# Commonwealth of Kentucky
# Workers' Compensation Board

**OPINION ENTERED: April 24, 2015**

CLAIM NO. 201088865

LANCE CARR PETITIONER

VS. **APPEAL FROM HON. STEVEN G. BOLTON, ADMINISTRATIVE LAW JUDGE**

FORD MOTOR COMPANY and
HON. STEVEN G. BOLTON,
ADMINISTRATIVE LAW JUDGE RESPONDENTS

**OPINION**
**AFFIRMING**

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

**ALVEY, Chairman.** Lance Carr ("Carr") appeals from the Opinion, Award and Order rendered December 1, 2014 by Hon. Steven G. Bolton, Administrative Law Judge ("ALJ"), awarding temporary total disability ("TTD") benefits, permanent partial disability ("PPD") benefits based upon a 1% impairment rating and medical benefits for a work-related

meniscus tear of the right knee occurring on February 8, 2010. The ALJ also found Carr sustained a temporary exacerbation of a pre-existing arthritic condition in the right knee which resolved following the surgical meniscus repair in March 2010. Carr was released to return to work in April 2010, and the ALJ declined to award future medical benefits for the arthritic condition. Carr also seeks review of the January 12, 2015 Order denying his petition for reconsideration.

On appeal, Carr argues the ALJ misunderstood Dr. Travis Clegg's testimony regarding causation and impairment, which in turn, led him to erroneously rely upon the opinions of Dr. Thomas Loeb. Because substantial evidence supports the ALJ's determination and no contrary result is compelled, we affirm.

Carr filed a Form 101 alleging he injured his "knee" on February 8, 2010 as he descended a step while carrying a piece of glass in the course of working as a quality leader for Ford Motor Company ("Ford").

Carr testified by deposition on June 27, 2012. The October 20, 2014 benefit review conference ("BRC") order and memorandum reflects Carr waived his right to a hearing. Carr was born on December 9, 1956 and has worked for Ford since at least 1988. For the past ten years, he has been a

quality leader in the trim assembly line. Carr stated on February 8, 2010, he was carrying a windshield and stepped off the platform onto the first of two steps, when his right knee “popped out, kicked out popped.” Carr was sent to the Ford medical clinic, where ice was applied. He returned to work the same day, only to return to the medical clinic again when his right knee symptoms worsened. At that time, Dr. Kathleen Harter ordered an MRI.

Carr was informed he had “a big tear in my meniscus.” Carr was referred to Dr. Greg Rennirt, who performed surgery on March 25, 2010. He received a series of injections following the surgery due to continuing right knee symptoms, which did not provide relief. Carr testified although he continues to work, he does so with difficulty due to his right knee pain, limited bending, and a limp.

Carr continued to work until the date of surgery. After a period of recovery, Carr was released to light duty work; however, Ford placed him on a no work available status since it was unable to accommodate his restrictions. Dr. Rennirt eventually released Carr to return to work without restriction on April 21, 2010. Since then, Carr has worked his regular job on a normal basis as a quality leader at Ford. Dr. Rennirt released Carr from his care on September 7, 2010, and he has not received additional treatment for

his right knee. Carr clarified he is not claiming a work-related left knee injury.

Carr sustained a minor injury to his right knee approximately three years prior to February 2010 while working for Ford which resolved after ice was applied. Carr was not placed on restrictions, missed no time from work, and continued to perform his regular job without difficulty.

Carr and Ford filed the treatment records from Dr. Harter of the Ford Dispensary and those of Dr. Rennirt. Carr reported to the Ford medical clinic on February 8, 2010 complaining of right knee pain, swelling and popping after the incident. Dr. Harter ordered an MRI. The February 11, 2010 right knee MRI demonstrated 1) a complex tear of the medial meniscus; 2) mild chondromalacia involving the medial femoral condyle, within the medial patellar facet and trochlear cartilage; 3) suspected mild grade I MCL sprain; and 4) moderate edema, most likely representing the sequelea of a ruptured Baker's cyst or extravasation from the GS bursa, and a small knee effusion. Dr. Harter referred Carr to Dr. Rennirt.

Carr treated with Dr. Rennirt from February 15, 2010 through September 7, 2010. Carr reported his right knee symptoms were due to the February 8, 2010 work accident. Dr. Rennirt reviewed the right knee MRI, which

showed a complex tear of the medial meniscus, as well as some chondromalacia of his patella and the medial femoral chondyle. Dr. Rennirt recommended a partial arthroscopic medial meniscectomy. The March 25, 2010 operative report reflects Dr. Rennirt performed a partial medial meniscectomy, along with a chondroplasty of the patellofemoral joint and mediofemoral condyle. The post-operative diagnoses were right medial meniscus tear, Grade 4 chondral lesion medial femoral condyle and Grade 3 lesion trochlea.

