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Workers Compensation independent review office

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SEPTEMBER 2017

ISSUE NUMBER 13

Bulletin of the Workers Compensation Independent Review Office (WIRO)

CASE REVIEWS (Recent cases)

The case reviews are not intended to substitute the headnotes or ratios of the cases. You are strongly encouraged to read the full decisions. Some decisions are linked to AustLii, where available.

[jurisdictional error; ambit of dispute in s 74 notice]

Mirarchi v CPA Australia Ltd [2017] NSWSC 1161

(Supreme Court of NSW: Adamson J, Date of Decision: 31 August 2017)

This decision involves a confirmed finding of jurisdictional error.

On 3 November 2006, the worker suffered a work-related injury to the right and left upper extremities in the course of her employment. It was agreed by the parties that the worker's left shoulder symptoms were the consequence of the right shoulder injury.

On or around July 2010, the worker claimed lump sum compensation for both shoulders under s 66 of the 1987 Act. On 16 July 2010, the parties entered into a complying agreement, which document excluded any reference to the left shoulder injury.

In or around 2011, and again in early 2015, the worker was further assessed by her doctor to be suffering a combined 27% WPI of the right and left shoulders. On 15 September 2015, she made a claim for further lump sum compensation. The insurer denied the claim on the basis of the effect of the Court of Appeal's decision in *Cram Fluid Power Pty Ltd v Green* [2015] NSWCA 250 (where it was held that a worker could only make "one claim" for permanent impairment lump sum compensation and that no amount is payable unless the degree of permanent impairment was greater than 10% WPI).

Following the enactment of the *Workers Compensation Amendment (Lump Sum Compensation Claims) Regulation 2015*, the worker's claim for further lump sum compensation was reinstated. The insurer then referred the worker for medical assessment to their own medical examiner, who certified a 1% WPI for scarring to her right elbow. The insurer denied liability on the basis that she failed to reach the

compensable threshold of greater than 10% WPI. The s 74 notice included a summary of their doctor's opinion on causation.

An AMS subsequently assessed the worker with 1% WPI, following the Registrar's referral of the "left upper extremity (shoulder)" and "right upper extremity (shoulder, wrist and elbow)". The AMS also included an opinion in the MAC that the symptoms of the left shoulder were not work-related. The worker appealed to a Medical Appeal Panel, which found no error and confirmed the AMS's assessment. In its reasons, the panel also found that the left shoulder injury was not work-related.

In considering the parties' submissions, the Court confirmed the common ground between the parties that the question of causation not be revisited and that the worker's degree of permanent impairment was the only issue that the Registrar was required to refer to the AMS for assessment. The parties also agreed that the MAC should be set aside on the basis of jurisdictional error. The Court found that the Registrar's referral to the AMS did not make it clear that the parties' dispute was confined to the worker's degree of permanent impairment and did not require a resolution as to causation since the latter was not in dispute (at [24]). According to the Court, this led to the AMS and the Medical Appeal Panel to misapprehend the ambit of the dispute.

The Court noted that the insurer's doctor's misplaced opinion as to causation, contained in the s 74 notice, caused the misapprehension, and stated that such an opinion "was irrelevant to the 'dispute' between the parties, since there was no issue of causation between them" (at [25]).

As a result, the AMS's original MAC, the decision of the Medical Appeal Panel and the Commission's COD were set aside by the Court, and the matter remitted back to be determined in accordance with the law.

The case demonstrated that care must be taken when defining a dispute in a s 74 notice, which will inform the exercise of the Registrar's power to refer the dispute for medical assessment.

[medical expert evidence]

***Dickson v Midcoast County Council t/as Midcoast Water* [2017] NSWWCC 197**

(WCC: Arbitrator Tim Wardell, Date of Decision: 22 August 2017)

The 29-year-old worker was injured while undertaking particularly heavy or strenuous work as a labourer on 17 August 2016. Concessions were made that he did not report the injury until after he had come back from holidays on 13 September 2016 (when he first reported the condition to his treating GP) and after the symptoms first became evident two weeks into his holiday during prolonged driving. He was subsequently diagnosed with left inguinal hernia.

The worker had surgical repair of the hernia. He then made a claim for weekly payments and medical treatment expenses. The insurer denied liability on the basis that the worker did not suffer an injury (s 4, 1987 Act) and that his employment was not a substantial contributing factor to any injury (s 9A, 1987 Act).

The insurer's medical expert, Prof Myers, formed an opinion that "the surgical literature no longer supports the proposition that inguinal hernia is caused by straining or due to chronic muscular effort" and that it is inevitable for people who are constitutionally predisposed to suffering hernias to develop the condition.

On behalf of the worker, Dr Hopcroft opined that there was a "direct relationship" between the work activities on or prior to 17 August 2016 and the "development" of the hernia, despite the evidence that relied on specific medical literature advanced by Prof Myers.

