

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F009656

CURTIS W. WALLACE,  
EMPLOYEE

CLAIMANT

UNITED HOIST & CRANE, INC.,  
EMPLOYER

RESPONDENT

ST. PAUL MERCURY INS. CO.,  
INSURANCE CARRIER

RESPONDENT

OPINION FILED JANUARY 26, 2005

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

Claimant represented by HONORABLE TERENCE JENSEN, Attorney  
at Law, Benton, Arkansas.

Respondents represented by HONORABLE JOSEPH KILPATRICK, JR.,  
Attorney at Law, Little Rock, Arkansas.

Decision of the Administrative Law Judge: Reversed.

OPINION AND ORDER

The respondents appeal an administrative law judge's opinion filed May 12, 2004. The administrative law judge found that the claimant proved additional medical treatment was reasonably necessary, "specifically treatment by a neurologist[.]" The administrative law judge also found that the claimant proved "his past treatment with Dr. Russell was reasonably necessary." After reviewing the entire record *de novo*, the Full Commission reverses the opinion of the administrative law judge. The Full Commission finds that the claimant did not prove he was entitled to additional treatment by a neurologist. We also find that the claimant

did not prove Dr. Russell's treatment was reasonably necessary in connection with the claimant's compensable injury.

I. HISTORY

The record indicates that Curtis Wallace, age 44, complained of neck pain, muscle soreness in his shoulders, and pain around his lower left hip and abdomen in November 1997. The claimant presented to Dr. Patricia G. McGarry on July 25, 2000. Dr. McGarry's notes appear to indicate that the claimant complained of a rash on his neck with pain and tingling.

The parties stipulated that the claimant sustained a compensable injury on August 23, 2000. The claimant testified:

Q. And when you were working, were you working on the ground? Were you in the air?

A. No, I was working - it was about 45, 50 foot up in the air and I was working using the scissor lift that, you know - it's about - it raises straight up, you know....

Q. Did you come in contact with some electrical wires?

A. Yes....Two 2 - they was four hundred - 480 volts and I had come in contact with two lines of it to the top of my head. I had two burns on the top of my head. So, they - so, it had to been two lines that got me, sucked me up in it, completely sucked me up and I lost consciousness....

Q. And you said you had burns on top of your head?

A. Yes, two.

Q. Okay. And did you have any other places on your body that -

A. Yeah. I had a hole in my chin....And then I also had one on my left elbow, where my left elbow had a hole like that too, a burn hole....

There are no medical records before the Commission contemporaneous with the claimant's compensable injury. The claimant saw Dr. Jim J. Moore, a neurological surgeon, on August 29, 2000:

The patient gives a history of an injury sustained on or about 8-23-00. He sustained a severe electric shock. The patient was on a crane repair and was going up, apparently 280 volts of wiring which apparently struck him in the head. He did not have on a hat. The patient has no recall of the electric shock. The only thing he remembers is going up to the work zone and the next thing he remembers is waking in his position where he had falled (sic) onto a scissors lift. The patient states that he had a visual blur of yellow for a matter of perhaps 30 to 60 seconds. In any event, he was evaluated in the emergency room by Dr. Marvin Liebovich. I have a copy of this report which indicates that the ECG was done and an x-ray of the right elbow was done which suggested the possibility of a small evulsion fracture. He has also (sic) Dr. William Joseph at St. Vincent's on two occasions. He ordered a CT of the brain. I have a report of this and this was dated 8-28-00. This was interpreted by Dr. Chism as being a normal or negative CT of the brain. The patient has some ongoing problems. He has a tremendous headache. He has had neck pain and he has had thoracic pain. He is wearing a sling for the right elbow injury and is to get orthopedic evaluation tomorrow by Dr. Richard Nix....

There was in 1998 an anterior cervical fusion at the VA Hospital....The patient tells me that the fourth and fifth digits of the right hand were affected at the time of his problem which would suggest that the level was C6/7....The patient also describes an MVA in 1999 which was treated with injection therapy both at Hot Springs and also by Dr. Valentine and from which he had good result. The patient's health has generally been otherwise good.