Following surgery, Carr continued to complain of pain and swelling. On May 4, 2010, Dr. Rennirt stated the continuing knee pain "is coming from the arthritis medially. Certainly, it is flared up from his injury, but I do not think the pain he is having now is just related to his surgery." Dr. Rennirt prescribed Carr an unloader brace and a series of three Hyalgan injections. On September 7, 2010, Dr. Rennirt noted the injections did not completely relieve Carr's pain. Dr. Rennirt stated non-surgical options had been exhausted, and he discussed a limited knee replacement with Carr. The record reflects Dr. Rennirt restricted Carr to sit down duty following surgery until April 26, 2010, when he was released to regular duty.

Dr. Rennirt prepared a July 10, 2012 "Impairment Rating" report, and two subsequent letters. In the July 10, 2012 report, Dr. Rennirt noted Carr underwent an arthroscopic procedure involving a medial meniscectomy and debridement of a "very deep chondral lesion which was full-thickness on his medial femoral chondyle." After performing an examination, Dr. Rennirt assessed a 1% impairment rating for the partial meniscectomy pursuant to the 5th Edition of the American Medical Association, Guides to the Evaluation of Permanent Impairment ("AMA Guides"). He further noted Carr has an antalgic gait and moderate to severe arthritic changes in the knee, "which would add 7 percent to his whole person impairment, but I am not sure if that is covered under his Workers' Compensation injury. In other words, I am not sure if Workers' Compensation has assumed responsibility for his arthritic changes in his knee." Dr. Rennirt concluded Carr has a 1% impairment rating based on his meniscus only, but would add 7% "if Workers' Compensation has accepted responsibility for the arthritic changes in the knee."

Following a conversation with counsel for Ford, Dr. Rennirt prepared a letter dated August 28, 2014 to clarify his statements regarding impairment. In relevant part, Dr. Rennirt stated as follows:

> . . . The arthritic lesion in his knee was not caused by his injury in 2010. I do believe it was acutely exacerbated, but the injury certainly did not cause the lesion, and I do not think that it made it any worse. I think the meniscus tear could be related to his trauma, but not the arthritic lesion.
>
> There is a good chance that Mr. Carr is going to need ongoing treatment for this, and he may at some point need either a limited or a full replacement of the knee. This in no way would be related to the trauma he had in 2010, as this lesion clearly pre-dated his injury.
>
> Just to be clear, I do not think that Mr. Carr's injury in 2010 in any way caused his arthritis. I do believe that the injury did cause an acute flare-up of his arthritis, but that flare-up should be over, and any treatment at this point is for a preexisting arthritic condition.

In response to questioning by counsel for Carr, Dr. Rennirt prepared another letter dated October 2, 2012. In that letter, Dr. Rennirt declined to change or alter his previous statements, stating, "There is absolutely no way that Mr. Carr's Workers' Compensation injury caused the cartilage lesion . . . his meniscus tear was likely caused by his injury, but there is, again, no way that this caused his cartilage lesion."

Ford submitted Dr. Loeb's May 27, 2014 report who evaluated Carr at its request. He opined Carr developed an

acute medial meniscus tear on February 8, 2010. He noted Dr. Rennirt found a longstanding, Grade 4 lesion in the medial femoral condyle and Grade 3 lesion in the trochlear intercondylar notch. Dr. Loeb stated he agreed with Dr. Rennirt regarding causation of the lesions. Dr. Loeb opined the findings represent advanced arthritic changes in the medial compartment, suggesting longstanding pre-existing degenerative changes in the right knee. He noted the surgery was performed six weeks after the original work injury, which was insufficient time to develop a Grade 4 lesion.

