MARSHALL L. SETHER, Employee/Appellant, v. WHERLEY MOTORS, INC., and MICHIGAN PHYSICIANS/SUPERIOR ER PLAN, Employer-Insurer, and BLUE CROSS & BLUE SHIELD OF MINN. and BLUE PLUS, Intervenor.

WORKERS' COMPENSATION COURT OF APPEALS
DECEMBER 30, 1999

No. [REDACTED SSN]

HEADNOTES

CAUSATION - MEDICAL TREATMENT. Substantial evidence, including expert medical opinion, supports the compensation judge's finding that the employee's medical treatment for chest pain in 1997 was not causally related to his work-related myocardial infarction in 1994.

REHABILITATION - ELIGIBILITY. Where the compensation judge only considered the employee's 1997 symptoms and treatment in determining whether the employee was entitled to a rehabilitation consultation, and did not consider whether the employee's work-related myocardial infarction, resulting in heart damage, and the employee's physical reaction to job stress since, represent substantial contributing factors in the employee's need for rehabilitation services, remand is necessary for the compensation judge to consider these factors in determining whether the employee is entitled to a rehabilitation consultation.

Affirmed in part and reversed in part.

Determined by: Rykken, J., Johnson, J., and Wheeler, C.J.
Compensation Judge: Gregory A. Bonovetz

OPINION

MIRIAM P. RYKKEN, Judge

The employee appeals the compensation judge's finding that his medical treatment between October 1997 and January 1998 was not causally related to his myocardial infarction on September 17, 1994, and appeals the compensation judge's order denying a rehabilitation consultation. We affirm in part and remand in part.

BACKGROUND

On September 17, 1994, Marshall L. Sether (employee) was injured while working for Wherley Motors, Inc., (employer) insured by Michigan Physicians/Superior ER Plan (insurer). On that date, the employee worked as the service department manager. Born on November 11, 1946, the employee was 47 years old on the date of injury. In his capacity as service manager, he occasionally was asked to assist in emergency situations by operating the employer's wrecker

and tow truck. On September 17, 1994, the employee was called to extricate a gasoline truck which had slid into a muddy ditch. The employee worked approximately two and a half hours attempting to free the truck from the mud. He began experiencing a "funny" sensation in his right arm. He suddenly felt nauseated, dizzy, and sensed a severe pain and pressure in his chest. The employee was driven immediately to Falls Memorial Hospital in International Falls, and was flown to St. Mary's Hospital in Duluth the following day. He was hospitalized until September 24, 1994, and underwent coronary angiography and angioplasty. Medical records from the Falls Memorial Hospital and St. Mary's Medical Center in Duluth confirm the diagnosis of a major anterior wall myocardial infarction treated with thrombolytic therapy.

The employer and insurer admitted liability for the anterior wall myocardial infarction, paid medical expenses on behalf of the employee, and paid approximately two and a half months of temporary total disability benefits until the employee's return to work in November 1994.[1] Following his return to work for the employer on or about November 28, 1994, the employee resumed his regular duties. Although he continued working as a service manager, the employee apparently found it necessary to adopt certain stress management techniques in order to reduce chest pain which he asserts resulted from stressful job situations. According to the testimony of an employer representative, James Wherley, changes were implemented in the service department after the employee returned to work, in response to the employee's concerns about stressful situations. Mr. Wherley also testified that the employer also encouraged the employee to assign tasks to co-workers, or to take some time off periodically when necessary. (T. 91-92.)

