RICHARD L. SOVELL, Employee/Petitioner, v. SWIFT-ECKRICH, INC., SELF-INSURED/GALLAGHER BASSETT SERVS. INC., Employer.

WORKERS' COMPENSATION COURT OF APPEALS
NOVEMBER 6, 2001

No. [REDACTED SSN]

HEADNOTES

VACATION OF AWARD - SUBSTANTIAL CHANGE IN CONDITION. The evidence offered in this case demonstrates a substantial change in the employee's medical condition sufficient to warrant vacation of the 1991 Award on Stipulation.

VACATION OF AWARD - VOIDABLE AWARD. Where the compensation judge improperly relied upon a presumption that the stipulation, which fully closed out future medical treatment for a condition allegedly caused by the employee's work injury, the 1993 Award on Stipulation was voidable. Because the 1993 Award on Stipulation can reasonably be seen in part as the result of a prior Award on Stipulation, which we have vacated on grounds of a substantial change in condition, equity requires that the 1993 Award on Stipulation also be vacated under the facts of this case.

Petition to vacate award granted.

Determined by Johnson, J., Rykken, J., and Wheeler, C.J.

OPINION

STEVEN D. WHEELER, Judge

The employee has petitioned to vacate two Awards on Stipulation, served and filed on January 10, 1991 and March 1, 1993, variously on the grounds of a substantial change in his medical condition, mistake and newly discovered evidence. We grant vacation of the Awards on Stipulation.

BACKGROUND

The employee, Richard L. Sovell, was born in 1951 and is 50 years old. He began working for the self-insured employer, Swift-Eckrich, Inc., in October 1987 at a weekly wage of $190.00. On February 10, 1988 the employee sustained an admitted work injury while working on the employer's turkey production line when a 25-pound frozen turkey fell from a cooler located about 10 feet above him, striking the back of his head, his neck and upper shoulder blades. He was briefly "knocked out" and then experienced neck pain, headaches and left upper extremity pain. (Ee Affidavit in Support of Motion to Set Aside Award/Petition to Vacate; Er Exh. 12: 5/18/89 chart note reviewing prior medical records.)

The employee was first seen by his family physician. He was given a neck brace, but he did not improve and his symptoms worsened. A cervical CT scan in April 1988 showed minimal foraminal narrowing on the left at C3-4 and C4-5 secondary to hypertrophic degenerative changes, with a fracture of the boney abnormalities. The employee underwent prolonged conservative treatment for chronic pain in the neck, left shoulder and left arm, including extensive physical therapy, exercise, medication, cervical traction and a TENS unit. He was eventually referred to a physiatrist, Dr. Janine Speier, M.D., who first saw the employee on November 10, 1988. At that time the employee was complaining of pain in the neck, left shoulder, left upper arm, and occasionally into the forearm and fingers. He was seen to exhibit significant pain behavior. Dr. Speier noted that the employee's problem could include a direct injury to the trapezius with significant muscle spasm, decreased range of motion of the left shoulder with probable adhesive capsulitis, and a component of a sympathetic dystrophy. The employee was next treated with a series of stellate ganglion blocks, which only provided temporary relief. (Er Exh. 12; Er Exh. 4: 10/24/89 report of Dr. Monsein summarizing prior treatment history.)

The employee was next referred to Dr. Erich S. Wisiol, a neurosurgeon. On April 28, 1989, Dr. Wisiol saw the employee and noted that there was a good deal of swelling in the employee's left arm and that he was refusing to use the arm. The employee was beginning also to complain of pain in his left lower extremity as well. The employee reported diffuse pain through the back of his neck from C3 to at least C7. He held his left arm with the shoulder in severe adduction and the left hand cradled. The left hand was grayish and its fingers were swollen. Dr. Wisiol diagnosed sympathetic dystrophy involving the left upper extremity. He recommended that the employee be admitted to the hospital for an MRI scan to include the brain and entire spine, and then to undergo a dorsal sympathectomy to the left upper extremity. (Er Exh. 1.)

