WorkCover independent review office

Level 4, 1 Oxford Street, Darlinghurst NSW 2010
T: 13 9476
contact@wiro.nsw.gov.au
www.wiro.nsw.gov.au

RECOMMENDATION FOLLOWING AN APPLICATION FOR REVIEW OF THE INSURER'S WORK CAPACITY DECISION PURSUANT TO SECTION 44(1)(c) OF THE *WORKERS COMPENSATION ACT* 1987*.*

SUMMARY:

a. The work capacity decision of the Insurer dated 19 August 2013 is set aside.

b. The applicant is to be reinstated to his weekly payments at the rate applicable immediately prior to 27 November 2013.

c. The payments are to be back-dated to 27 November 2013.

d. The payments are to continue until such time as a further work capacity decision is made and comes into effect.

Background

1. The applicant seeks procedural review of a work capacity decision made by the Insurer on 19 August 2013. The decision stated that payments were to cease on 27 November 2013. The applicant sought internal review. The concurring Internal Review Decision (IRD) was issued on 17 October 2013. The applicant subsequently sought Merit Review by the WorkCover Authority, which issued a recommendation on 13 May 2014. Application was made to this office on 12 June 2014. I am satisfied that the application is within time and on the correct form.

2. The applicant was injured on 24 August 2004 while lifting heavy luggage in the course of his employment as a taxi driver. The injury was to his lower back. The Insurer made weekly payments as required under the provisions of the *Workers Compensation Act* 1987 (1987 Act) for all relevant periods.

3. The applicant was in receipt of compensation by way of weekly payments immediately before 1 October 2012. Accordingly Clause 8 of Part 19H of Schedule 6 to the 1987 Act required the Insurer to conduct a work capacity assessment for the purpose of facilitating the application of the amended weekly benefits provisions to the applicant's claim.

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Clause 17 of Schedule 8 to the Workers Compensation Regulation 2010 (the Regulation) required the transitioning process to be completed *"within 18 months"* of 1 October 2012.[1]

4. The relevant version of the *WorkCover Work Capacity Guidelines (Guidelines)* is the one which came into effect on 12 August 2013. The *Guidelines* provide instructions and guidance to Insurers regarding the appropriate and consistent application of work capacity assessments and decisions. They operate as delegated legislation. As such, they must be complied with in order for a decision to be validly made.

5. Once the Insurer has conducted an assessment then the Insurer is required to make a work capacity decision. Where that decision involves a reduction in or cessation of the weekly benefits payable to the injured worker then the Insurer is required to give proper notice to the worker (see section 54(2)(a) of the 1987 Act).

Submissions by the applicant

6. Section 44(1)(c) of the 1987 Act states that this review is "*only of the insurer's procedures in making the work capacity decision and not of any judgment or discretion exercised by the insurer."* The applicant's submissions, provided by a legal practitioner, largely addressed the merits of the case; that is, the very object of judgement or discretion of the Insurer excluded by section 44(1)(c) and therefore could not be relevant to this review. The only submission made by the applicant of a procedural nature concerned the currency of medical opinion. The most recent work capacity certificate stated that the applicant could only work 4 hours per day, whereas earlier certificates had conceded an ability to work for 8 hours per day.[2] The applicant makes the salient point that "current work capacity" is being examined, not work capacity as of several weeks, months or years in the past.[3]

Submissions by the insurer

[1] This clause expired on 31 March 2014.
[2] Raising the question as to why weekly compensation had been paid previously. The same earlier certificates had a lifting restriction of 10 kilograms, unlikely to debar a person from driving taxis.
[3] See paragraph 8 *infra* on the nature of "evidence as to work capacity."

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7. The Insurer produced a helpful timeline, file notes and some direct rebuttal of the submissions of the applicant. The Insurer submitted overall that the applicant had addressed merit issues, rather than procedural faults. As far as their submissions go, I accept them.