According to the employee's testimony, he had never experienced heart-related symptoms prior to his September 1994 injury. Since that injury, however, he has experienced periodic chest pain symptoms and has undergone medical examinations for those symptoms. On November 3, 1994, he consulted his physician when he noted burning and pain in his chest after bicycling. The employee contends that periodically in 1995 and 1996, his chest pain recurred when he experienced stress or felt under pressure at work. For example, on one occasion when dealing with an unruly customer who refused to pay for a repair, the employee noted chest pain. At times when he "had a problem" with an employee, the pain recurred. (T. 42, 44.) The employee occasionally took Nitroglycerin when experiencing this pain and sensation; sometimes, but not always, the Nitroglycerin alleviated his symptoms. In May and June 1996, the employee attended four psychotherapy sessions with Dr. Jeffrey Hartwig, at Dr. Helleloid's recommendation, to address his reaction to stressful situations and his depression.

Following a cardiac consultation on February 16, 1995, Dr. David Mast referred the employee for cardiac testing to address the employee's fatigue. He underwent a stress Thalium and Holter monitor test, which indicated a dilated left ventricle and a fixed defect in the low anterior wall, low inferior wall and septum without reperfusion. The employee was able to

[1] The record does not indicate whether the employee was ever assigned a permanent partial disability rating, nor whether the employer and insurer paid any permanency benefits to the employee.

exercise for 10 minutes without ST segment changes. Dr. Mast concluded that the employee's fatigue probably related to his diabetes.

On June 26, 1996, the employee underwent a cardiac consultation with Dr. Gale Kerns, in part due to an aching sensation in his left shoulder and upper left chest. Cardiac tests indicated good functional capacity, with no clear evidence of ischemia following an exercise stress test.[2] Dr. Kerns concluded that, based upon the employee's blood sugar levels and symptoms, his primary problem was his borderline diabetes. Dr. Kerns also recommended medication as a protective measure if he developed left ventricular dysfunction. The employee received medical treatment for his diabetic condition; by at least 1997, the employee was diagnosed as being an insulin-dependent diabetic.

On October 30, 1997, the employee was confronted with a stressful situation at work. The overhead garage door at the shop was jammed, making it impossible to remove from the shop those vehicles which had been repaired and or to allow unrepaired vehicles to enter the shop for repair. The employee felt quite agitated because customers were waiting for their cars. (Finding 7.) According to the employee, he "got really wound up over it." (T. 45.) He noted pains in his chest and returned home; his wife immediately drove him to the Falls Memorial Hospital. His chest felt heavy and his symptoms were worse than they had been since his 1994 injury, and so the employee deemed it necessary to report to the hospital.

The employee's October 30, 1997, blood test indicated high enzymes, possibly indicative of a cardiac condition, but provided inadequate criteria to diagnose the cardiac-related condition of thrombolytics; the employee was prescribed and started on Heparin and Nitroglycerin. Progress notes from Falls Memorial Hospital on October 31, 1997 indicate that the employee had no pain since the previous evening. Although his blood enzymes were slightly elevated, and the preliminary diagnosis was that the employee may have experienced angina, the examining physicians had difficulty determining that fact. The physicians noted that the employee's four-day long cold may have resulted in his chest symptoms. Dr. Helleloid recommended review with a cardiologist, and the employee therefore was taken by ambulance to St. Mary's Hospital in Duluth, where he was hospitalized between October 31-November 4, 1997.

Based on the employee's 1994 myocardial infarction, his coronary artery disease and other risk factors, including family history of heart attacks, extensive testing was performed at St. Mary's Medical Center to rule out further cardiac symptoms. Those test results were inconclusive. His initial electrocardiogram indicated a (previous) anterolateral myocardial infarction with normal sinus rhythm and no acute ischemic change. The treadmill stress test, which included ten minutes of exercise, did not result in any chest discomfort during or after the exercise. A resting electrocardiogram demonstrated a normal sinus rhythm. Chest x-rays and

[2] Myocardial ischemia is defined as deficiency of blood supply to the heart muscle, due to obstruction or constriction of the coronary arteries. Dorland's Illustrated Medical Dictionary, Edition 28 (1994).

ECHO cardiogram indicated that the employee's heart condition had not substantially changed since similar studies done shortly after his 1994 myocardial infarction.

