OPINION ENTERED: NOVEMBER 16, 2012

CLAIM NO. 201199926

JOHNNY PHILPOT PETITIONER

VS. **APPEAL FROM HON. GRANT S. ROARK, ADMINISTRATIVE LAW JUDGE**

COMMONWEALTH OF KENTUCKY
DEPARTMENT OF TRANSPORTATION
and HON. GRANT S. ROARK,
ADMINISTRATIVE LAW JUDGE RESPONDENTS

OPINION
AFFIRMING

* * * * * *

BEFORE: ALVEY, Chairman, STIVERS and SMITH, Members.

SMITH, Member. Johnny Lee Philpot, Jr. ("Philpot") appeals from the June 4, 2012 Opinion, Order and Award rendered by Hon. Grant S. Roark, Administrative Law Judge ("ALJ"), and from the ALJ's July 6, 2012 order denying his petition for reconsideration. The sole issue on appeal is whether the ALJ erred in finding the Kentucky Department of Transportation ("KYTC") was not responsible for bariatric surgery. We disagree and affirm.

Philpot filed his Application for Resolution of Injury Claim on August 19, 2011, alleging an injury to his low back on December 12, 2010, when he fell across a guardrail.

During the pendency of the claim, Philpot filed a medical fee dispute on November 8, 2011, requesting KYTC be required to approve bariatric surgery so that he could lose sufficient weight to enable him to undergo back surgery recommended by Dr. Amr El-Naggar.

In response, KYTC filed a medical fee dispute on December 27, 2011, indicating it received a report from Dr. Banerjee stating no aggressive medical, surgical or chiropractic treatment, epidural blocks or any operation was needed for the injury. KYTC indicated it was contesting compensability of all medical treatment related to the alleged work injury.

Philpot testified by deposition on October 26, 2011 and at the hearing held April 3, 2012. He acknowledged having back problems prior to the work injury but stated “it would ease up to where I could tolerate it.” He stated he had continuing pain in his back since December 13, 2010. He had tried to lose weight in the past but was never able to do so. He noted Dr. El-Naggar suggested he undergo bariatric treatment. Philpot planned to have bariatric surgery but

his insurance was canceled and he had no funds to pay for it.

At the hearing, Philpot testified Dr. El-Naggar indicated back surgery could not be performed until Philpot lost 100 pounds. When asked why he delayed having bariatric surgery, Philpot stated:

> Well, of the time whenever my back had started hurting me, you know, like, flare-ups and stuff like that, it would just go away. You know, the pain would go away until it was tolerable. It wouldn't go away 100%, but – and I just – just – just blowed [sic] it off and didn't do it.

Treatment notes from Dr. William Brooks in 2005, indicate Philpot reported a one year history of lower back and right leg pain. Dr. Brooks diagnosed disc degeneration and recommended bypass surgery. Philpot returned in June 2009 reporting a six year history of lower back and hip pain related to a 2005 work injury. Dr. Brooks diagnosed degenerative disc disease at L4–5 and morbid obesity. Dr. Brooks opined Philpot would continue to have problems unless he lost weight. Dr. Brooks noted Philpot had been on multiple diets to no avail and, therefore, bariatric surgery was clearly, medically indicated. Dr. Brooks stated “if he does not get his weight shed, I fear he will continue to deteriorate and may require surgery which would undoubtedly

condemn him to disability retirement." On May 13, 2010, Dr. Brooks again recommended weight reduction and bariatric surgery. Dr. Brooks noted Philpot had been diagnosed with "degenerative disc disease over which morbid obesity had been placed, causing him a lot of back pain."

A September 2010 report from Dr. Amr El-Naggar indicates Philpot presented with low back pain resulting from a lumbar injury in 2005 sustained while Philpot was working for KYTC. Dr. El-Naggar diagnosed lumbar degenerative disc disease, low back pain, lumbar radiculopathy, and joint pain. He saw again Philpot February 21, 2011 following a new MRI and x-rays. Philpot reported low back and bilateral leg pain with numbness in the bottom of his right foot. No mention was made of the December 12, 2012 work injury. Dr. El-Naggar reviewed the recent MRI and indicated Philpot would be considered for L4–5 posterior lumbar interbody fusion if he did not improve after epidural steroid injections. Dr. El-Naggar noted Philpot needed to lose 80 pounds before being considered for surgery. In September 2011, Dr. El-Naggar recommended Philpot lose 100 pounds before he would consider proceeding with the L4–5 fusion.