Prof Myers maintained that "inguinal hernia can no longer be accepted as work caused according to the scientific literature" and dismissed Dr Hopcroft's opinion as unsustainable because the expert did not have express knowledge of the current surgical literature.

The arbitrator rejected Prof Myers' opinion and the medical literature upon which it was advanced, and expressed concern that the respondent insurer engaged the doctor "in circumstances where it could be reasonably certain that it knew what opinion he was going to express, that opinion being a general and universal one unrelated to the circumstances of any particular case".

At [53], the arbitrator stated that:

> "[The conduct of the insurer] seems somewhat inconsistent, at least in spirit, with the objectives of the workers compensation system as set out in section 3 of the 1998 Act and the [medical examination guidelines], which emphasise the independence and impartiality expected of a doctor conducting an examination and providing a report on behalf of a worker or an insurer based on the examination undertaken."

In rejecting Prof Myers' evidence, the arbitrator found that the medical literature appeared to form a positive causal connection between heavy physical exertion and the development or aggravation of an inguinal hernia, contrary to what was being proffered by the doctor (at [59]).

In making this finding, the arbitrator set out three relevant fundamental legal principles:

- Cases are determined on the evidence presented and on their merits, rather than by reference to general studies and literature (which can still be taken into account);

- Determinations are made on the balance of probabilities and require the tribunal to be satisfied that the relevant causal connection is more probable than not;

- Where medical science admits the possibility of a causal connection between a particular activity and a pathological condition, a tribunal is able to consider the whole of the evidence and take into account a temporal connection between the activity and the manifestation of the pathology in order to find a causal connection has been made out on the balance of probabilities.

On the balance of probabilities, the arbitrator accepted Dr Hopcroft's evidence that the worker's heavy work caused or aggravated and rendered symptomatic the inguinal hernia, despite the circumstances that the worker may have had pre-existing weakness of the abdominal musculature or tissues (at [85]), and that the worker did suffer such a development or aggravation of a left inguinal hernia due to the heavy work (at [86]). The arbitrator further held that the employment was a substantial contributing factor to such an injury (at [95]).

[application of ss 59A(2) and 59A(3): limit on medical treatment payments]

***Hedges v Dr Dan White, Executive Director of Catholic Schools and Legal Representative for Sydney Catholic Schools* [2017] NSWWCCPD 34**

(WCC: Keating P, Date of Decision: 9 August 2017)

On 20 October 2014, the worker sustained an acoustic shock injury which caused tinnitus in her left ear, when two very loud noises were emitted while she was using a walkie talkie clipped to her clothing at shoulder height. She sought medical advice from her treating doctor, who recommended neuromonic treatment (which would involve the worker visiting St Vincent's Hospital in Darlinghurst once a month and undertaking some form of music therapy through a listening device for two hours a day and for the next six to nine months).

As the claim was found to have been made on 23 October 2014 and the worker was not in receipt of weekly payments for any incapacity, and was never medically assessed, the parties agreed that her entitlement to such medical treatment expenses ceased on 23 October 2016, pursuant to s 59A(2)(a)(i) of the 1987 Act. The insurer denied liability but accepted that the neuromonic treatment was reasonably necessary medical treatment.

The worker argued that, even if the entitlement period had ceased, she would be entitled to the payment of the medical treatment on the basis that she would also be entitled to weekly payments compensation (under s 36 of the 1987 Act) when she starts receiving treatment, pursuant to s 59A(3) and relying on the decision of Roche DP in *Flying Solo Properties Pty Ltd t/as Artee Signs v Collet* [2015] NSWWCCPD 14 (*Collet*).

The arbitrator determined that the worker was barred by s 59A(2)(a)(i) and distinguished the current matter from *Collet* in that the worker in *Collet* required a period of hospitalisation and a period of time off work following the surgery, whereas the worker in this case was to undergo neuromonic treatment at an audiology clinic (at [60] of the arbitrator's decision).

The arbitrator found no evidence concerning how many hours a week the worker was working, what her hours of work were and what the audiology clinic's operating hours were, before concluding (at [69] of her decision) that: "Even if the period of treatment extended for the six-month period referred to by [the treating doctor], and there were six visits made over the six-month period to the audiology clinic, I am not persuaded on the evidence at this stage that there would be entitlement to weekly benefits. [The worker] would need to prove that there was an incapacity while attending the clinic and that weekly compensation was 'payable' to her in the relevant period. After reviewing the evidence, I am not satisfied that the onus of proof has been discharged."

On appeal, the worker argued that there was error of law and/or fact and that the arbitrator failed to provide adequate reasons, and submitted that there was:

- error in declining to make orders consistent with *Collet*;
- error in determining the treatment sessions would amount to "half a day" and not explaining the basis for such a determination;

- error in not addressing the fact that the worker could not perform work and would be incapacitated;

- error in finding that any weekly payments entitlement would be based on s 37, not under s 36 as the worker posited.