Dr. Loeb noted it is not uncommon for a patient to have an asymptomatic lesion in the knee which becomes symptomatic after a meniscal tear. However, there was no evidence of any acute articular surface damage from the work injury. Dr. Loeb stated the right knee would have become symptomatic whether or not he sustained the meniscal tear due to the progressive nature of the condition. Dr. Loeb opined, “At most the injury may have temporarily or transiently exacerbated the underlying arthritic problem, but the effects of any soft tissue injury to the articular surface would have subsided very quickly after the arthroscopic management of his medial meniscus tear.” Dr. Loeb stated although Carr experienced right knee problems

immediately following the arthroscopic procedure suggesting a rapid progression of his arthritic condition, his work injury neither caused nor exacerbated the arthritic condition on a long-term basis. Dr. Loeb stated any further treatment regarding the right knee would be based on his pre-existing arthritic condition, and he emphasized the effects of the work injury have long since subsided subsequent to the surgical procedure. Like Dr. Rennirt, Dr. Loeb assessed a 1% impairment rating for the medial meniscus tear pursuant to the AMA Guides.

Carr submitted the September 21, 2012 report of Dr. Travis Clegg who noted the February work injury, and March 25, 2010 surgery. Dr. Clegg performed an examination, and stated a right knee x-ray taken the day of his evaluation demonstrated medial joint space narrowing and mild patellofemoral arthrosis. The September 21, 2012 right knee radiological report was attached, in which Dr. Michael Schmidt displayed no acute abnormality. Dr. Clegg diagnosed Carr as status post meniscectomy of right knee; medial compartment chondromalacia and arthritis; and patellofemoral joint chondromalacia and arthritis. Dr. Clegg stated in relevant part as follows:

> . . . it does look like this has been compounded by his meniscectomy and it is difficult to say for sure when the

> osteochondral lesions occurred, if they occurred with his work injury, but it is certain that the meniscectomy is going to cause aggravation of this injury and accelerate the process.

Dr. Clegg found Carr is a candidate for Visco supplementation and he recommended a topical anti-inflammatory. Dr. Clegg noted Carr will probably require a knee replacement in the future if conservative approaches fail.

Dr. Clegg also testified by deposition on January 8, 2013. He is a practicing orthopedic surgeon, but is not board certified. Dr. Clegg explained he disagreed with Dr. Schmidt's interpretation of the September 21, 2012 right knee x-ray. Dr. Clegg stated he personally reviewed the films, and stated the findings are consistent with osteochondral lesions. Dr. Clegg explained a Grade 4 lesion is a complete cartilage loss in the affected area. Dr. Clegg stated osteochondral defects can occur acutely as a result of trauma or as a result of progressive arthritis. Dr. Clegg stated it was possible the lesions occurred as a result of the work-related meniscus tear. Dr. Clegg could not determine "in terms of more probable than not" whether the lesions were in fact present prior to the February 2010 work injury. But if he had to guess, "I would say, you know, there was a chance, probably chances are more likely

that there was something there before, but again, it's impossible for me to know that based on what I'm seeing."

Regardless of when the lesions occurred, Dr. Clegg reiterated the meniscectomy would aggravate the injury or accelerate the process due to the following reason:

> A: That's because when you take out 75 percent of the meniscus, then that accelerates the progression of arthritis, which is when an osteochondral lesion, is essentially, it's a loss of cartilage, and not having the cushion between the knees that's going to accelerate the pain and progression of arthritis, has been shown in several studies.

Dr. Clegg clarified when he is using the word "accelerates," he is looking at the progression of Carr's knee problem going forward after the surgery, not the time between the February 8, 2010 work accident and the March 25, 2010 surgery. Dr. Clegg stated he did not find any fault with the reasoning expressed by Dr. Rennirt, but later clarified they do in fact have a difference of opinion. Dr. Clegg also agreed Dr. Rennirt would be in a better position to determine the cause and effect of Carr's right knee injury since he is the treating physician who performed the March 25, 2010 surgery.

On cross-examination, Dr. Clegg stated when you remove the meniscus to the extent of that undergone by Carr,

studies have shown this will lead to a progression of "knee problems with arthritis" which will cause aggravation of the injury and accelerate the process regardless of whether the underlying chronic condition is acute or chronic. He also stated his opinions are within reasonable medical probability. Finally, Dr. Clegg stated his future treatment recommendations are for knee pain caused by the arthritic condition only.

Counsel for Carr sent a June 3, 2013 letter to Dr. Clegg regarding the attainment of maximum medical improvement ("MMI") for an unrelated *left knee* condition.[1] Counsel requested if Carr had reached MMI, "I would like to know what your opinion is regarding impairment." In a report dated July 23, 2013, Dr. Clegg indicated Carr reached MMI on June 1, 2013 and assessed a 2% impairment rating pursuant to the AMA Guides for a partial meniscectomy. Dr. Clegg did not specifically state whether his report addressed Carr's right or left knee.