Dr. Timir Banerjee evaluated Philpot on March 30, 2011. He noted Philpot had been treated for back pain continually

since 2003. He also noted that on May 13, 2010 Dr. Brooks indicated degenerative disc disease and obesity were causing Philpot's pain symptoms and he had suggested surgery and steroid injections. Dr. Banerjee opined Philpot's medical condition was not caused by the work injury. However, he noted progressive changes in the back was due to excessive weight and diabetic neuropathy. He noted the 2009 MRI was similar to Philpot's most recent MRI.

Dr. Banerjee found no evidence of disc herniation or nerve root compression. He concluded Philpot was at maximum medical improvement ("MMI") with regard to temporary dysfunction related to a lumbar sprain. He assigned a 12% impairment for a lumbar condition existing since at least 2005. He also assigned 0% impairment for the work injury, objectively, but stated he would assigned 3% impairment rating for complaints of pain pursuant to the AMA Guides. In April 2011, Dr. Banerjee indicated 50% of the 3% impairment for pain was due to the work injury. In an addendum, Dr. Banerjee indicated Philpot sustained no harmful change as evidenced by objective medical findings with regard to the work injury.

Dr. David Muffly performed an orthopedic evaluation on November 17, 2011. He reviewed lumbar spine MRI films from April 2, 2009 and January 10, 2011, which revealed

degenerative disc disease changes at L4–5 and L5–S1. He noted progression of findings at the L4–5 disc level. Dr. Muffly diagnosed lumbar degenerative disc disease and lumbar radiculopathy associated with disc protrusion at L4–5 causing nerve impingement. He concluded Philpot sustained a worsening of his condition due to the work injury. Dr. Muffly assigned a 16% impairment rating pursuant to the AMA Guides of which 50% attributed to a pre-existing active condition. He recommended continued treatment which would likely require surgery. He placed Philpot at MMI as of the date of his examination.

Dr. Timothy Kriss evaluated Philpot on February 20, 2012. Philpot reported a history of a prior lumbar work-related injury sustained in 2005 with flare-ups that always completely resolved. Dr. Kriss noted the medical records indicated otherwise. Noting Philpot weighed 395 pounds, Dr. Kriss concluded Philpot's most serious medical condition was morbid obesity which caused almost all of his other serious medical conditions including diabetes, hypertension, hyperlipidemia, obstructive sleep apnea, low back pain and accelerated degenerative changes. Dr. Kriss noted Dr. Brooks had been treating Philpot since 2005 and had recommended gastric bypass surgery. Dr. Kriss stated virtually every treating doctor had strongly recommended

weight loss as the primary means to treat Philpot's back pain. He assigned a 7% impairment pursuant to the AMA Guides for a pre-existing active condition of back pain that had required substantial treatment for almost a decade.

Dr. Kriss found no objective evidence of radiculopathy and no worsening of condition attributable to the work injury. He concluded Philpot's morbid obesity and associated medical conditions were progressively disabling him. The slip and fall incident resulted in a temporary exacerbation of a long-standing, pre-existing, active multifactorial lumbar condition attributable to the 2005 lumbar injury.

Philpot presented at the Baptist Regional Medical Center emergency room on December 13, 2010, and was diagnosed with a contusion to the low back and acute exacerbation of chronic back pain attributable to a work incident. He was taken off work and released to return to work on December 15, 2010.

