WiRO
WorkCover independent review office

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**RECOMMENDATION FOLLOWING AN APPLICATION FOR REVIEW OF THE INSURER'S WORK CAPACITY DECISION PURSUANT TO SECTION 44(C) OF THE *WORKERS COMPENSATION ACT 1987.***

1. The injured worker is the applicant for a review of a work capacity decision made by a scheme agent of the Workers Compensation Nominal Insurer ("Insurer").

2. The applicant suffered injury to her respiratory / immune system on or about 10 January 2009 in the course of her employment as a procurement manager with the Insured.

3. As a result of the injury the applicant was unable to return to her pre-injury employment with the Insured. The applicant was able to find alternate employment on 11 March 2013 and performed suitable duties between 20 to 30 hours per week. The applicant has been paid weekly payments for all relevant periods and therefore was an existing recipient of weekly payments of compensation immediately prior to 1 October 2012.

4. On 12 June 2013 the Insurer advised the applicant in writing of a work capacity decision which had been made on that date. She was advised that her entitlement to ongoing weekly payments of workers compensation would be terminated on 18 September 2013 since she was found to have no entitlement under Section 38 of the *Workers Compensation Act* 1987 (the 1987 Act).

5. At the time of the work capacity decision the applicant was working 20 hours per week at the hourly rate of $30.00 per hour. The applicant's current weekly earnings were determined to be $600 per week gross in accordance with Section 43(1)(d) of the 1987 Act.

6. The Insurer also advised the applicant that they had determined that she was not working or earning to her maximum potential as required under Section 38 of the 1987 Act.

7. The Insurer made a decision that the applicant was able to work between 30 to 40 hours per week in suitable employment and she had the capacity to earn between $900 and $1200 gross per week. The Insurer

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advised the applicant that she had no entitlement to weekly payments of compensation under Section 38.

8. The applicant was advised that her entitlements to treatment expenses under Section 60 of the 1987 Act would cease on 19 September 2014 in accordance with Section 59 of the 1987 Act.

9. The applicant requested an internal review of the Insurer's decision. That review was responded to by the Insurer in writing on 12 August 2013. The review confirmed the original work capacity decision.

10. On 8 September 2013 the applicant made an application to the WorkCover Authority of New South Wales for a merit review of the Insurer's work capacity decision. That merit review application was received within the 30 day period. A WorkCover merit review was completed and a Statement of Reasons issued on 17 October 2013. The merit reviewer upheld the original decision of the Insurer. The merit reviewer found that the applicant had no entitlement to weekly benefits in accordance with Section 38 of the 1987 Act.

11. On 29 October 2013 the applicant requested the Independent Review Officer to undertake a review of the decision of the Insurer pursuant to Section 44(1)(c) of the 1987 Act. I am satisfied that the applicant has made the application within the time provided by that section and on the correct form.

**Applicant's Stated Grounds for seeking Procedural Review**

12. The applicant's grounds for seeking procedural review are as follows:

    (i) The selection of an appropriate medical practitioner for the examination of the applicant;
    (ii) Ensuring that all relevant medical evidence was provided to the independent medical examiner;
    (iii) The applicant alleges that her injury has not stabilised and the work capacity assessment is made based upon a stable injury;
    (iv) The applicant alleges that her nominated treating doctor cannot be viewed as an 'expert' in the management of her condition;

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(v) Ensuring that the Insurer meets the responsibility of establishing and managing an injury management plan 'tailored' to the worker's condition;

(vi) The request to have the work capacity assessment carried out by a suitably qualified specialist with current information was not responded to by the merit review;

(vii) The merit review decision mentions that the applicant is still employed. The applicant advises that at the time of the merit review she had ceased working and was in receipt of Centrelink payments;

(viii) The request for the Insurer to provide current medical evidence to the merit review was not responded to or acted upon;

(ix) The applicant's application for internal review decision was dated 1 August 2013. The applicant received the Insurer's letter dated 12 August 2013 on 16 August 2013;

(x) The application for merit review was acknowledged on 8 September 2013. The decision was not made until 17 October 2013 – 70 days later. The decision should have been delivered within 30 days;

(xi) The applicant alleges that her pre-injury earnings at the time of injury were $115,000 pa.

## Submissions by the Insurer

13. The Insurer made no submissions in response to the application.

## Legislation

14. Section 44(1)(c) of the 1987 Act limits the scope of procedural review to a review only of:

> The insurer's procedures in making the work capacity decision and not of any judg[e]ment or discretion exercised by the insurer in making the decision.