The employee was admitted to Abbott-Northwestern Hospital on May 22, 1989 and was seen that same day by Dr. Adamarie Multari, M.D., for a consultation. Dr. Multari noted the absence of any significant cord or spinal pathology, and suspected that the major component of the employee's disease was psychogenic illness, with multiple somatic complaints suggestive of a somatiform disorder. (Er Exh. 3.)

The MRI scan done at the hospital was interpreted by Dr. Douglas Yock, a neuroradiologist, as showing a large lateral ventricular body and questionable absence or hyperplasia of the septum pellucidum. There was no evidence of a disc herniation or significant disc bulge in the spinal canal. Some narrowing of the foramina on the left at C3-4 and C4-5 and on the right at C6-7 were noted, along with a probable small lumbar disc herniation at L5-S1 with no compression of the dural sac or adjacent nerve roots. (Er Exh. 5: 12/1/89 summary report.)

A left upper dorsal sympathectomy was performed on May 24, 1989 with removal of the second and third dorsal sympathetic ganglia on the left side. The employee experienced some initial warming and decreased swelling in his left arm and some increase in his shoulder range of movement, but the relief of symptoms was short-lived and they subsequently returned to the pre-operative level. (Er Exh. 5: 12/1/89 summary report.)

On July 26, 1989, the employee was seen again by Dr. Speier six weeks after undergoing the sympathectomy. He was continuing to undergo physical therapy for active and

passive range of left arm motion, but still had significant contraction and a decrease in his willingness to move the limb. Other physical complaints included some tingling in both legs below the knees and some brief pain in the right arm when lifting weight. Dr. Speier felt that apprehension of movement, increased muscle tension, depression and poor insight into his condition were among the factors inhibiting a recovery. (Er Exh. 12.)

The employee returned to Dr. Wisiol for reevaluation on September 12, 1989. He was no better following the sympathectomy and complained of aching and pain in the neck, left side of the face, eyes and chest, particularly about the left shoulder girdle. He had complaints of feeling nauseated associated with intermittent vomiting. In addition to continuing complaints of prostadynia, the employee, for the first time, was complaining of pain in both knees, thighs and ankles. Dr. Wisiol noted that, despite physical therapy, the employee had not used his left arm effectively for the last two to three months. The employee held the left arm in an immobile position adducted at the shoulder and with the elbow flexed. Examination of the cranial nerves was noted as "within normal limits." Neck extension was limited by about 5 degrees but flexion and lateral twisting were normal. Deep tendon reflexes in the right upper extremities were normal, but could not be determined in the left upper extremities because of the employee's pain response to touch or motion. Deep tendon reflexes in the lower extremities were equal and active. Dr. Wisiol noted that the MRI had failed to reveal significant spinal cord pathology or significant disc problems. He considered the exact etiology of the employee's problems to be an enigma, with most of the organic causes ruled out. He opined that a great deal of the employee's difficulty was related to a severe emotional disturbance with depression, and recommended that the employee be seen and evaluated at a pain clinic and that serious thought should be given to psychiatric care. In his view, there was no need for further neurosurgical intervention or study. (Er Exh. 2: 9/12/89.)

The employee was evaluated for chronic pain treatment by Dr. Mathew Monsein on October 24, 1989. At that time, the employee reported tingling in the right leg and right foot, tingling and numbness in the left leg, increased pain with movement of his head, tingling in the left side of his face and over his left eye, upper back soreness and left arm swelling and stiffness. He also reported difficulty in breathing at night and panic attacks. The most significant pain continued to be left arm pain, with the employee claiming to be unable to move his arm at all because of pain and discomfort. The employee reported he was unable to drive a car and needed help from his wife when dressing as he was unable to button his shirt or pants. Dr. Monsein opined that the employee would be unable to participate in a pain clinic due to his significant overlay. In his opinion, the employee appeared to be totally disabled from any type of gainful employment. He was concerned that this could become permanent in the absence of an appropriate treatment intervention, and suggested that the employee undergo an inpatient physical therapy approach. (Er Exh. 4.)