The September 1, 2012 and October 20, 2014 BRC orders reflect benefits per KRS 342.730, work-relatedness/ causation and exclusion for pre-existing disability/

[1] The letter does not identify the exact condition of Carr's left knee or what treatment has been rendered for the left knee. However, the claim was placed in abeyance on February 22, 2013 pursuant to a motion by Carr, which stated he had undergone surgery on his left knee and would not be able to attend a scheduled independent medical examination.

impairment were identified as the contested issues. These BRC orders also reflect Carr did not seek enhancement of an award by the multipliers contained in KRS 342.730(1)(c) 1 or 2.

The ALJ summarized the evidence, including the opinions of Drs. Clegg, Rennirt and Loeb. He noted the uncontroverted testimony of Carr that, other than a brief right knee strain, he suffered from no symptomology whatsoever prior to the work injury. The ALJ accepted Carr's account of his previous medical history and the facts surrounding his injury as accurate since there is no contradictory evidence in the record.

The ALJ stated Carr suffered a work-related injury on February 8, 2010 requiring surgery. He then noted the question before him is whether Carr is entitled to a 1% impairment rating assessed by Drs. Rennirt and Loeb, or an 8% assessed by Dr. Rennirt if the arthritic condition is included. He then provided the following analysis:

> So we start with an avowedly pre-existing arthritic condition being extant, but not active or disabling insofar as the evidence is concerned. To be characterized as active, an underlying pre-existing condition must be symptomatic and impairment ratable pursuant to the *AMA Guidelines* immediately prior to the occurrence of the work related injury. Moreover, the burden of proving the existence of a

pre-existing condition falls upon the employer. Finley v. DBM Technologies, 217 S.W.3d 261 (Ky. App., 2007). So, when work related trauma causes a dormant degenerative condition to become disabling and to result in a functional impairment, the trauma is the proximate cause of the harmful change. Hence, the harmful change comes within the definition of injury. McNutt Construction v. Scott, 40 S.W.3d 854 (Ky., 2001).

Here, the Defendant/Employer's argument, based upon Dr. Rinnert's[sic] confusing and somewhat contradictory statements, is that even though the arthritic condition was not active prior to the traumatic incident, it was not aroused into disabling reality by that incident. But for Dr. Rinnert's[sic] opinion to make sense, it had to be aroused into disabling reality by some instrumentality, or Dr. Rinnert[sic] would not have assigned a WPI rating of 7% according to the AMA *Guides to the Evaluation of Permanent Impairment, 5th Ed.*

I think that based upon his written statements, Dr. Rinnert[sic] was trying to help out his patient. He believed that the Defendant's carrier had already approved payment for the Hyalgan injections in Mr. Carr's knee, which were clearly for his arthritis. So what he was saying in his impairment rating of July 10, 2012 was that "… if Worker's Compensation *has accepted responsibility for the arthritic changes in the knee…*"(emphasis supplied), then he would add 7% to his whole person impairment.

In other words, he only assigned a 1% WPI for the meniscus alone. He does not assign 7% to the moderate to severe arthritic changes as the result of the

injury, but only if "… Workers Compensation has assumed responsibility for his arthritic changes in his knee." I believe this to be so because Dr. Rinnert[sic] goes out of his way in his August 28, 2012 letter to Defendant's counsel to emphasize that while he felt the injury temporarily exacerbated Plaintiff's existing osteoarthritis, he in no way believed that the injury caused the lesions or made them any worse. He specifically related that the meniscus tear could be related to the trauma, but not the arthritic lesion.

In this instance, I do not believe the authority in McNutt Construction v. Scott (supra) is controlling. Instead, I am persuaded by the medical opinion of Dr. Thomas Loeb, M.D. as being the most complete, accurate, compelling and persuasive medical evidence in the record pertaining to this issue.

Therefore, any compensable injury is limited to a 1% impairment rating for the meniscus tear on February 8, 2010, as well as medical treatments related to the temporary exacerbation of the arthritic condition that pre-existed prior to February 8, 2010. Any period of exacerbation of that arthritic condition would have resolved following the repair of the meniscus tear in March 2010 and release to return to work in April, 2010.