Therefore while it remains the case that no discretion is unreviewable[1], the Insurer's discretion when making a work capacity decision appears only to be reviewable in the course of merit review or Judicial review.

[1] *See Padfield v Minister of Agriculture, Fisheries and Food [1968] AC 997*

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15. The procedures to be followed by the Insurer are set out in the *WorkCover Work Capacity Guidelines* and *WorkCover Review Guidelines*. Both sets of *Guidelines* should be complied with in order for a work capacity decision to be validly made. Given the overall beneficial nature of the 1987 Act and the serious consequences to workers if decisions are made incorrectly, strict compliance with the *Guidelines* is required.

16. The relevant version of the *Guidelines* is the one dated 28 September 2012 and which applied to all claims from 1 January 2013. That publication provides that the *Guidelines* provide instructions and guidance to Insurers regarding the appropriate and consistent application of work capacity assessment.

**The Process of the Insurer**

17. The decision reached by the Insurer was certainly within the range of available decisions. The decision was indeed upheld by the merit review service.

18. The important consideration on procedural review is not why a decision is made, but how it is made.

**My Reasons:**

19. The grounds upon which the applicant seeks to rely can be dealt with shortly. Grounds (i) – (iv) and (vi) – (vii) are not procedural grounds. The issue of the applicant's pre-injury earnings in ground (xi) are not relevant as a result of the transitional provisions (which are explained later in this decision).

20. In respect of ground (v) - the work which the applicant was performing at the time of the work capacity decision was working from a home environment in accordance with the medical requirements on the work capacity certificate. This guideline was complied with.

21. The issues raised in grounds (ix) and (x) are timeframes which were not complied with however they do not relate to the work capacity decision.

22. The Insurer has made no submissions about compliance with the relevant statutory provisions and guidelines.

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23. Since procedural review requires a scrutiny of the decision-making processes of the Insurer, including examination of compliance with legislation and *Guidelines* rather than a consideration of submissions made by either party, the review process may proceed despite the absence of relevant submissions from either party. Any demonstrable error on the part of the Insurer may invalidate the decision.

24. There is in my view breaches of the *Guidelines* which are sufficient to invalidate the work capacity decision made by the Insurer.

25. The one major difficulty which faced the Insurer in making its work capacity decision is the requirement contained in Clauses 5 and 5.1 of the *Guidelines*. That was in the following terms:

***"Clause 5***

***Work capacity decisions should be made in line with the Best Practice Decision-Making Guide."***

and then:

***"Clause 5.1***

***When making a work capacity decision the insurer should follow the Best Practice Decision Making Guide."***

26. That Guide did not exist and has never existed or been published by WorkCover.

27. I find the Insurer has failed to follow the procedure as set out in the *Guidelines* in making the work capacity decision of 12 June 2013 as it did not (and through no fault of its own) comply with the requirements of Clauses 5 and 5.1.

28. Further breaches of the *Guidelines* include that the work capacity decision fails to clearly explain to the applicant that as an existing recipient of workers compensation payments she is required to be 'transitioned' under Section 38. It is not explained that the transitional

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rate which is used as the applicant's pre-injury earnings is a prescribed amount and not the applicant's actual pre-injury earnings. The Insurer fails to quantify the transitional rate in the notice. Further, the work capacity decision fails to explain the mathematical calculations of what is deemed to be the applicant's pre-injury earnings and what the Insurer has determined is the applicant's capacity to earn. An ineffective attempt to clarify the Insurer's position is made in the Internal Review letter directed to the applicant dated 12 August 2013.

29. *Guideline 5.4.2* states that the work capacity decision notice must clearly reference the relevant legislation and explain the line of reasoning for the decision. The Insurer has failed to do so.

30. Further, the above *Guidelines* also state that the work capacity decision notice must advise the applicant that any documents or information that have not already been provided to her can be provided on request to the Insurer. The Insurer has failed to so advise the applicant.

31. I find that the work capacity decision is accordingly not effective and the weekly payments amendments do not as yet apply to the applicant.

**My Recommendation:**

32. For the reasons set out above I recommend that the Insurer make another work capacity decision, according to the *Guidelines*.

33. Since the applicant was an existing recipient as at 1 October 2012, she remains entitled to receive her pre-transition rate of weekly benefits until such time as she is validly transitioned under the Act. The applicant should have her payments restored from 19 September 2013.

34. Noting the binding nature of these recommendations I recommend that the Insurer takes my views into account, and I recommend that the Insurer immediately gives effect to them.

Tracey Emanuel
Delegate of WorkCover Independent Review Officer
9 January 2014