The employee was seen by Dr. David R. Johnson, M.D., for a neurological evaluation on December 1, 1989. Dr. Johnson's primary diagnosis was of reflex sympathetic dystrophy ("RSD"), secondary to the 1988 work injury, involving the left upper extremity including both the arm and the hand. Dr. Johnson further opined that this was superimposed over a serious psychiatric disorder of long standing, as well as multiple prior injuries, including several prior significant head injuries. The doctor noted that the employee was unable to work and

anticipated that he would never go back to work in the future. He considered the employee to have reached maximum medical improvement. (Er Exh. 5.)

On May 10, 1990, apparently while in the hospital for the proposed inpatient physical therapy program, the employee was seen for acute urinary retention by a urologist, Dr. William Engel, M.D. Dr. Engel had previously treated the employee, both before and after the work injury, for occasional problems of apparent prostatitis and testicular pain. No urologic abnormality was found, and Dr. Engel opined that the employee's urinary problem was related to the primary medical problem of a chronic pain syndrome and sympathetic dystrophy of his left side following the work injury to his neck, as well as to the medications the employee had been receiving for pain relief from the work injury, which in combination apparently precipitated acute urinary retention. The employee was catheterized to relieve the accumulation of residual urine. (Er Exh. 5: 5/10/90.)

The employee was again seen by Dr. Monsein at the Sister Kenny Institute on May 11, 1990. Dr. Monsein noted that extensive inpatient physical therapy had not provided relief for the employee's symptoms and that diagnostic studies had not indicated the specific etiology of his discomfort. Because of increasing disability, not only in his left arm, but now starting to affect both arms and legs, the employee was being considered for a combination of chronic pain evaluation and psychiatric evaluation. The employee was seen to hold his left arm stiffly. Even light touch caused extensive pain behavior, and the doctor could not move his left arm. The employee had difficulty with both voluntary movement of the left leg or allowing Dr. Monsein to handle it. Dr. Monsein suggested a combination of pain medication, psychiatric evaluation and a chronic pain program as well as continuing anti-depressant treatment, which he thought would be the very last chance for the employee to return to any sort of a functional living status. (Er Exh. 12.)

The employee was admitted to Abbott Northwestern Hospital in May 1990. After one day on the medical unit he was transferred to the psychiatric unit, where he was seen by a psychiatrist, Dr. Ed Chua, M.D., in consultation for a severe conversion disorder. Dr. Chua noted that the employee's left arm was beginning to show dystrophy because of disuse and was developing contractures. Because of the failure of analgesia and surgery to help, Dr. Chua believed there were psychological reasons at a very unconscious level which were involved in the employee's holding his arm in this position of disuse. Dr. Chua recommended that he continue working with the employee for at least two weeks, to be followed with a transfer to an outpatient program or the chronic pain clinic for continued treatment. (Er Exh. 3: 5/16/90.) In addition to psychiatric treatment, the employee underwent a course of physical therapy, an interthecal morphine injection for pain relief, and oral analgesics. After one and a half weeks at the psychiatric unit the employee was transferred to the chronic pain rehabilitation clinic for three weeks of further treatment. (Er Exh. 13.)

Following this treatment, Dr. Monsein reported that the employee had not had any major improvement, although psychologically he was less depressed. The employee's left hand continued to be swollen and the employee continued to be unable to use it due to pain. He continued to walk with a limp and complain of persistent low back and left leg pain. In Dr. Monsein's view, the employee's prognosis for rehabilitation remained extremely poor.

Dr. Monsein recommended that the employee try to become involved in some type of structured daily activity, such as a sheltered workshop. (Exh. 13.)

In December 1990 the employee and the self-insured employer entered into a stipulation for a full, final and complete settlement, except for future medical treatment, in return for a lump sum payment to the employee of $175,000. The stipulation recited claims by the employee for an injury to the head, neck and shoulders, a consequential psychological injury, as well as a consequential injury to his eye as a result of shoulder surgery. The employee claimed that he was permanently and totally disabled, and that he had sustained a 35% whole body permanent partial disability rating as a result of the injury to the left arm under Minn. R. 5223.0090, subp. 4 (causalgia), as well as permanency for an alleged brain injury under Minn. R. 5223.0060. Despite his claim of permanent total disability, the employee also claimed entitlement to vocational rehabilitation services. The employer, on the other hand, claimed that the employee was not permanently totally disabled, that he had reached maximum medical improvement and that his permanency was less than alleged, asserting that the employee's psychological and psychiatric problems were not the result of a brain injury but instead were solely related to his nonwork-related pre-existing psychological problems. The stipulation for settlement was reviewed by a compensation judge and an Award on Stipulation was served and filed on January 10, 1999. (Judgment Roll; Er Exh 6).