Dr. Moore did not report any "burn holes" on the claimant's body. The claimant saw Dr. Richard A. Nix on August 30, 2000:

Curtis Wallace was electrocuted 7 days ago at work when the top of his head struck a wire of about 500 volts. Is seeing Dr. Jim Moore for neck and back problems since this. He injured his right elbow and hip....

Dr. Nix assessed "traumatic olecranon bursitis right" and "contusion right hip." Dr. Nix treated the claimant conservatively and expected a "good recovery."

Dr. Moore noted on September 6, 2000:

Since I saw this patient initially, he has had a number of additional studies. The spine films, cervical and thoracic, showed no evidence of compression fracture. The cervical films do demonstrate the level of the previous ACF at the C5/6 level. The EEG as interpreted by Dr. Rutherford is considered to be a normal awake and asleep recording. The patient, as best I can tell, is subjectively better. He has seen Dr. Nix who feels that he has a bursitis rather than an evulsion fracture and apparently is scheduled to see him again in about another week....

At this point I don't think that anything should be necessarily recommended....I will still recommend that he remain in an off work status

although at a progressively increasing physical activity level.

Dr. Nix saw the claimant on September 13, 2000 and observed "full shoulder motion with no crepitus....Previous x-rays showed no discreet fracture, only a small calcific density at the triceps insertion." Dr. Nix assessed "traumatic olecranon bursitis, improved."

The claimant also continued to follow up with Dr. Moore, who arranged conservative treatment.

Dr. Moore referred the claimant to Dr. George T. Schroeder, an ophthalmic surgeon, who began treating the claimant on October 18, 2000. Dr. Schroeder wrote on October 20, 2000 that the claimant had findings "consistent with early development of electric cataracts, consistent with his history of injury. He may be becoming presbyopic but it is more likely that musculoskeletal factors, most reasonably attributable to his injury, are the chief cause for his headache; we did not find anything in his refraction or extraocular muscle exam that would be an apparent cause for an eyestrain headache."

The claimant returned to Dr. McGarry on October 27, 2000, with a chief complaint of left shoulder pain. Dr. McGarry's notes at that time appeared to indicate that the

claimant had reportedly injured his left shoulder and neck 7-10 days earlier.

The claimant returned to Dr. Nix on October 30, 2000 "for evaluation of his left shoulder, hip, and knee. He has had continued problems in this area and symptoms seem a bit worse than his prior visit. No complaints about the prior olecranon bursitis, which appears to have resolved. His original electrical shock was 480 volts." Dr. Nix assessed "multiple foci of pain. With his electrical shock, must rule out rotator cuff damage."

The impression from an AR/MR of the left shoulder taken November 6, 2000 was "mild subacromial bursitis" and "mild impingement with a Neer Type III acromion process."

Dr. Moore stated on November 8, 2000, "although I do not feel that the patient's complaints are other than musculoligamentous in origin, especially in view of the previous problems he has had in the cervical area, I will go ahead and order a cervical MRI on him."

The impression from an MRI of the cervical spine taken November 14, 2000 was "Interbody fusion C5/C6. Mild posterior bulges are seen at C4/C5 and C6/C7. Mild disc desiccation is present at these levels. Moderate bony neural foraminal narrowing on the right at C3/C4."

Dr. Moore noted on November 28, 2000, "The MRI is obtained, shows the evidence of the previous interbody fusion but no evidence of disc herniation. There is some foraminal narrowing at C3-C4 on the right....At this point, depending on what Dr. Nix has to say, I think he could be returned to some limited activities of work in the 25-pound weight range." The record contains the following Addendum from Dr. Moore:

Shortly after I prepared the 11-28 report, the patient advanced a concern about shooting jerking electric type pains in the extremities, upper and lower, right and left greater in lowers. There is no warning and he is fearful of falling. Neurologically there is nothing obvious. I arranged for a sampling EMG/NCV upper and lower to be done by Dr. Rutherford. The study was done the same day. Dr. Rutherford reported that it was a normal study. My opinions as stated are unchanged.