Any continuing complaints of arthritic change or requests for a total knee replacement are related to the pre-existing severe arthritic condition, as evidenced by Grade 3 and 4 lesions present on February 10, 2010, and the continuing arthritic condition that is not related to the meniscus tear which was repaired in February of 2010. A permanent partial impairment award

> shall be limited to a 1% functional impairment rating for the meniscus tear and repair.
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> Any future medical benefits related to the arthritic changes were limited to the time for the temporary exacerbation of benefits and cannot be extended to future benefits for arthritic changes or a total knee replacement under the authority of Robertson v. United Parcel Service, 64 S.W.3d 284 (Ky. 2001) and Mullins v. Mike Catron Construction/Catron Interior Systems, Inc., 237 S.W.3d 561 (Ky. App. 2007).
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> I also note that Dr. Clegg only awarded a 2% WPI initially, but then stated that he agreed with Dr. Rinnert[sic]. I did not see a specific finding of 7% from Dr. Clegg.

The ALJ found Carr "suffered a work-related injury consisting of a meniscus tear in the right knee accompanied by a temporary exacerbation of a pre-existing arthritic condition of February 8, 2010," and stated he relied upon the opinion of Dr. Rennirt and Carr's testimony. The ALJ relied upon Dr. Loeb's opinion in finding Carr has a 1% impairment rating due to his work injury. The ALJ awarded PPD benefits, TTD benefits and medical expenses relating to the meniscus tear only.

Both parties filed petitions for reconsideration. Carr made the same argument he now raises on appeal. Except for correcting clerical errors, the ALJ denied Carr's petition stating the alleged error is "essentially a disagreement with

my interpretation of the medical evidence in the record... ."

On appeal, Carr argues the ALJ "incorrectly outlined the testimony of Dr. Clegg and that in turn, as it related to both causation and impairment caused the ALJ to erroneously rely upon Dr. Thomas Loeb as the most credible testimony." In support of his argument, Carr quotes the ALJ's summary of Dr. Clegg's records and testimony, as well as his analysis regarding the pre-existing condition. Carr then quoted portions of Dr. Clegg's testimony stating the progression of arthritis will occur when 75% of a person's meniscus is removed, like in Carr's case, and progression refers to Carr's knee problems going forward without a meniscus. After quoting those portions of the ALJ's decision, Carr asserts the ALJ clearly misconstrued the testimony of Dr. Clegg. He also stated the ALJ erroneously stated Dr. Clegg assessed either a 2% impairment rating or an 8% impairment rating. Carr argued to the ALJ if the arthritic condition was dormant and non-disabling, he would be entitled to the 8% impairment rating assessed by Dr. Rennirt, or if not, a 1% impairment rating. Carr requests the claim be remanded to the ALJ to reconsider Dr. Clegg's testimony and for additional findings of fact regarding credibility.

As the claimant in a workers' compensation proceeding, Carr had the burden of proving each of the

essential elements of his cause of action, including causation and the appropriate impairment rating. Snawder v. Stice, 576 S.W.2d 276 (Ky. App. 1979). Because Carr was unsuccessful in his burden regarding his arthritic condition, the question on appeal is whether the evidence compels a different result. Wolf Creek Collieries v. Crum, 673 S.W.2d 735 (Ky. App. 1984). "Compelling evidence" is defined as evidence that is so overwhelming, no reasonable person could reach the same conclusion as the ALJ. REO Mechanical v. Barnes, 691 S.W.2d 224 (Ky. App. 1985). The function of the Board in reviewing the ALJ's decision is limited to a determination of whether the findings made by the ALJ are so unreasonable under the evidence they must be reversed as a matter of law. Ira A. Watson Department Store v. Hamilton, 34 S.W.3d 48 (Ky. 2000).

As fact-finder, the ALJ has the sole authority to determine the weight, credibility and substance of the evidence. Square D Co. v. Tipton, 862 S.W.2d 308 (Ky. 1993). Similarly, the ALJ has the sole authority to judge all reasonable inferences to be drawn from the evidence. Miller v. East Kentucky Beverage/Pepsico, Inc., 951 S.W.2d 329 (Ky. 1997); Jackson v. General Refractories Co., 581 S.W.2d 10 (Ky. 1979). An ALJ is vested with broad authority to decide questions involving caustion. Dravo

Lime Co. v. Eakins, 156 S.W. 3d 283 (Ky. 2003). The ALJ may reject any testimony and believe or disbelieve various parts of the evidence, regardless of whether it comes from the same witness or the same adversary party's total proof. Magic Coal Co. v. Fox, 19 S.W.3d 88 (Ky. 2000); Whittaker v. Rowland, 998 S.W.2d 479 (Ky. 1999). Mere evidence contrary to the ALJ's decision is not adequate to require reversal on appeal. Id. In order to reverse the decision of the ALJ, it must be shown there was no substantial evidence of probative value to support his decision. Special Fund v. Francis, 708 S.W.2d 641 (Ky. 1986).