The chart note of October 31, 1997 from St. Mary's Medical Center indicates the equivocal nature of the physicians' conclusions as to the etiology of the employee's symptoms:

> He has not had recurrent symptoms of chest discomfort until yesterday when at work he began to note left upper chest pain which is described both as a dull pressure and also a sharp pain . . . .He had tried Nitroglycerin spray without relief. I believe his pain during his hospitalization is also not quickly responsive to Nitroglycerin administration. His initial electrocardiogram [done on 10/30/97] outside showed an anterolateral myocardial infarction but no definite acute transmural ischemic change . . . .an outside electrocardiogram dated 10/31/97 shows normal sinus rhythm and an anterolateral myocardial infarction and no acute ischemic change. . . . Specifically his symptoms feel a bit different than he experienced with his prior infarct both in severity but also in specific character. As well his symptoms were not immediately responsive to nitroglycerin administration and it is uncertain if this was due to significant underlying ischemia or simply non cardiac pain. His outside cardiac enzymes were mildly abnormal though his electrocardiogram showed no specific change.

The initial diagnosis made by Dr. Elliot and Dr. Helleloid, on October 30-31, 1997, was probable angina. According to the November 4, 1997 discharge summary from St. Mary's Medical Center, Dr. Heltne, cardiologist, diagnosed atherosclerotic coronary heart disease, chest pain and diabetes mellitus. Dr. Heltne recommended no angioplasty at that point, but did prescribe Captropril, a medication which is used to treat hypertension and congestive heart failure. Dr. Heltne stated that "I think our goals of therapy should be that of reduced work for this myocardium." (Joint Ex. 1.) The employee was provided with a referral for stress management, and a prescription for a low fat, low cholesterol diabetic diet. He was advised to remain off work until November 10, 1997, and was advised that if he had recurrent discomfort, Dr. Heltne would recommend an angiography.

At the time of a follow-up examination with Dr. Helleloid on November 11, 1997, the employee reported that his occasional chest pain was "of a real concern to him as it almost always seemed to come when he [was] under pressure in the work situation." Dr. Helleloid examined the employee both for his diabetic condition and his arteriosclerotic heart disease. Dr. Helleloid addressed the employee's assertions about his stress level at work and recommended that the employee consider changing his employment, stating as follows:

> Relative to the work situation I think that his response to the stressors at his work setting have become fairly well defined. I

> think he has put forth genuine and substantial effort to work this out differently from a stress management stand point and while there certainly are always the chances that he could get things changed around and get the feeling that things are satisfactory, I think the chance of that being a successful effort is realistically quite modest and serious consideration of changing his employment situation is perhaps the most realistic avenue of potential success in terms of minimizing his risk for future additional acute heart problems.

Dr. Helleloid re-examined the employee on December 23, 1997. On that date, Dr. Helleloid again addressed the issue of the employee's reported work-related stress and its effect on the employee's cardiac condition, and recommended that the employee change jobs in order to reduce job stress which had the potential for endangering his health. Dr. Helleloid stated as follows:

> . . . [W]e have to conclude that the safest thing for him medically is to continue to consider finding an entirely deferent [sic] job setting. There is always some risk that the new job setting would entail similar pressures but I think knowing what the issues are going in and structuring the situation properly in the beginning and working from the beginning to see that it isn't working out in a way that is detrimental to his health. All in all he has a better chance of success than trying to adjust his current situation in a way that is going to be satisfactory in the long term.