The claimant returned to Dr. Nix on December 11, 2000:

He has complaints of pain in left shoulder, left hip, and left knee anteriorly. Previous MRI showed subacromial bursitis and type III acromion....X-rays of left shoulder, left hip, and left knee appear normal.

Dr. Nix assessed "left traumatic subacromial bursitis."

Dr. Moore noted on January 2, 2001:

The last report on this patient was 11-28. Since that time he has seen Dr. Nix which was on December 11 at which time he advised that there were some problems with the rotator cuff in the left shoulder and Dr. Nix suggested injected (sic) the shoulder without any relief....The patient also advised Dr. Nix that he was having left knee

symptoms at which time radiographs were obtained and apparently some further investigation is being considered from the orthopedic standpoint. The patient also complains that the right shoulder is also symptomatic and that he has a bursal tear in the right elbow. On palpation today there is a small nodularity, tender at the level of the olecranon....

At this particular point, I am not sure there is much justification in pursuing anything neurosurgical. It would appear that the majority of the problems are going to have to be resolved from the orthopedic standpoint which is Dr. Nix' specialty. I will defer to him at this time. Unless something additional changes I will hold any return evaluation leaving this to his ongoing orthopedic assessment and treatment. On (sic) additional factor is that the pain medication (Lortab) will have to be determined by Dr. Nix. I do not feel there is any neurosurgical justification for its continued use.

The claimant was examined by another orthopedic specialist, Dr. Norman Sims, on May 9, 2001. Dr. Sims wrote on June 27, 2001:

Mr. Wallace returned today after the follow up visit of May 9, 2001. On that visit, he complained of bilateral shoulder pain secondary to an electric shock injury in August of 2000. At physical examination on that date, the day that I saw him, on May 9, was well within normal limits. I ordered x-rays on that day and he subsequently went to the x-ray examination. I have reviewed those x-rays and they are found to be entirely within normal limits. Mr. Wallace has a hard time accepting the fact that there are no physical findings to justify his pain pattern. I talked to Dr. Nazarian about whether there is anybody available to see this patient because of his overwhelming complaints which have no physical justification. Dr. Nazarian suggested that the patient be referred to Mental Health to see,

specifically, Dr. Clothier. An appointment will be made for that referral.

The record indicates that the claimant missed a subsequent mental health appointment.

On July 24, 2001, Dr. Ayman Abdel-Halim, a pain manager, diagnosed "spondylolisthesis." Dr. Abdel-Halim stated on November 20, 2001, "s/p Electric shock August 23, 2000. The patient had been seen by Neurosurgery, Ortho (DR SIMS) and myself. UNFORTUNATELY the cause of the Pain is not determined yet."

Dr. Johnny K. Smelz saw the claimant on March 21, 2002, and planned additional diagnostic testing.

A neurosurgeon, Dr. Anthony E. Russell, noted on October 23, 2002, "Curtis Wallace returns today after a lengthy absence. This is a gentleman who apparently has a history of polyneuropathy as well as a given diagnosis of fibromyalgia. He has not had any recent studies....We will plan to have him undergo EMG and nerve conduction studies by Dr. McCoy and return afterwards for review."

Dr. Russell noted on November 25, 2002 that EMG and nerve conduction studies "were consistent with a chronic right C5/6 radiculopathy but no polyneuropathy....In light of this further evaluation of the spine will need to be

performed. We will plan to have him undergo a cervical myelogram and returns (sic) afterwards for review."

Dr. Russell wrote on December 9, 2002:

Curtis Wallace is a gentleman who is being followed in this neurosurgery clinic for chronic pain. This gentleman's history is significant for having been involved in an electrocution like incident at work. Apparently he came in contact with an electrical source on the top of his head. Since that time he has had multiple areas of pain and tenderness throughout the body. A particular problem is the right shoulder area, which is quite painful and also experiences weakness. This history is consistent with a polyneuropathy/fibromyalgia type picture.