The Board, as an appellate tribunal, may not usurp the ALJ's role as fact-finder by superimposing its own appraisals as to the weight and credibility to be afforded the evidence or by noting reasonable inferences could otherwise have been drawn from the record. Whittaker v. Rowland, supra. So long as the ALJ's ruling with regard to an issue is supported by substantial evidence, it may not be disturbed on appeal. Special Fund v. Francis, supra.

On review, we find Carr's appeal to be nothing more than a re-argument of the evidence before the ALJ. After careful review of Dr. Clegg's records and deposition testimony, as well as the ALJ's opinion, we find he accurately summarized the evidence and had a complete

understanding of the issues before him. It is undisputed Carr sustained at least a right knee meniscus tear due to the February 8, 2010 work injury warranting a 1% impairment rating. The primary issue before the ALJ was whether Carr's arthritic right knee condition was compensable.

The ALJ correctly noted the employer bears the burden of proving an active, pre-existing condition, and to be characterized as active, it must be symptomatic and impairment ratable pursuant to the AMA Guides immediately prior to the occurrence of the work related injury. Finley v. DBM Technologies, 217 S.W.3d 261 (Ky. App. 2007). On the other hand, the ALJ also correctly noted when a work-related trauma causes a dormant degenerative condition to become disabling and to result in a functional impairment, the trauma is the proximate cause of the harmful change which falls within the definition of injury. McNutt Construction v. Scott, 40 S.W.3d 854 (Ky. 2001). The ALJ continued with his analysis of Dr. Rennirt's admittedly equivocal letters addressing causation and ultimately found the treating physician attributed only the meniscus tear to the work injury. The ALJ pointed to the August 28, 2012 letter in which Dr. Rennirt stated while Carr's work injury temporarily exacerbated his existing osteoarthritis, he did not believe the injury caused the lesions or made them any

worse. He specifically stated that the meniscus tear could be related to the trauma, but not the arthritic lesion.

Similarly, Dr. Loeb opined Carr's work injury at most "may have temporarily or transiently exacerbated the underlying arthritic problem, but the effects of any soft tissue injury to the articular surface would have subsided very quickly after the arthroscopic management of his medial meniscus tear." Dr. Loeb stated although Carr experienced right knee problems immediately following the arthroscopic procedure, the work injury neither caused nor exacerbated the arthritic condition on a long-term basis. Dr. Loeb stated any further or additional treatment regarding the right knee would be based on his pre-existing arthritic condition, and emphasized the effects of his work injury have long since subsided after his surgical procedure.

The opinions of Dr. Rennirt and Loeb, upon which the ALJ relied, constitute substantial evidence supporting the ALJ's determination of causation and impairment, and no contrary result is compelled. While Carr is able to identify contrary evidence in his favor, primarily the report and testimony of Dr. Clegg, this is not adequate for reversal on appeal. The ALJ, as fact-finder, has full discretion to determine the physician or physicians upon which he relies. If "the physicians in a case genuinely

express medically sound, but differing opinions as to the severity of a claimant's injury, the ALJ has the discretion to choose which physician's opinion to believe." Jones v. Brasch-Barry General Contractors, 189 S.W.3d 149, 153 (Ky. App. 2006).

The ALJ was presented with conflicting opinions regarding the cause of Carr's arthritic condition, and he simply chose to rely upon the opinions of Drs. Loeb and Rennirt rather than the opinion of Dr. Clegg. This was well within his discretion. The ALJ provided a more than adequate summary of the evidence demonstrating his understanding of the issues before him, and outlined his analysis in support of his ultimate conclusion. Therefore, because substantial evidence supports the ALJ's determination Carr sustained a work-related meniscus tear warranting a 1% impairment rating, as well as a temporary exacerbation of a pre-existing arthritic condition resolving following the surgery and release to return to work in April 2010. Likewise, we find no error in the ALJ declining to award future medical benefits related to the arthritic changes pursuant to Robertson v. United Parcel Service, 64 S.W.3d 284 (Ky. 2001) and Mullins v. Mike Catron Construction/ Catron Interior Systems, Inc., 237 S.W.3d 561 (Ky. App. 2007), and only awarding medical benefits for the meniscus tear.

Accordingly, the December 1, 2014 opinion and the January 12, 2014 order on petition for reconsideration by Hon. Steven G. Bolton, Administrative Law Judge, are hereby **AFFIRMED.**

ALL CONCUR.

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