In the June 4, 2012 opinion, the ALJ found Philpot had a pre-existing, active lumbar condition unrelated to his work injury or activities but sustained a new additional impairment and injury due to the accident on December 12, 2010. The ALJ determined the work injury caused an 8% functional impairment rating. He concluded Philpot was

entitled to medical treatment pursuant to KRS 342.020 for his lumbar condition including recommended lumbar epidural steroid injections. However, the ALJ found the proposed lap-band or gastric bypass surgery was not work-related or compensable. The ALJ's June 4, 2012 Opinion, Order and Award stated as follows:

> Having determined that plaintiff suffered a new lumbar injury on December 13, 2010, it follows that he is entitled to medical treatment for that condition since that date, including the recommended lumbar epidural steroid injections. In this respect, the defendant employer's medical fee disputes are resolved in favor of the plaintiff. However, with respect to any proposed lap–band or gastric by–pass surgery to reduce plaintiff's weight, it is determined any such surgery would not be work–related or compensable as the medical records clearly establish such surgery was recommended for plaintiff's prior, active condition and, as such, is not due to the effects of the work injury and is not compensable.

Philpot filed a petition for reconsideration on June 14, 2012, arguing no lumbar surgery had been recommended until Dr. El-Nagger did so in 2011, and the necessity of lap band or bypass surgery at this time is to prepare him for compensable spinal surgery. Thus, Philpot argued the necessity for the bariatric surgery was directly related to the recommended fusion surgery.

The ALJ rendered an order on July 6, 2012 ruling as follows:

> Plaintiff's Petition for Reconsideration is **DISMISSED**. In dismissing the petition for reconsideration the ALJ finds that Plaintiff was recommended to undergo this procedure to treat his morbid obesity (weighing upwards of 400 pounds) five years before the December 12, 2010 work injury. Furthermore, seven months before the work injury he was again recommended to undergo gastric bypass surgery for weight loss. Plaintiff failed to undergo this procedure but instead "just blowed [sic] it off." (Final Hearing Transcript, pg. 17) He then suffered an injury on December 12, 2010. His weight has remained relatively consistent with his pre-injury weight, and based on medical records he actually lost seven pounds following his work injury. (Kriss, pg. 19) The proposed gastric bypass surgery has not been recommended to treat any condition related to the work injury. Instead it has been recommended consistently for a period of five years to treat Plaintiff's morbid obesity which is wholly unrelated to the work injury and has not been worsened by his work injury. The evidence confirms that the injury has had no effect on his morbid obesity. As a result, the requested bypass surgery is deemed to be not related to treat the effects of the work injury and not compensable pursuant to KRS 342.020.

On appeal, Philpot argues KYTC should be ordered to pre-certify the bariatric surgery in order to promote his weight loss as a prerequisite to the lumbar fusion surgery.

Philpot states he was unable to find any appellate case in Kentucky directly on point. Thus, he relies upon the Board's opinion in Blue Chips Installation, Inc. v. Steven C. Denniston, DWC Nos. 02–97692 and 02–84410, rendered February 18, 2005. That case involved the compensability of dental treatment needed as a prerequisite to low back surgery. Philpot argues that, in the case *sub judice*, the fact bariatric surgery had been recommended prior to the injury begs the question. He argues the prior recommendation is not dispositive. He also notes the need for bariatric surgery at present is to enable him to undergo the lumbar fusion surgery recommended by Dr. El-Naggar.

Philpot argues the prior recommendation of bariatric surgery does not equate to the surgery being required. He contends that, prior to the work injury, the surgery was optional and now it is mandated. Philpot notes he will not be allowed to undergo the fusion surgery to optimize his recovery from the work injury until he has the bariatric procedure and loses the necessary weight.

The Board's decision in Blue Chips, *supra*, provides useful guidance and an account of authority from other jurisdictions. In that decision, this Board stated as follows:

Both parties have done a commendable job in citing to the extraterritorial authority available to inform our decision on this issue. We will begin, however, by noting the statutory authority for an award of medical benefits in Kentucky. KRS 342.020(1) provides, in pertinent part, as follows:

> In addition to all other compensation provided in this chapter, the employer shall pay for the cure and relief from the effects of an injury or occupational disease the medical, surgical, and hospital treatment, including nursing, medical, and surgical supplies and appliances, as may reasonably be required at the time of the injury and thereafter during disability, or as may be required for the cure and treatment of an occupational disease.