On January 22, 1992, the employee was seen by Dr. Monsein in follow up. He reported having increased problems with headache, pain and panic attacks. The employee's physical examination remained unchanged. Dr. Monsein's impression was of RSD, myofascial pain syndrome, depression and a somatization disorder. The employee was again seen by Dr. Monsein on July 14, 1992. He continued to have diffuse musculoskeletal pain and swelling of his left arm, and now also complained of pain in his right arm and pain and swelling of both legs, particularly in the right ankle. Examination now showed not only decreased range of motion in the left arm but also some slight decreased range of motion in the right arm. (Exhs. 3, 14.)

The employee had some additional treatment by a proctologist, a gastroenterologist and Dr. Engel for anal and rectal problems in 1992. A review of the employee's medical records was conducted at the request of the self-insured employer on November 18, 1992 by Dr. Michael J. Bozivich, M.D., a specialist in internal medicine, for an opinion as to whether these problems were related to the work injury. Dr. Bozivich opined that the employee's anal and rectal problems were unrelated to the employee's left arm RSD or to any organic brain injury. (Er Exh. 8.)

On February 5, 1993, the employee and the self-insured employer entered into a further stipulation for settlement concerning the employee's claim for payment of medical bills for urological treatment and for evaluation and treatment of his anal or rectal problem. The employee agreed to a full, final and complete close-out of all future medical treatment for any anorectal or urological conditions allegedly related to the work injury in return for a lump sum payment of $752.10 to pay for the unpaid medical mileage, prescriptions and medical bills paid by the employee for treatment for urological and anorectal problems to date. On March 1, 1993, a compensation judge issued an Award on Stipulation predicated on the presumption that the stipulation was fair and reasonable, both parties having been represented by counsel. (Judgment Roll; Er Exh 7.)

Medical records from mid-1993 to 1998 have not been provided by the parties, and it is unclear whether the employee sought medical treatment during this period for the effects of the work injury.

On April 28, 1998, the employee was seen by Dr. Monsein with multiple somatic complaints, including pain in his neck and both arms, with the right arm having become as disabled as the left arm, such that the employee was unable to use it. The employee complained of intermittent bowel incontinence and frequent urinary incontinence. Dr. Monsein's impression was that the employee had "decompensated." Dr. Monsein referred him for ongoing mental health care with a psychiatrist. (Er Exh. 16.)

The employee was again seen by Dr. Monsein on October 16, 1998. Dr. Monsein noted that the employee had been involved in his pain clinic about six years earlier and had continued to be symptomatic, with complaints of pain in his back, down his left arm and down his left leg. He had marked hypersensitivity to touch over the left arm and to some degree over the right leg with allodynia. There was swelling of the left arm and puffiness of its fingers. Range of motion of the lumbar spine was decreased, and the employee continued to walk with a limp. On the same day, the employee was also seen by a urologist, Dr. Pratap K Reddy, M.D. The employee reported difficulty urinating for the past month, as well as pain in the right testicle and pain in the rectum. Dr. Reddy diagnosed a combination of underlying benign prostatic hyperplasia and prostatitis. The employee was started on medication to treat prostatitis. (Er Exh 11; Ee Exh. 8.)

On February 18, 1999, Dr. Engel wrote a letter to Dr. Monsein stating that the employee now had a problem with urinary retention, which in his view was related to his ongoing chronic back and brain problems and pathology. (Ee Exh. 8.)