At a follow-up cardiac consultation with Dr. Kerns on January 7, 1998, Dr. Kerns diagnosed atherosclerotic coronary artery disease, chest discomfort that is not clearly ischemic in origin, left ventricular dysfunction due to heart muscle damage but without overt congestive heart failure, and diabetes mellitus. Dr. Kerns prescribed Lisinopril and Toprol XL, which are medications used to treat hypertension, congestive heart failure and angina pectoris. Dr. Kerns also recommended follow-up care for his diabetic condition. At a January 13, 1998 appointment with Dr. Helleloid, the employee reported still having some chest pain, with variable response to Nitroglycerin. On February 2, 1998, Dr. Helleloid discussed implementing changes in the employee's work setting to decrease his level of stress. At a February 10, 1998 appointment, Dr. Helleloid stated that "if there does not look like there is going to be a satisfactory change [in the employee's work situation] then I think we have to again consider him moving away from that particular work environment."

At an April 16, 1998 appointment with Dr. Helleloid, the employee again reported minimal burning across his sternum and in his upper left chest, not exertion-related. At that point, the employee advised Dr. Helleloid that none of the proposed changes had been made in the employee's work setting. On May 21, 1998, the employee reported to Dr. Helleloid that he still noticed the mild burning across his sternum, in his upper left chest. The employee also reported that he felt he continued to be placed in positions of stress on a regular basis. By July 14, 1998, the employee consulted Dr. Helleloid, and discussed with him methods he uses to avoid stressful

situations at work. The employee continued to consult Dr. Helleloid on a monthly basis, through at least December 1998 (the latest medical report included in the hearing record).

On February 25, 1998, the employee filed a Rehabilitation Request, requesting a rehabilitation consultation. The employer and insurer responded that the employee was not eligible for rehabilitation services and that there was no need for a rehabilitation consultation as the employee had continued to work at his original job since late 1994. The employee filed two medical requests, on March 5 and April 21, 1998, requesting payment for medical expenses incurred in 1997-1998, at the Duluth Clinic, Falls Memorial Hospital and St. Mary's Medical Center. The employer and insurer denied payment for these services, asserting that the medical records submitted did not show a causal relationship between the 1997 medical treatment and the employee's 1994 work-related injury.

The employer and insurer also requested an opportunity for an independent medical review. Dr. Mark H. Johnson conducted a medical record review on behalf of the employer and insurer, and issued a report dated July 12, 1998. (Joint Ex. D-1.) Dr. Johnson opined that the employee's hospitalization in October 1997 was not related to his September 1994 injury. Dr. Johnson stated as follows:

> Any progression of his heart disease would have been due to his multiple risk factors and not as a result of the 1994 injury. The reasons for his hospitalization on October 31, 1997 were to rule out an acute ischemic based cardiac event such as a heart attack or unstable angina pectoris. These conditions were ruled out and the source of these pains was felt to be non ischemic and perhaps stress related. In any event, they cannot be logically related in any substantial way to the September 1994 heart injury.

Dr. Johnson also found no objective medical basis for the recommendation that the employee change jobs.

In two decisions and orders pursuant to Minn. Stat. § 176.106, served and filed August 11, 1998, Compensation Judge Jerome Arnold granted the employee's request for a rehabilitation consultation with a QRC of the employee's choosing, and also determined that the employee's medical treatment in 1997 and 1998 was necessitated in substantial part due to the employee's work injury of September 18, 1994, and was reasonable treatment for observation, stabilization and diagnosis of the employee's condition.

The employer and insurer appealed, requesting a formal hearing or commissioner review conference. After the hearing on February 11, 1999, in Findings and Order served and filed June 24, 1999, the compensation judge determined that the evidence was equivocal at best as to whether the employee's chest pain in October 1997 was cardiac pain and that neither the underlying symptomatology nor need for care and treatment in 1997 was a direct result of the myocardial infarction of September 17, 1994. The compensation judge also denied the

employee's request for a rehabilitation consultation, specifically finding that since the 1994 work injury was not a substantial contributing cause of the employee's symptomatology and hospitalization in the autumn of 1997, therefore it was not a substantial contributing cause for the need for a rehabilitation consultation.

The employee appeals from the compensation judge's denial of his medical and rehabilitation claims, alleging that the 1994 work-related injury represents a substantial contributing cause to the employee's need for both the 1997-1998 medical treatment and the requested rehabilitation consultation.