KRS 342.0011(15) defines "medical services" to mean "medical surgical, dental, hospital, nursing, and medical rehabilitation services. . . ." and KRS 342.0011(32) defines "physician" to include dentists among other healthcare providers. Thus, it is clear that the expense of dental treatment may be assigned to the employer if such treatment is reasonably required for the cure and relief from the effects of a work injury.

In the case *sub judice*, it is undisputed that the dental condition for which Denniston requires treatment before he may undergo surgery was not caused by his work for Blue Chips. Instead, Denniston's theory of recovery and the ALJ's award of benefits, rests on the principle that the employer

takes the employee as it finds him. This principle is acknowledged in Quality Wood Products Corp. v. The Industrial Commission, et.al., 97 Ill.2d 417, 454 N.E.2d 668, 73 Ill. Dec. 571 (1983), relied upon by Blue Chips herein. Blue Chips' reliance is misplaced, inasmuch as the evidence in Quality Wood, supra, showed that the noncompensable, ancillary conditions for which the claimant was treated during his hospitalization were "not connected with" his work-related lumbar fracture. Id. at 423. There is nothing in the record summarized by the Illinois high court to suggest that the treatment of the claimant's non-work-related conditions was a prerequisite or otherwise related to the surgery he required to address his work-related lumbar fracture. Where treatment of a non-work-related condition is concurrent with but discrete from treatment of a work-related injury, we would agree that the former is not the responsibility of the employer. That is not the case here, however.

It is undisputed that Denniston's dental condition must be addressed before he may undergo surgery that is reasonable and necessary for the cure and relief of his work-related low back injury. In his authoritative treatise, Professor Larson offers the following observation with respect to the treatment of this issue by the various jurisdictions reviewed:

> A final question related to the issue of breadth of the concept of medical expenses is: how much is the employer expected to do in the way of improving claimant's condition? Mississippi has held that the employer's duty stops when the employee has been

> returned to a point where he or she is no worse off than before the injury. This means that the employer cannot be charged with the cost of repairing various non-work-related conditions that are discovered in the course of treatment or surgery for a compensable condition.
>
> An exception may be recognized, however, when the nonindustrial condition must be dealt with in order to achieve the optimum treatment of the compensable injury. Thus, when it was necessary to treat claimant's preexisting bronchitis to prepare the claimant for surgery for the industrial injury, the carrier was liable for the hospital expenses entailed. Similarly, in a Pennsylvania case, a claimant, hospitalized for a specific compensable injury, had many other ailments tended to at the employer's expense. The claimant had suffered a broken neck during a lunchtime football game on the employer's premises. During his hospitalization, the claimant had surgery performed for the removal of stones from his bladder, treatment for ulcers on his back, a series of spinal taps, a 'split thickness graft to his sacrum' and numerous laboratory tests and X-rays. The court held that although some of the services were 'domiciliary' they were incidental to his receiving proper medical attention during his disability.

Arthur Larson, Larson's Workers' Compensation, § 94.03[5] (2003), (footnotes omitted).

Rank v. Lindblom, S.Dak., 459 N.W.2d 247 (1990), is a South Dakota case cited by Professor Larson and also by Blue Chips as support for its theory of noncompensability. Here, too, Blue Chips' reliance is misplaced. Indeed, we interpret that case as support for the ALJ's award of medical benefits under the facts of the case *sub judice*. In Rank, supra, the evidence showed that the claimant had suffered from non-work-related pulmonary problems for quite some time. Treatment of those pulmonary problems was necessary before the claimant could undergo surgery for his work-related knee injury. In holding that the employer was not responsible for treatment of the non-work-related condition, the court was careful to state the following caveat:

> There may be instances where preoperative care must be covered under workers' compensation insurance, such as in emergency situations or where the treatment for non-work-related disease would be unnecessary but for the work related injury. It is important in this case, however, to note that although the preoperative care administered here was for the specific purpose of preparing Rank for surgery, Rank had significant disease that should have been treated regardless of impending surgery.