On July 14, 1999, Dr. Engel saw the employee and noted that the employee's causalgia problem was progressing and had become very severe, now affecting essentially all of his extremities and trunk, and in turn causing progressive problems with voiding. Judging by the severity of his ongoing pain and symptoms, Dr. Engel opined that the employee's voiding pattern would never be normal again. He opined that the employee's bladder functioned satisfactorily but that the employee's muscle spasms and pain caused the urinary retention. He recommended a suprapubic cystostomy. (Ee Exh. 2.)

On July 14, 1999, Dr. Monsein noted that the employee continued to have symptoms associated with RSD and related to the work injury, including persistent pain in his neck and down into the left arm, and a Horner's syndrome. In addition, the employee had developed diffuse pain through his body, with secondary swelling of his right arm and pain in his back, neck and legs. While the doctor noted that the issue of RSD spreading to other extremities was somewhat controversial, he opined that this certainly appeared to be the case in the employee's situation. Dr. Monsein did not think the employee's gastrointestinal problems or prostate condition were necessarily related to the work injury but stated he would defer to Dr. Engel with regard to the prostate condition. Dr. Monsein noted that, from the standpoint of pain management, he did not have a lot to offer the employee. (Ee Exh. 5.)

On July 28, 1999, the employee underwent a cystoscopy and trocar suprapubic cystostomy. In a letter dated February 16, 2000, Dr. Engel explained that the employee's partial paralysis due to causalgia had progressed to the point where the employee was unable to urinate, and that the suprapubic cystotomy was required to keep his bladder empty and was likely a permanent situation. Dr. Engel opined that the employee's dystrophic response, although unusual, was clearly related to his neck injury and is a long-term complication of severe dystrophy. (Ee Exhs. 1, 3.)

On March 14, 2000, the employee was seen by Dr. Monsein who recorded that he presented with multiple symptoms that were very difficult to define, including persistent and total body pain, ongoing problems with bladder spasm, frequent bladder infections and frequent fever and chills, and diffuse musculoskeletal pain. Dr. Monsein noted that the employee's symptom complex was overwhelming, and it was uncertain whether it was due entirely to a profound somatization disorder or whether the employee did have a neurologic problem that would benefit from medical intervention. Dr. Monsein recommended that the employee's bladder problems and chills be further assessed. (Er Exh. 15.)

Following a medical record review on behalf of the self-insured employer, Dr. Lyle Lundblad, D.O., opined in a report dated May 19, 2000, that the employee's urological problems in July 1999 and his bladder condition were unrelated to the original injury, as MRI studies failed to demonstrate any cervical pathology which would contribute to a bladder dysfunction. In his view, RSD could not affect bladder function. (Er Exh. 18.)

The employee returned to Dr. Monsein on September 7, 2000. On that date, he was now using a wheelchair. He reported progressive vision loss in both eyes. Dr. Monsein stated he was at a loss as to providing assistive treatment. Due to the significant decline in functioning and medical condition, the employee was referred to the Mayo clinic. (Ee Exh. 12.)

In a letter dated October 26, 2000, Dr. Engel discussed the progression and history of the employee's urological problems and again expressed his opinion that the employee's causalgia or sympathetic dystrophy itself has resulted in the retention of urine and the necessity for a catheter. He opined that the employee was 100 percent disabled and that this had been as a result of progressive decline since he first saw him in 1988. (Ee Exh. 8.)

In a letter dated February 6, 2001, Dr. Monsein set out the history of the employee's conditions and provided his medical opinion. Dr. Monsein stated that over the subsequent 11 years there had been a progressive deterioration in the employee's clinical situation, in which the employee had developed increasing pain, disability and dysfunction to the point where he was basically unable to ambulate without a wheelchair. He had developed a dysfunctional bladder and now required a permanent suprapubic catheter; he had developed severe pain in the rectum, pain in the right upper extremity and in both legs, and had increasing problems with his vision. Dr. Monsein opined that "his condition has substantially worsened since the injury of 2/10/88 . . . Moreover, it was not contemplated in 1990 that the patient's condition would deteriorate to such an extent as it currently has." He stated that while in May 1990 he had rated the employee with a 35 percent permanent partial disability for his RSD to the left arm, he would now rate the employee with an additional 35 percent permanency for RSD in the right arm, as well as a further 10 percent

for the dysfunction of each lower extremity. He offered a 30 percent permanency rating for the employee's bladder dysfunction. (Ee Exh. 7.)

