W.3d 153 (2000). What constitutes reasonably necessary treatment under the statute is a question of fact for the Commission to decide. *Hamilton v. Gregory Trucking,* 90 Ark. App. 248, 205 S.W.3d 181 (2005).

In reviewing decisions from the Commission, we view the evidence in the light most favorable to the Commission's findings, and we affirm if the decision is supported by substantial evidence. *Smith v. City of Fort Smith,* 84 Ark. App. 430, 143 S.W.3d 593 (2004). If reasonable minds could reach the conclusion of the Commission, its decision must be affirmed. *KII Construction Co. v. Crabtree,* 78 Ark. App. 222, 79 S.W.3d 414 (2002). The Commission has the authority to accept or reject medical opinions, and its resolution of the medical evidence has the force and effect of a jury verdict. *Poulan Weed Eater v. Marshall,* 79 Ark. App. 129, 84 S.W.3d 878 (2002).

In this case, appellee's injury and first surgical procedure left him with a marked decrease in the range of motion in his left middle finger that impaired his ability to perform his job. The Commission accepted the opinion of Dr. Moore that the tenolysis procedure was both reasonable and necessary, giving his opinion more weight than those offered by Drs. Rhodes and Collins, upon which appellant's argument relies. The Commission resolved the conflict in the medical evidence in appellee's favor, and thus we are not able to say that the Commission's decision is not supported by substantial evidence. Accordingly, we affirm.

Affirmed.

GLOVER and BAKER, JJ., agree.