The Legislation

8. Section 44B sets out the evidence relevant to a worker's work capacity. It is instructive to read the section in full for two reasons: first, it reveals that the only documents seemingly relevant are "work capacity certificates" provided to insurers by workers, and secondly it shows that "currency" of medical opinion in relation to work capacity is, at least inferentially, very strictly defined:

> **44B Evidence as to work capacity**
>
> (1) A worker must provide to the insurer:
>
> (a) certificates of capacity in accordance with this section in respect of the period in respect of which the worker is entitled to weekly payments, and
>
> (b) a declaration in the form approved by the Authority as to whether or not the worker is engaged in any form of employment or in self-employment or voluntary work for which he or she receives or is entitled to receive payment in money or otherwise or has been so engaged at any time since last providing a certificate under this section.
>
> (2) If a decision to reject a claim for weekly payments or to terminate weekly payments is set aside, a worker is not required to comply with this section in respect of any period from the date that the decision took effect until the day on which the decision is set aside.
>
> (3) A certificate of capacity must:
>
> (a) be a certificate given by a medical practitioner in a form approved by the Authority, and

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> (b) certify as to the worker's incapacity for work and whether the worker has a current work capacity or has no current work capacity during the period, not exceeding 28 days, stated in the certificate, and
>
> (c) specify the expected duration of the worker's incapacity.
>
> (4) A certificate of capacity may cover a period exceeding 28 days if:
>
> (a) the person giving the certificate states in the certificate the special reasons why the certificate covers the longer period, and
>
> (b) the insurer is satisfied that, for the special reasons stated, the certificate should be accepted.
>
> (5) A certificate of capacity is of no effect to the extent that it relates to a period that is more than 90 days before the certificate is provided.
>
> (6) The insurer may discontinue weekly payments of compensation if the worker fails to comply with a requirement under this section within 7 days after the requirement is communicated to the worker by the insurer.
>
> **Note :** Section 270 of the 1998 Act also allows an insurer to require medical evidence and authorisations about incapacity for work when weekly payments begin.

There is nothing in this section which authorises an insurer to rely on "vocational assessments," reports from Independent Medical Examiners, "employability reports" or reports from "injury management consultants." There is no other section in the legislation which addresses the issue of relevant evidence. Clause 3 of the *Guidelines* has only this to say:

> "The certificate of capacity is one of the many sources of information used to help inform a tailored approach to injury management and return to work planning for each worker."

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While the above quote from the Guidelines clearly anticipates other forms of evidence to assist with injury management and return to work, there is nothing there to justify the argument that any such evidence is relevant for the purposes of assessing work capacity under section 43.

Similarly, the periods in section 44B(3)(b), (4) and (5) clearly indicate that work capacity can only be certified prospectively for 28 days in the absence of "special reasons" and may not cover any period in the past exceeding 90 days. It follows that if these time restrictions apply to workers, they must equally apply to insurers. It further follows that medical evidence of any kind more than 118 days old is not good evidence of current work capacity.

All of the above might be read with an eye to clause 5.1 of the *Guidelines*, which purports to set out such "new information" as the insurer may rely upon when making a work capacity decision. This is described as "… new information that relates to the worker's capacity for employment[4] which may affect the calculation of weekly payments." Precisely how "new" this information need be is not said. We are told that it " ..may include but is not limited to" the following:

- Evidence of the worker's pre-injury wages or current wages;
- *WorkCover NSW Certificate of Capacity*;[5]
- A change in the worker's personal circumstances;
- Confirmation that the worker has returned to work;
- Confirmation that the worker has become unable to work at all, or as much as they had been;
- A report from a medical practitioner or allied health practitioner;
- A workplace rehabilitation report; and
- An investigation report.

From my reading of section 44B it is clear that the last three bullet points are *ultra vires*.

The Decision

[4] As opposed to "work capacity."
[5] Interestingly, "certificate" rather than "certificates" is used.