STANDARD OF REVIEW

On appeal, the Workers' Compensation Court of Appeals must determine whether "the findings of fact and order [are] clearly erroneous and unsupported by substantial evidence in view of the entire record as submitted." Minn. Stat. § 176.421, subd. 1 (1992). Substantial evidence supports the findings if, in the context of the entire record, "they are supported by evidence that a reasonable mind might accept as adequate." Hengemuhle v. Long Prairie Jaycees, 358 N.W.2d 54, 59, 37 W.C.D. 235, 239 (Minn. 1984). Where evidence conflicts or more than one inference may reasonably be drawn from the evidence, the findings are to be affirmed. Id. at 60, 37 W.C.D. at 240. Similarly, findings of fact should not be disturbed, even though the reviewing court might disagree with them, "unless they are clearly erroneous in the sense that they are manifestly contrary to the weight of the evidence or not reasonably supported by the evidence as a whole." Northern States Power Co. v. Lyon Food Prods., Inc., 304 Minn. 196, 201, 229 N.W.2d 521, 524 (1975).

"[A] decision which rests upon the application of a statute or rule to essentially undisputed facts generally involves a question of law which [the Workers' Compensation Court of Appeals] may consider de novo." Krovchuk v. Koch Oil Refinery, 48 W.C.D. 607, 608 (W.C.C.A. 1993).

DECISION

Medical Treatment

The employee sought medical treatment in 1997 after noting chest pain similar to but more severe than the symptoms he periodically experienced since his 1994 work-related heart attack. Due to the employee's myocardial infarction in 1994, and also due to his underlying coronary artery disease and risk factors for heart-related conditions, the employee's physicians conducted extensive testing and evaluations in 1997, to rule out any cardiac condition. The employee's physicians, both at Falls Memorial Hospital and St. Mary's Hospital in Duluth, deemed it necessary to conduct those diagnostic tests to fully evaluate the specific nature of the employee's symptoms.

The medical evidence was equivocal as to whether the employee was actually experiencing cardiac pain in 1997, even though the symptoms the employee experienced in 1997 were similar to those symptoms he experienced periodically since 1994, and even though the physicians noted chest pain which was both typical and atypical of angina. The testing determined that there was likely no cardiac condition present in 1997, at least not a condition that required any further medical intervention at that time other than medication, stress reduction and low cholesterol diet. Even though the diagnostic testing was necessary to rule out any further complications or aggravation or continuation of symptoms from the employee's 1994 injury, the testing ruled out any additional myocardial infarction and angina in 1997.

As outlined in Minn. Stat. § 176.135, an employer and insurer "shall furnish any medical, psychological, chiropractic, podiatric, surgical and hospital treatment, . . . as may reasonably be required at the time of the injury and anytime thereafter to cure and relieve from the effects of the injury." Payment for medical treatment can include the costs of diagnostic testing performed to eliminate possible causes of an employee's continued symptoms. Neeb v. Collins Electrical Co., slip op. (W.C.C.A. 1993), citing Braatz v. Total Constr. & Equip., slip op. (W.C.C.A. May 19, 1992); Klaven v. Northwest Medical Ctr., slip op. (W.C.C.A. Sept. 24, 1991). However, to be awarded, medical expenses must be causally related to an employee's work-related injuries. Lang v. H&W Motor Express, 42 W.C.D. 402 (W.C.C.A. 1989).