The employee now petitions this court to vacate both the January 10, 1991 and March 1, 1993 Awards on Stipulation.

DECISION

A. January 10, 1991 Award on Stipulation

This court's authority to vacate an award on stipulation executed prior to July 1, 1992 is governed by Minn. Stat. §§ 176.461 and 176.521, subd. 3 (1990). Under this statute, an award may be set aside if the employee makes a showing of good cause. Case law applicable to this version of the statute held that such grounds may exist if "(a) the award was based on fraud; (b) the award was based on mistake; (c) there is newly discovered evidence; or (d) there is a substantial change in the employee's condition." Stewart v. Rahr Malting Co., 435 N.W.2d 538, 539, 41 W.C.D. 648, 649 (Minn. 1989); Krebsbach v. Lake Lillian Coop. Creamery Ass'n, 350 N.W.2d 349, 353, 36 W.C.D. 796, 801 (Minn. 1984).

In this case, the employee claims good cause to vacate the award on stipulation based on a substantial change in medical condition. Factors this court considers in making this determination include change in diagnosis, change in employee's ability to work, additional permanent partial disability, the necessity of more costly and extensive medical care and services than initially anticipated, and whether there is a causal relationship between the employee's condition and the injury covered by the settlement. Fodness v. Standard Café, 41 W.C.D. 1054, 1060-61 (W.C.C.A. 1989).

Considering these factors, we note that the employee, prior to the stipulation, bore a primary diagnosis of severe RSD in the left upper extremity. He now has the additional diagnoses of RSD in the right upper extremity and in both the left and right lower extremities. The change in diagnosis does support the claims of substantial change in condition.

The employee was arguably permanently totally disabled prior to the stipulation and remains so now. This evidence supports a conclusion that there has not been a substantial change in condition. We do note, however, that the employee's ability to function in tasks of everyday living and in recreational activities has been markedly affected by the worsening of his physical condition. He now must use a wheelchair, whereas he was able to walk, albeit with a limp, at the time of the stipulation. Even for some time following the 1991 Award on Stipulation, Dr. Monsein was recommending that the employee become involved in structured activity in a sheltered workshop setting, and this kind of activity appears highly unlikely under the employee's present condition as currently described in the medical records.

Medical treatment for the employee's work injury was not closed out in the 1991 Award on Stipulation, and the question of whether the employee may need additional or more costly medical treatment is therefore not particularly relevant to the question of a substantial change in condition with respect to that Award.

The employee's whole body permanent partial disability as rated by Dr. Monsein has markedly increased, with that physician offering a further 35 percent rating for the RSD in the right arm, 10 percent for the right leg, and 10 percent for the left leg. The self-insured employer has not disputed causation of the employee's RSD condition as related to the 1988 work injury. A further 30 percent permanency rating has been offered by Dr. Monsein for the employee's bladder dysfunction condition. While causation for this latter condition is disputed, there is evidence in the form of the expert medical opinion of Dr. Engel on which a compensation judge could reasonably base a finding of a causal nexus with the work injury.

The self-insured employer argues that the employee should have anticipated the worsening of his condition, pointing to the fact that the employee already had occasional symptoms of tingling, pain and contraction in the right arm and both lower extremities prior to the 1991 Award on Stipulation, and further pointing out that a handwritten chart note at the Sister Kenny Institute dated May 7, 1990 contains the notation: "If anyone could develop a total body reflex sympathetic dystrophy, this man is on the way . . . ." We note, first, that while this note suggests that the spreading of the employee's RSD to other extremities was seen as *possible* in 1990, Dr. Monsein, presumably the author of this chart note taken at his clinic, stated in his letter, however, that "it was not contemplated in 1990 that the patient's condition would deteriorate to such an extent as it currently has." (Ee Exh. 7.)