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9. Under the heading "[**The Insurer's**] **Decision**" and following the words "[t]this decision has been made because:", we are treated to a summarised recitation of the contents of section 43(1), or at least the bulk thereof, in a pentalogue of truncated bullet points. The applicant is advised that he has current work capacity, and s 43(1)(a) is cited (without being quoted or paraphrased) and that process follows through suitable employment (s 43(1)(b)), earning capability (s 43(1)(c)), and PIAWE (s 43(1)(d)), none of which is particularly exceptional or objectionable. What is both particularly exceptional and objectionable is what appears next. Having blithely skated past s 43(1)(e), the insurer produces this effort:

> "Any other decision of [the Insurer] that affects your entitlement to weekly payments of compensation including a decision to discontinue the amount of weekly payments of compensation payable on the basis of any decision referred to above (Section 43(1)(f))."

10. It need hardly be said that the syntactical gymnastics required to make sense of the foregoing are beyond common reason.[6] To list "any other reason" as a reason for doing something achieves the feat of misdescribing an irrelevant consideration, something which results in the decision being invalid for reasons which are not knowable.[7] It is clearly a demonstrable error.

11. *Guideline* 5.3.2 requires the Insurer *"to state the impact of the decision on the worker in terms of their entitlement to weekly payments, entitlement to medical and related treatment expenses and return to work obligations."* The decision correctly states that treatment and related expenses are no longer payable 12 months after weekly payments cease. The decision does not refer to section 59A(2) of the 1987 Act, rather it refers only to section 59, which is a completely different section. This is therefore a demonstrable error.

[6] "Reason" in this context has no relation to "reason" used in paragraph 9 *supra*, or in what follows.
[7] Donald Rumsfeld might have missed his calling after all.

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12. In addition, section 59A(3) of the 1987 Act states that the applicant may, after the entitlement to compensation for medical expenses ends, become eligible for further payments for medical expenses if the applicant becomes entitled to compensation for weekly benefits at some stage in the future and for such time as those weekly payments continue. This was not disclosed by the Insurer. This is also therefore a demonstrable error.

13. The Insurer later seeks to set out the documents "relied upon in making this decision." The documents set out are named as follows (*sans* numbering):

- Vocational assessment report
- Final exercise report
- WorkCover Certificate of Capacity/Medical Certificates
- Job seeking logs
- Employability report including approval of vocational options
- Injury management consultation report
- Progress report (from a vocational assessment service provider)
- Email (from the same vocational assessment service provider)

All of this is interesting and only the first part of point 3 seems to come within "evidence of work capacity" as contemplated in section 44B. Since the second part of point 3 refers to more than one medical certificate, it must also be outside the requirements of both *Guideline* 5.1 and section 44B.[8]

FINDING

14. I find that the Insurer has failed to follow the procedures as set out in the WorkCover *Guidelines* which is a requirement of Section 44A of the 1987 Act. The Insurer has also failed to follow the 1987 Act and the *Workers Compensation Regulation* 2010.

RECOMMENDATION

[8] See footnote 5 *supra*.

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15. I recommend that the Insurer conduct a new work capacity assessment in accordance with the WorkCover *Guidelines* and make a new work capacity decision.

16. I recommend that the Insurer pay the applicant the weekly benefit to which he was entitled immediately prior to 27 November 2013 until such time as he is properly transitioned. Those payments should continue from 27 November 2013 being the date on which they ceased.

17. Since the applicant is not currently in receipt of weekly payments, clause 21 of schedule 8 of the *Regulation* cannot apply and payments may resume immediately. The applicant is not required to produce work capacity certificates for the period from 27 November 2013 to date by virtue of the operation of section 44B(2) of the 1987 Act. These recommendations are binding on the insurer: see section 44(3)(h) of the 1987 Act.

Wayne Cooper
Delegate of the WorkCover Independent Review Officer
18 July 2014