"The burden is on the employee to prove by a fair preponderance of the evidence that he is entitled to workers' compensation benefits." Fisher v. Saga Corp., 463 N.W.2d 501, 501, 43 W.C.D. 559, 560 (Minn. 1990). The burden also is on the employee to establish that medical care and treatment rendered is causally related to the work injury and is reasonable and necessary. Buda v. Pillsbury Company, 38 W.C.D. 516 (W.C.C.A. 1986), as cited in Dorr v. General Office Prods., slip op. (W.C.C.A. March 13, 1990). "Where two opposing inferences can be drawn with equal justification from the same circumstantial evidence, it cannot be said that one preponderates over the other, and in that event the party having the burden of proof must lose. If different inferences can justifiably be drawn from the evidence in the case, the inference drawn by the factfinder will not be disturbed on appeal." Dille v. Knox Lumber/Div. of Southwest Forest, 452 N.W.2d 679, 681, 42 W.C.D. 819, 823 (Minn. 1990).

Based on the equivocal medical evidence, and the testing which ruled out any further cardiac condition, it was reasonable for the compensation judge to determine that there was no causal relationship between the employee's 1994 work-related injury and his 1997 condition. While it is clear from the record that the employee's physicians in 1997 took into consideration the employee's history of heart attack in 1994, there is evidence contained within the record which a reasonable mind might accept as adequate to support the compensation judge's determination that the myocardial infarction of September 17, 1994 was not a substantial contributing cause of the employee's symptomatology in late October 1997 nor the need for hospitalization, care and treatment.

This evidence, in part, was presented in Dr. Johnson's report. While the compensation judge did not specifically comment on the report of Dr. Johnson, the judge's

memorandum makes it clear that he reviewed the medical evidence (which included Dr. Johnson's report) that stated there was no relationship between the 1997 and 1998 medical treatment and the employee's myocardial infarction. It is well established that a judge has the right to choose among conflicting medical experts, Nord v. City of Cook, 360 N.W.2d 337, 37 W.C.D. 364 (Minn. 1985) and therefore it was within the judge's discretion to follow Dr. Johnson's opinion in determining that there was no causal relationship between the employee's 1994 work-related injury and his medical treatment in 1997 and 1998. We affirm the compensation judge's denial of the employee's claim for payment of medical expenses.

Rehabilitation Consultation

Also at issue is the employee's claim for a rehabilitation consultation. The employee argues that his treating physician has recommended that he change his employment, in order to reduce the job stress, thereby reducing the potential deleterious effects on his health. The compensation judge, however, denied the employee's claim for a rehabilitation consultation. In Finding 16, the compensation judge found that:

> Having determined that the myocardial infarction of September 17, 1994 was not a substantial contributing cause of the employee's symptomology and hospitalization in the autumn of 1997 the Court specifically finds that the myocardial infarction of September 17, 1994 is not a substantial contributing cause for the need for the employee to undergo a rehabilitation consultation.

Based upon Finding 16, it appears that the compensation judge based his determination on entitlement to a rehabilitation consultation solely on his conclusion that the 1997 symptoms and hospitalization did not relate back to the employee's 1994 heart attack. The judge's denial of a rehabilitation consultation was made absent any finding whether the heart attack of September 17, 1994, the heart damage resulting from that heart attack and the employee's physical reaction to job stress since 1994 all represent substantial contributing factors in the need for a rehabilitation consultation at this time.

The employee relies upon Dr. Helleloid's opinions in support of his claim for a rehabilitation consultation. Dr. Helleloid has repeatedly recommended that the employee seek work elsewhere than his current position as a service department manager. At various times between the employee's 1994 work-related injury and his 1997 hospitalization, Dr. Helleloid discussed with the employee the need to revise his work setting in order to reduce his reactions to job-related stress. The employee testified that certain revisions were agreed to by the employer but not put into place. These revisions were intended to reduce the periodic chest pains the employee claimed resulted from his stress.

In his December 12, 1997 letter, Dr. Helleloid opined that "flare-ups of his symptoms have been primarily related to stressful issues at work." Dr. Helleloid further stated that:

> It appears that your heart trouble relates directly to your original heart attack at work and continues to progress in a way that is related to your work. I believe that finding a different job would contribute substantially to reducing your risk for additional serious heart trouble.