We recently performed CT myelogram on Mr. Wallace. This study shows a foraminal nerve root compression at C3-4 on the right, which would account for some of the shoulder pain. On the other hand this does not explain the multiple areas of tenderness in the muscles, joints and tendons.

The literature indicates that patients who have suffered electrical injuries will typically develop a process similar to fibromyalgia, which actually mimics an autoimmune disease. Mr. Wallace currently has nothing that would require surgical intervention at this point. Instead I would like to have him evaluated by someone in pain management who may be better able to treat the symptoms of the problem as well as alleviate the underlying source. We will attempt to have this scheduled from this office. I have not scheduled a routine follow-up for Mr. Wallace here. I am convinced that the patient is sincere in his complaints. I did let him know that once the major source of pain has resolved he can recontact this office so that we can address the right shoulder pain, which clearly is related to the nerve root compression at the level of the C3-4 foramen on the right.

Dr. Mahmood Ahmad, a pain medicine specialist, wrote on July 17, 2003, "The above-mentioned patient is under my treatment for management of his chronic pain syndrome since January 3, 2003. He suffers from chronic neck and shoulder pain which is due to an underlying disc herniation at the C4 level. This resulted from an electrocution injury when a violent abnormal movement of his neck occurred." Dr. Ahmad recommended "spinal cord stimulation."

Dr. Russell noted on August 1, 2003, "He has had a complete trial of conservative therapy with Dr. Ahuad (sic) at Southwest Hospital. Apparently his pain specialist has recommended that he undergo a stimulator implant. Before proceeding with this I would like to make absolutely certain that we are not dealing with a fixed lesion that may require resection or may be causing direct spinal cord or nerve root compression....We will plan to proceed with both cervical and lumbar MRI scan as soon as possible."

Dr. Russell assessed the following on August 11, 2003:

MRI of the lumbar spine shows a grade I-II spondylolisthesis of L5 on S1. This is causing clear compression of the L5 nerve roots at the level of the foramen. This does appear to be significant compression and correlates quite nicely with his ongoing symptoms.

In the cervical region the fusion appears to be adequate. The levels above and below the fusion appear to be deteriorating but there is no evidence of a nerve root compression or spinal

cord compressive lesion at either of these levels. I indicated to Mr. Wallace that I see nothing on his current cervical studies that would lend itself to any further intervention from a surgical standpoint. On the other hand he continues to have pain down both arms in what appears to be an ulnar like distribution on the left, which has become aggressively more severe as time has progressed....The studies performed by Dr. McCoy were consistent with a C5 and C6 radiculopathy on the right, but apparently the left side at that time either was not tested or was normal. In any event, I believe that in order to document progression we need to repeat the EMG and nerve conduction studies. We will plan to do this within the next few weeks so that we can formalize a final plan for treatment.

A pre-hearing order was filed with the Commission on January 12, 2004. The claimant contended, among other things, that he was entitled to "payment of medical benefits incurred in the past" and "additional medical treatment." The respondents contended that the claimant "was fully treated for his on-the-job injuries and was released to return to work on February 8, 2001, with no restrictions."

The claimant returned to Dr. Russell on March 15, 2004:

Unfortunately this gentleman who suffered an electrocution injury is still having significant pain in his shoulders, arm, neck, back and both legs. This despite adequate pain medication. The cervical myelogram was positive for disk protrusion but the patient's symptoms appear to be more of a C8 dermatome pattern, rather than a C6/7. The patient also complains of severe muscle pain throughout his body as well as recent visual changes. The patient indicates that none of this was present prior to the injury that occurred some time ago. At this point I am going to have Mr. Wallace see a neurologist to determine if there is

any muscle injury that may have been brought about by the electrocution injury that may be treatable. He may require muscle biopsy. Further medications may be necessary. He may require further surgery of the cervical spine as well. We know that he has a spondylolisthesis in the low back, but at this time that does not seem to be a major problem. Because of my upcoming retirement I will not see Mr. Wallace in follow-up, but he will be able to see someone in follow-up through this clinic should the need arise.