The President rejected the worker's submissions and found that:

- the arbitrator made findings on "incapacity" consistent with *Collet* in determining that whether the worker may have an "incapacity" when attending the clinic for treatment is not determinative of whether or when weekly compensation was "payable" to her (at [60]-[61]);

- the arbitrator did not err in finding that the proposed treatment would involve "half a day" and was unexplained because such findings were consistent with the worker's own evidence and that of her treating doctor (at [62]);

- the arbitrator did not err in finding that the worker could not perform work duties and would be relevantly incapacitated while away from work and undergoing treatment; the findings of fact were open to the arbitrator (there was no evidence concerning the worker's hours of work, the audiology clinic's operating hours, no medical evidence of incapacity, etc) (at [63]-[65];

- the arbitrator made no mention of s 37 but, in fact, identified that s 36 would apply in the event that the worker established an entitlement to weekly payments, and there was therefore no error; because of the absence of evidence, the arbitrator was correct in finding that no s 36 entitlement to compensation could apply;

- the arbitrator had discharged her statutory obligation to provide sufficient reasons for the decision, and was within the standard that must be determined relative to the nature of the decision itself and the decision maker; when considering the adequacy of reasons a decision must be read as a whole: (*NSW Police Force v Newby* [2009] NSWWCCPD 75, *Mayne Health Group t/as Nepean Private Hospital v Sandford* [2002] NSWWCCPD 6 and *Beale v Government Insurance Office (NSW)* (1997) 48 NSWLR 430 considered).

For these reasons, Keating P confirmed the arbitrator's determination.

PROCEDURAL REVIEW UPDATES (WCD reviews)

All the procedural reviews of WCDs are published by the WIRO and can be accessed at wiro.nsw.gov.au/information-lawyers/work-capacity-decisions

Decision WIRO – 5317 (13 September 2017)

[Work capacity decision (WCD) set aside because irrelevant provision applied]

On 26 April 2017, the insurer made a WCD which advised that the worker's weekly payments would be reduced to $nil on 26 August 2017. The WCD noted the worker was within the second entitlement period (less than 130 weeks of weekly payments) under s 37 of the 1987 Act, but that he would be within the third entitlement period under s 38 of the 1987 Act by the time the WCD came into effect some four months later (in August 2017).

The insurer reasoned that the reduction in the weekly payments was due to the worker's failure to comply with the requirements under s 38(3) of the 1987 Act.

The worker sought an internal review from the insurer, which confirmed the original decision.

On merit review, SIRA identified a procedural error in the decision, stating that the insurer prospectively applied the provisions in s 38 where such requirements did not apply at the time of the making of the WCD.

The worker argued on procedural review that the insurer incorrectly applied the provisions in ss 38(3)(b) and (c) of the 1987 Act where they could not have been relevant at the time.

The WIRO found the WCD was invalidly made on the basis of a provision which was not at the time relevant to the worker's situation.

In setting aside the WCD and recommending a new decision be made, the WIRO stated that:

- "… Based on nothing more than an extrapolation from the applicant's current situation, the Insurer proceeded to advise that he was in breach of section 38(3), having failed to return to work for at least 15 hours per week and not earning at least $183 per week. A serious flaw with this argument is that the applicant cannot have failed to comply with section 38(3) until he is required to do so. It is not possible for the Insurer, the employer or the applicant himself to know what he will be doing in four months' time. It is equally impossible to determine that a worker will definitely be in breach of section 38(3). As the Authority correctly said, the prospective application of section 38(3) when it did not yet apply was "incorrect" and might need to be "rectified" (at [20]).

- " … The sole grounds for terminating the applicant's payments were said to be found within section 38(3), and that section was prematurely and therefore erroneously applied. It follows that this is an error of law which is by definition a procedural error of the type susceptible to review by this Office" (at [21]).

CASE STUDIES (Cases from ILARS and the WIRO Solutions Group)

Each week, the WIRO Solutions Group and ILARS receive hundreds of inquiries and referrals and deal with various issues concerning workers compensation claims and disputes. The following notes are examples of those issues.

Successful back payment of more than $100,000 weekly benefits

A worker's claim to be reimbursed for consultation expenses with his treating doctor was declined by his insurer without explanation, despite the latter paying for his medical treatment bills.

Pursuant to s 52A of the 1987 Act, the worker's entitlement to weekly payments ceased to be payable in August 2012. The worker had disputed this and subsequently received an award for weekly payments in 2014 for a closed period from August 2012 to 31 December 2012.

Since the weekly payments ceased, however, the worker continued to regularly provide certificates of capacity to the insurer.

The insurer also confirmed they had been paying for medical treatment because the worker received compensation for a 14% WPI of his left shoulder and cervical spine, which gave him medical entitlements until December 2017.