(Joint Ex. A-2.) It is not clear from the judge's findings and order that he considered whether the employee's current condition resulted at least in part from his 1994 heart attack, and whether it substantially contributes to his periodic chest pains which seem to be precipitated by job-related stress. There is no indication in the compensation judge's findings and order whether he evaluated the employee's current job, any physical work restrictions resulting from the employee's 1994 work injury, and any medical recommendations concerning changing employment.

A rehabilitation consultation is intended to determine whether an employee is a "qualified employee," as defined in Minn. R. 5220.0100, subp. 22, to receive rehabilitation services. Minn. R. 5220.0100, subp. 26. "[A] rehabilitation consultation must be provided by the employer to an injured employee upon request of the employee." Minn. Stat. § 176.102, subd. 4(a). (Emphasis added.) Although an employer may be exempt from this provision if a timely request for a waiver is filed,[3] we find no evidence in the file that a waiver was requested here. Based on that fact alone, the employee should be allowed to undergo a rehabilitation consultation. However, as stated in Schierman v. Diversified Printers, slip op. (W.C.C.A. January 13, 1998), "employers and insurers may not always be held strictly responsible for a rehabilitation consultation on request simply because an employee at some point has been injured at work." Certain defenses and threshold liability issues may be asserted in opposition to a request for a rehabilitation consultation. See Judnick v. Sholom Home West, slip op. (W.C.C.A. August 4, 1995).

For example, the employer and insurer argue that the compensation judge did not find that the employee was restricted or unable to continue in his normal job duties as a result of the 1994 injury. The sole reference to the employee's ability to continue working at his previous pre-injury job is listed in Finding 6, wherein the judge states that "returning to work with the employer herein on or about November 28, 1994 the employee returned to his regular employment duties." (Finding 6.) However, the record is replete with references to the adjustments the employee personally has made to cope with his job-related stress, the psychological counseling he has undergone in order to address these purported stress issues, and the opinion of his treating physician, Dr. Helleloid, that adjustments needed to be made in the employee's job situation to alleviate the affects of the alleged job-related stress on the employee's heart condition.

As medical support for their position, the employer and insurer rely upon Dr. Mark Johnson, who found no objective medical basis for the recommendation that the employee change

[3] See Minn. R. 5223.0110, subp. 7; 5220.0120, subp. 2.

jobs. In Dr. Johnson's opinion, certain presumptions must be true to support a recommendation for a job change; if the employee's job were the sole source of significant psychological stress in the employee's life, if his symptoms could be shown to directly relate to stress, and if another job could be found that could be reasonably expected to be devoid of stress, then a job change might be recommended. Since Dr. Johnson found none of these presumptions to be true, and since the employee's records indicated he sustained no detectible progression of his heart disease since 1994, Dr. Johnson found no basis to support a change in the employee's job.

The employer and insurer further argue that it is appropriate for a judge to deny a rehabilitation consultation in situations where an employee has not shown any underlying entitlement to workers' compensation benefits. Derosier v. Albrecht Co., slip op. (W.C.C.A. Feb. 5, 1999) and Kautz v. Setterlin Co., 40 W.C.D. 206 (W.C.C.A. 1987). In this case, however, the judge has not specifically stated that the employee is not entitled to any workers' compensation benefits at the present time, as a result of his 1994 work-related injury. The compensation judge denied payment for specific medical expenses related to treatment in 1997. The judge did not specifically address whether the employee had any residual effects from his 1994 injury which could constitute, or at least point to, the need for a rehabilitation consultation at this point.

As a result, we remand this matter to the compensation judge for further determination as to whether the employee continues to experience any residual disability from his 1994 work-related injury, and whether the employee works under any physical work restrictions as a result of that injury, which could serve as a basis for the need for a rehabilitation consultation. If the employee has any ongoing disability as a result of his 1994 work-related injury, it appears that a rehabilitation consultation is required under the statute, since no waiver was requested by the employer and insurer.