Id. at 250-51.

Thus, we believe the facts in Rank, supra, to be distinguishable from the case *sub judice*. Although good dental health may well advise Denniston's undergoing treatment for his cavities regardless of the surgery recommended by Dr. Shaffer, there is no

evidence in the record to compel such a finding. It was reasonable for the ALJ to conclude on the facts presented below that Denniston's dental condition could go untreated indefinitely but for Dr. Shaffer's refusal to perform surgery in the absence of proper treatment. While the court in Rank, supra, also makes note that the claimant's pulmonary problems were not of an emergent nature requiring immediate medical attention, the quote excerpted above suggests that emergency situations would constitute only one of multiple fact scenarios in which preoperative care for a non-work-related condition might be deemed compensable.

Likewise, we do not read the court's holding in Allstate Insurance Co. v. The Industrial Commission of Arizona, 126 Ariz. 425, 616 P.2d 100 (App. 1980), as limited to emergency situations. Blue Chips apparently interprets the Arizona court's ruling as limited to instances in which treatment of a non-work-related condition is necessary in order to address a work-related injury of an urgent nature. From our own review of Allstate, supra, however, it does not appear that the court's holding or rationale was in any way based upon or limited to emergency work injuries. In fact, the court's summary of the case indicates that the claimant had been admitted to the hospital for a diagnostic myelogram and possible laminectomy. A routine urinalysis and EKG performed pursuant to the hospital admission revealed an abnormally high protein level and an atrial fibrillation. Perhaps Blue Chips intends to suggest that the non-work-related condition must be of an emergency nature and necessary to the

treatment of a work-related condition (of an emergency nature or not) in order to be found compensable. Again, however, we do not so read the Allstate opinion, which specifically holds as follows:

> It is generally accepted that where an industrial injury results in surgery which aggravates a preexisting condition or causes further complications, the entire result is an industrial responsibility.
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> * * * *
>
> The question then is whether this reasoning should apply to pre-surgery treatment necessary to place the injured employee in a condition to undergo surgery related to an industrial injury. In reviewing the evidence, which we view in a light most favorable to sustaining the award . . . we find that the reasonable inferences from the evidence support the hearing officer's conclusion that the medical intervention occasioned at the time for the atrial fibrillation and the renal shutdown were related to the procedures undertaken in preparation for the industrially related myelogram and lumbar surgery, and these preexisting conditions would not have required treatment 'but for' the impending surgery.

Id. at 102. Further support for our interpretation of Allstate, supra, is found in a subsequent decision by the same court, Arrowhead Press, Inc. v. Indus. Comm. of Ariz., 134 Ariz. 21, 653 P.2d 371 (App. 1982).

We believe the circumstances of the case *sub judice* to be most similar to those before the Arizona court in Arrowhead, supra, where the court summarized the pertinent facts and its rationale as follows:

> The evidence presented at the hearing revealed that one of claimant's physicians, Robert Briggs, M.D., was of the opinion that it was necessary for claimant to be treated for the bronchitis so that she could undergo the anesthesia required for the knee procedures. . . . There was also evidence that claimant would not have been hospitalized if she had suffered only from the bronchitis. Thus, we hold that there was sufficient evidence to support the administrative law judge's finding that the hospital treatment of the bronchitis was reasonably necessary and was incurred to place claimant in a condition to undergo surgery for her industrial injury. . . . Here, unlike in [Ross v. Industrial Commission, 112 Ariz. 253, 540 P.2d 1234 (1975), *overruled on other grounds*], the bronchitis treatment was necessary so that the *industrial* condition could be treated. In Ross, the treatment of the non-industrially injured eye was not undertaken as a precondition to the treatment of the industrially injured eye and thus was not the responsibility of the carrier.

Id. at 373.

The Arizona Court of Appeals later declined to extend its holding in

Arrowhead, supra, to a situation involving a non-work-related condition that would have required treatment notwithstanding the industrial injury at issue. Beasley v. Indus. Comm. of Arizona, 175 Ariz. 521, 858 P.2d 666 (App. 1993). The court distinguished Beasley, supra, from its earlier holdings on grounds that "[i]n neither case would the unrelated condition have required treatment 'but for' the existence of the industrial injury." Id. at 668.