Second, we note that the requirement that a substantial change in condition be reasonably unanticipated arises with the codification of prior case law cited above, with certain changes, in a 1992 amendment to Minn. Stat. § 176.461 which was not effective until July 1, 1992. The 1991 award on stipulation in this case pre-dated the effective date of the statutory amendment. "[U]nder pre-1992 case law, the inquiry in a change-of-condition case was restricted to the extent of improvement or worsening of the injury on which the original award was based." Franke v. Fabcon Inc., 509 N.W.2d 373, 377, 49 W.C.D. 520, 525 (Minn. 1993). For awards dated prior to July 1, 1992, whether any change in the employee's condition was or could have been reasonably anticipated at the time of the award is not considered. Id.

Based on consideration of each of the Fodness factors, several of which show marked deterioration of the employee's condition, we conclude that the employee has established a substantial change in condition warranting vacation of the 1991 Award on Stipulation under the applicable law.

B. March 1, 1993 Award on Stipulation

The 1993 Award on Stipulation was a full, final and complete close-out of past, present and future medical treatment for any urological or anal-rectal condition allegedly related to the employee's injury, in return for payment by the self-insured employer of certain to-date medical expenses, amounting to $752.10. The employee requests vacation of the 1993 Award on Stipulation on the basis of a substantial change in condition, mistake, and newly discovered evidence. We do not reach the employee's grounds for vacation as the 1993 Award on Stipulation was improperly issued by the compensation judge and is voidable in the discretion of this court where appropriate in the interests of equity.

In issuing the Award on Stipulation, the compensation judge relied upon Minn. Stat. § 176.521, subd. 2, which provides, in relevant part:

> A settlement agreement where both the employee or the employee's dependent and the employer and insurer and intervenors in the matter are represented by an attorney shall be conclusively presumed to be reasonable, fair, and in conformity with this chapter *except when the settlement purports to be a full, final and complete settlement of an employee's right to medical compensation* under this chapter or rehabilitation under § 176.102. A settlement which purports to do so must be *approved* by the Division, a Compensation Judge, or Workers' Compensation Court of Appeals. (Emphasis added.)

The compensation judge improperly relied on this presumption as the stipulation was a full, final and complete settlement of medical benefits for a condition alleged to be causally related to the employee's work injury. This court has previously granted petitions to vacate where the compensation judge failed to comply with the terms of the statute requiring that the judge first review the terms of the stipulation. For example, in Musta v. Ellison Meats, 43 W.C.D. 219, *summarily aff'd* (Minn. Aug, 2, 1990), this court found null and void an award which foreclosed rehabilitation where the compensation judge improperly relied on the statutory presumption. In cases where a compensation judge has jurisdiction to issue an Award on Stipulation but relies improperly on the presumption of fairness and reasonableness contained in Minn. Stat. § 176.521, the judge's Award is voidable by this court, after consideration of the equities involved. See Sondrol v. Del Hayes & Sons, Inc., 47 W.C.D. 659, 665 (W.C.C.A. 1992).

At the time of the 1993 stipulation, the parties had already entered into a full, final and complete settlement of the employee's claims arising from the 1988 work injury, excepting only future reasonable and necessary medical treatment. The employee had a single episode of inability to void, requiring a short-term catheterization, as well as some rather nebulous ongoing anal-rectal pain symptoms. The causal nexus between these problems and the work injury was disputed, with medical evidence on both sides of the issue. Nothing in the medical records suggests that the employee's physicians anticipated that the urological problem would recur or become permanent. No permanent partial disability rating was therefore offered in association with the urological condition. The employee sought payment of the medical bills associated with the evaluation and brief treatment of these problems, and agreed to accept the full, final and complete close-out of future medical expenses in order to avoid the uncertainty of litigation. While we might be disinclined to vacate the 1993 Award based solely on this situation taken alone, it appears to us that the parties' motivations for the 1993 settlement were inextricably intertwined with the existence of the prior, 1991 Award on Stipulation. The fact that the employee had already agreed to a full, final and complete close-out of all of his non-medical claims certainly affected the manner in which the employee assessed the weight of the alternative to settlement, litigation, in seeking to recover this limited dollar amount of medical treatment then at issue.

As we have vacated the 1991 Award on Stipulation, we consider that vacation of the 1993 Award on Stipulation is, therefore, the most equitable approach under the facts of this case.