The parties deposed Dr. Russell on March 22, 2004. The claimant's attorney questioned Dr. Russell:

Q. What would be the benefit of seeing a neurologist at this point in time, Doctor?

A. Well, neurologists are typically going to treat - there are types of people that will treat chronic pain. Neurologists can treat them if they're neuropathic in nature, and his sounded neuropathic. Chronic pain from arthritis and things like that, I generally send them to just a pain specialist, rather than a neurologist. But I also wanted to get the neurologist's input, to see if maybe there was some type of muscle disease or something that I had missed, because that's not my area of expertise. I thought they might want a muscle biopsy, a nerve biopsy, or something like that, to look and see if there was some type of process going on that might be causing all this.

Q. Okay, sir. Mr. Wallace was injured August 23<sup>rd</sup> of 2000, when he contacted some electrical - he went into an electrical wire, and may have fallen a distance. What findings do you attribute to the electrical injury of Mr. Wallace?

A. Well, it's hard to say. I mean, there are no real fixed injuries on him that have objective, clear-cut evidence of anything that I can say, within reasonable medical certainty, came directly from the electrical injury. Typically, electrical injuries, you know, it's a rapid burst of electricity through there. If it blows a hand off

or something, then you would see that. But if it just shoots the electricity through you, a lot of times, it doesn't leave a trace, and then all you've got are subjective things like pain, muscle injury and things like that, that really you have no way of diagnosing to know what the source of the pain is. So in his case, I was never really able to pinpoint anything that I could say, with a reasonable degree of certainty, was directly related to the electrical injury on him.

Q. All right. Did you find any objective findings, other than the C-5/6 area?

A. The C-5/6 area was the previous fusion area?

Q. Right.

A. The spondylolisthesis is something that I think - and I warned him, will need to be addressed at some point. That's a chronic process. That's not something that was caused by the electrical injury. That's been there for life. As far as the neck goes, I think the radiologist, in their report they mentioned some bulging and things like that, but other than that, I really didn't see anything....

Q. Well, the pain that Mr. Wallace is having, do you think that was caused by the electrical injury?

A. Based on his history, yes.

Q. And the only objective findings we would have to show that he sustained an injury, would just be the exit wound from the electrical current?

A. That would be it. I think that, you know, for completeness sake, because we are dealing with something that has very few objective findings, I think you - I hate to bring this up, but a complete neuropsych battery may be the best thing you could do, to determine if there are any subtle (sic) chronic changes, you know, as far as pain and things of that nature go....

The respondents' attorney questioned Dr. Russell:

Q. And as I understood your testimony, you have no objective findings of an electrical injury?

A. Not at the time that I saw him, no.

Q. And none since that time?

A. No.

Q. And no objective basis for any kind of permanent impairment for any electrical injury?

A. No.

Q. What you have are his complaints of pain; is that correct?

A. Subjective complaints of pain, yes.

Q. And his complaints have moved from - moved about in his body; isn't that correct?

A. Correct.

Q. They don't follow any kind of dermatomal pattern, that you can say it's coming from this spot or that spot; is that correct?

A. I haven't been able to attribute him to a specific nerve root or anything of that nature, no.

Q. And the neck problems, and the low-back problems are not related to any kind of electrical injury?

A. The fusion in his neck and the spondylolisthesis are not, no.

After a hearing before the Commission, the administrative law judge found that additional medical treatment by an ophthalmologist was reasonably necessary in

connection with the claimant's compensable injury. The respondents do not appeal this finding. The ALJ found, "The claimant has proven by a preponderance of the evidence that additional medical treatment, specifically treatment by a neurologist, is reasonably necessary in connection with his compensable injury." The ALJ also found, "The claimant has proven by a preponderance of the evidence that his past treatment with Dr. Russell was reasonably necessary in connection with his compensable injury." The respondents appeal the last two findings to the Full Commission.