The rationale set forth in Arrowhead, supra, was relied on by a Colorado appeals court in Public Serv. Co. of Colo. v. Indus. Claim App. Office, Colo. App., 979 P.2d 584 (1999), also cited by Denniston herein. In Public Serv. Co., supra, the court held that treatment of the claimant's non-work-related bipolar disorder was compensable where the evidence supported the finding that such care was a reasonably necessary prerequisite to surgical treatment of his industrial injury. The Colorado court also found support in Professor Larson's treatise, concluding as follows:

Furthermore, we conclude that ancillary preoperative treatment is a pertinent rationale for reasonably necessary care of a non-industrial disorder, when such must be given 'in order to achieve the optimum treatment of the compensable injury.' 5 *Larson's Workers' Compensation Law, supra*, at § 61.13(e).

Id. at 585.

Having reviewed the statutory plan for provision of medical treatment for work-related injuries in Kentucky, and being informed by the foregoing extraterritorial authority, we conclude

that the employer may be held liable for the cost of ancillary treatment of a non-work-related condition that is reasonably required in order to achieve optimum treatment of the compensable injury. The employer is not liable for treatment of a non-work-related condition that is totally independent of the compensable injury and for which treatment would have been required notwithstanding the compensable injury.

The final case cited to us by Blue Chips, In the Matter of Compensation of Brooks v. D & R Timber, 55 Or. App. 688, 639 P.2d 700 (1982), represents the latter scenario. The dispositive facts in Brooks, supra, are analogous to those in Ross, supra, (cited by the court in Arrowhead, supra,) and inapposite to the case *sub judice*. Brooks, supra, involved the compensability of a surgical procedure where an arthroscopy was carried out to investigate complaints of pain following a work-related injury to the knee and, in the course of the procedure, a non-work-related condition was discovered and treated. It did not involve the compensability of a non-work-related condition for which treatment was required before surgery could be carried out on a work-related injury, as is the case herein.

There is substantial evidence in the record, consisting of the testimony of Dr. Shaffer, to support the ALJ's conclusion that the dental treatment at issue is reasonably required in order for Denniston to undergo the surgical procedure recommended for the cure and relief of his work-related lumbar injury. There is nothing in the record to suggest that the dental treatment - though perhaps advisable or desirable -

> would have been *required* notwithstanding the proposed surgery.

Here, the ALJ was correct in finding the bariatric surgery had been recommended for at least five years prior to the work injury. The ALJ is also correct in noting Philpot's weight did not significantly change after the work injury. Thus, we find no error in the ALJ's finding Philpot's obesity was unrelated to, and had not been worsened by, the work injury. The ALJ could reasonably conclude Philpot's obesity was a condition requiring treatment regardless of the recommended spinal surgery. As was the case in Rank v. Lindblom, 459 N.W.2d 247 (S.Dak. 1990), here Philpot had a significant condition that should have been treated regardless of impending surgery.

In his July 6, 2012 order, the ALJ made additional findings concerning whether Philpot's obesity was related to the work injury or worsened by the injury. The ALJ found the bariatric surgery was recommended prior to the work injury. Dr. Brooks stressed that failure to undergo bariatric surgery could have adverse effects on Philpot's condition. Substantial evidence indicates the bariatric surgery was necessary rather than just recommended prior to the work injury and thus not compensable. As we stated in Denniston, *supra*, we do not believe the ALJ erred in finding

the employer is not liable for treatment of a non-work-related condition that is totally independent of the compensable injury and for which treatment would have been required notwithstanding the compensable injury. The evidence falls short of compelling a finding the bariatric surgery was necessary for treatment of Philpot's work-related spinal injury.

Accordingly, the June 4, 2012 Opinion, Order and Award rendered by Hon. Grant S. Roark, Administrative Law Judge, and the July 6, 2012 order denying Philpot's petition for reconsideration are **AFFIRMED**.

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