The current treating doctor referred to injuries to the lumbar and thoracic spine, which were not the injuries for which the worker was previously compensated. The insurer ultimately declined liability for these injuries in August 2017.

WIRO reviewed the COD which did not stipulate any determination regarding ongoing weekly payments. WIRO requested the insurer to review the worker's entitlements to weekly payments in line with his current certificates of capacity provided since 2014, and particularly in circumstances where s 52A had been repealed.

WIRO suggested the worker had made further claims in that he continued to provide the insurer with certificates of capacity, which contained sufficient information that constituted valid claims for weekly payments.

The insurer advised that the worker had not made any further claims since receipt of his award in 2014, but agreed to review any further claims.

The insurer then determined that from 31 December 2012 until the present date, the worker was entitled to weekly payments. It went on to reimburse the worker for the total amount of more than $100,000 to compensate for the past periods during which the worker did not receive the entitlement and for which certificates of capacity were provided. It found the worker to be entitled to ongoing weekly payments at a rate which represented 80% of his current PIAWE.

Use of iPhone recommended as hearing aids-compatible

A treating audiologist recommended to a worker that she should obtain an iPhone, as it was his opinion that the device is compatible with hearing aids and would greatly assist her. The insurer denied liability.

The audiologist wrote to the worker's lawyers and advised that the worker has "expressed difficulties in hearing conversations both through his home phone and existing mobile phone devices". According to the treatment provider, the clinical explanation for such a need is based on how the iPhone device would benefit the worker in not only improving her hearing during phone conversations but also in blocking out competing sounds around her. The audiologist indicated that she has "very poor speech discrimination".

WIRO asked the insurer to review their decision to decline the request for an iPhone, on the basis that the treating audiologist recommended it, and it would greatly improve the worker's quality of life after the injury.

On further review, the insurer approved the purchase of an iPhone.

WIRO ACTIVITIES & NEWS

New guide on section 39 matters

A WIRO Wire has been issued, which provides further information to lawyers about issues arising from s 39 of the 1987 Act.

WIRO WIRE: Section 39 Guide – Information for lawyers for injured workers

WIRO ILARS Policy Review

A WIRO Wire has been issued with a call for feedback on the ILARS policy review. We are grateful for the feedback we received from ALSPs.

WIRO WIRE: WIRO ILARS Policy Review – Feedback Welcome

Workers Compensation Commission procedural requirements on appeal

The WIRO notes Commission's ***e-Bulletin No. 71*** wherein a reminder has been issued about the standards accepted and procedural requirements that need to be complied with in lodging arbitral appeals under s 352 of the 1998 Act.

The e-Bulletin can be found in the Commission's website on www.wcc.nsw.gov.au.

Guide to merit reviews

Practitioners should note the SIRA Dispute Resolution Services' *A guide to Workers Compensation Merit Reviews*, published on 27 September 2017.

The guide can be accessed here: *A guide to Workers Compensation Merit Reviews*

WIRO Solutions Brief

Issues 10 and 11 of the *WIRO Solutions Brief* have been published. The newsletter is a regular insurer brief distributed to scheme agents on updates and other information relevant to the operations of the WIRO. To subscribe to the *WIRO Solutions Brief* and/or the *WIRO Bulletin*, please send an email to editor@wiro.nsw.gov.au.

Check out ***WIRO Solutions Brief* – Issue 10** and ***WIRO Solutions Brief* – Issue 11** on the WIRO website.

WIRO meets with insurers

WIRO invites all insurers to undertake a meeting with the office to discuss the general operation of the workers compensation scheme and the operation of the WIRO Solutions Group. WIRO regularly meets with insurers to provide insurer-specific feedback on performance and to discuss systemic issues identified by the WIRO Solutions Group.

If you would like to arrange a meeting with the WIRO Solutions Group, please contact Jeffrey Gabriel at jeffrey.gabriel@wiro.nsw.gov.au or (02) 8281 6308.

FROM THE WIRO

The WIRO office is celebrating its milestone fifth year of operation since it was established in 2012 at the time of very significant legislative changes to the scheme. During this time, my office has continued to advocate for further reform to improve the scheme for all stakeholders, but particularly injured workers. This advocacy has often been in response to various inquiries and reviews, such as the recently announced statutory review of the *State Insurance and Care Governance Act 2015.* I will be preparing a submission.

Further information is available at www.parliament.nsw.gov.au/lawandjustice.

Finally, I would like to thank the ALSPs who took the time to provide suggestions for improvement to the ILARS Policy and other documents, as requested in our recent WIRE. All of this feedback will be carefully considered in our review.

If you wish to discuss any scheme issues or operational concerns with respect to this office please contact my office through editor@wiro.nsw.gov.au in the first instance.

Kim Garling

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