## II. ADJUDICATION

\_\_\_\_\_An employer must promptly provide such medical treatment as may be reasonably necessary in connection with the injury received by the employee. Ark. Code Ann. §11-9-508(a). The claimant must prove by a preponderance of the evidence that he is entitled to additional medical treatment. Morrow v. Mulberry Lumber Co., 5 Ark. App. 260, 635 S.W.2d 283 (1982). What constitutes reasonably necessary medical treatment is a question of fact for the Commission. Wright Contracting Co. v. Randall, 12 Ark. App. 358, 676 S.W.2d 750 (1984).

In the present matter, the Full Commission reverses the administrative law judge's finding that the claimant proved he was entitled to treatment from Dr. Russell and additional

neurological treatment. The claimant has a prior history of multi-focal physical pain. The claimant sustained a compensable injury on August 23, 2000. The claimant testified that he received two electric "burns" on top of his head, a "hole" in his chin, and another "hole" in his left elbow. The medical records corroborate none of the claimant's testimony in this regard. There are no medical records before the Commission contemporaneous with the August 23, 2000 compensable injury. The claimant did report a "severe electric shock" to Dr. Moore, but Dr. Moore did not describe any holes or burn marks on the claimant's body. The ALJ determined that VA medical records corroborated the existence of a "scar" on the claimant's chin. The ALJ was apparently referring to two nurses' notes found at CX 1, p. 44-45, where it was written, "PT has scar on his chin where electrical current came out through chin." The Full Commission finds that these March 2001 nurses' notes are based on the claimant's inaccurate history and are entitled to no probative weight. There is no probative evidence before the Commission indicating that the claimant received any sort of "burns," "holes," or "scars" as a result of the August 23, 2000 injury. Nor is there any evidence of trauma to the claimant's head.

In any event, Dr. Moore reported on August 29, 2000 that a post-injury CT of the brain had been normal. Dr. Moore reported that the claimant had a "small evulsion fracture" on his right elbow. Dr. Nix subsequently assessed bursitis in the claimant's elbow along with a right-hip contusion. Dr. Moore wrote in September 2000 that the claimant had not re-fractured his cervical spine ( after a reported 1998 injury), and that an EEG performed by Dr. Rutherford was normal. A November 2000 MRI showed bursitis and a mild impingement in the claimant's left shoulder - no surgery was recommended for this condition. A November MRI showed the prior fusion and bulging in the claimant's cervical spine. The Commission also notes that with regard to the claimant's arm and leg muscles, an EMG/NCV performed by Dr. Rutherford in November 2000 was normal.

Dr. Moore stated in January 2001 that there was no justification "in pursuing anything neurosurgical." An orthopedist, Dr. Sims, could find nothing in June 2001 to justify the claimant's pain symptoms. Dr. Abdel-Halim in November 2001 could not determine the cause of the claimant's pain. We note that Dr. Smelz planned more diagnostic testing in March 2002, but the claimant chose not to follow up with Dr. Smelz.

The Full Commission finds that the claimant's condition resulting from his compensable injury resolved no later than March 21, 2002, after he ceased treating with Dr. Smelz. The treatment provided by Dr. Russell beginning in October 2002 was not reasonably necessary in connection with the claimant's compensable injury. The Full Commission notes that Dr. Russell proposed additional diagnostic testing to ensure the claimant had no muscle abnormalities as a result of the compensable injury, but such diagnostic testing had already been carried out by Dr. Rutherford in November 2000, and the claimant's condition was found to be normal. Dr. Moore, a neurological surgeon and the first primary treating physician, did not recommend further "neurological" treatment. Dr. Russell agreed that the claimant's neck and back were not harmed in the 2000 injury. Dr. Russell also agreed that his assessment of an "electrical injury" was based primarily on the claimant's history, which history the record shows was not credible. The preponderance of evidence demonstrates that the respondent-employer promptly provided the claimant all reasonably necessary medical treatment in connection with the claimant's compensable injury. The claimant has not proved that he is entitled to additional medical treatment for his compensable injury.

Based on our *de novo* review of the entire record, the Full Commission finds that the claimant did not prove by a preponderance of the evidence that he was entitled to additional neurological treatment. We also find that the claimant did not prove that Dr. Russell's treatment was reasonably necessary in connection with the claimant's compensable injury. We therefore reverse the administrative law judge's findings in that regard. This claim is denied and dismissed.

IT IS SO ORDERED.

\_\_\_\_\_  
OLAN W. REEVES, Chairman

\_\_\_\_\_  
KAREN H. MCKINNEY, Commissioner

Commissioner Turner dissents.

**DISSENTING OPINION**

I respectfully dissent from the majority opinion. I find that claimant is entitled to the recommended treatment by a neurologist and that his past treatment with

Dr. Russell was reasonable necessary to treat his compensable injury.

In assessing whether a given medical procedure is reasonably necessary for treatment of the compensable injury, we analyze both the proposed procedure and the condition it seeks to remedy. Deborah Jones v. Seba, Inc., Full Commission Opinion filed December 13, 1989 (D513553).

Treatment intended to reduce or enable a claimant to cope with chronic pain attributable to a compensable injury may constitute reasonably necessary medical treatment within the meaning of Ark. Code Ann. § 11-9-508. Billy Chronister v. Lavaca Vault, Full Commission Opinion filed June 20, 1991 (D704562). While the results obtained may be a consideration in some cases, the primary considerations are the nature of the service in relation to the compensable injury. Tonnie Crisp v. Weyerhaeuser Corporation, Full Commission Opinion filed July 27, 1993 (D812922). Moreover, the compensability or non-compensability of medical services is not dependent on a retrospective evaluation of the results obtained from the service. Joyce Hager v. St. Edward Mercy Medical Center, Full Commission Opinion filed July 25, 1990 (D408662).

Claimant has complained of wide-spread pain since being electrically shocked. Dr. Russell has opined that

these complaints are typical of patients who have been electrically injured. After being unable to identify the source of claimant's pain, Dr. Russell has recommended that claimant see a neurologist for evaluation of muscle disease or injury. Claimant has not yet undergone the recommended muscular evaluation and has not been evaluated by a physician specializing in electrical shock injuries.

In denying additional medical treatment, the majority opinion references pain that claimant experienced prior to this injury. I find that the majority errs in finding that claimant's current widespread pain is a continuation of his previous localized pain. This previous pain, primarily around his neck and shoulders, is clearly distinguishable from the total body pain that claimant has experienced since his injury. In fact, Dr. Russell has opined that some of his current neck and shoulder pain is contributable to a prior neck surgery and related spondylolisthesis. However, the origin of claimant's widespread pain is still unknown, other than beginning after claimant incurred the electrical shock.

The majority has also referenced Dr. Moore's opinion that claimant did not need any further "neurosurgical" treatment. However, the majority later interpreted Dr. Moore's opinion as not recommending further

"neurological" treatment. It is a great leap in analysis to conclude that because a claimant is not a candidate for neurosurgery, that he or she is not entitled to any further treatment by a neurologist.

Most astounding is the majority's conclusion that claimant is not credible because there are no records supporting his electrical shock injury and his account of the related exit wounds. The parties do not even dispute that claimant incurred a compensable injury, yet the majority boldly denies this event and turns it into a credibility issue. In fact, the pre-hearing order states that the parties stipulated that claimant incurred a compensable injury on August 23, 2000. The majority's willingness to make findings clearly contrary to the parties' stipulation is troubling.

In conclusion, I find that the majority has erred in denying compensation for Dr. Russell's treatment and additional neurological treatment because claimant's condition has yet to be adequately diagnosed or treated. It is well settled within the medical community, as noted by Dr. Russell, that electrical shock injuries are difficult to trace. Nonetheless, claimant is undoubtedly having continued widespread pain as a result of the admittedly compensable injury. As such, I find that Dr. Russell's

treatment was reasonably necessary and that claimant is entitled to additional medical treatment.

For these reasons, I dissent.

SHELBY W. TURNER, Commissioner