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(1)(c) OF THE *WORKERS COMPENSATION ACT* 1987.

SUMMARY:

a. **The work capacity decision of the Insurer dated 22 July 2013 is set aside.**

b. **The applicant is to be reinstated to his weekly payments at the rate applicable immediately prior to 30 October 2013.**

c. **The payments are to be back-dated to 30 October 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 22 July 2013. The decision stated that payments were to cease on 30 October 2013. The applicant sought internal review. The Internal Review Decision (IRD) was issued on 20 September 2013. The applicant sought Merit Review by the Authority on 31 October 2013. The Merit Review was issued on 8 May 2014, 198 days later. The applicant did not receive the Merit Review until 19 May 2014.[1]

2. The applicant was injured on 19 October 2004. The injury was to his right shoulder. He was unable to return to suitable employment with the employer but was able to obtain suitable employment with another employer. The Insurer made weekly payments as required under the provisions of the *Workers Compensation Act* 1987 (1987 Act).

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. Clause 17 of Schedule 8 to the Workers Compensation Regulation 2010 (the

[1] An impressive 209 days after the application was made.

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Regulation) required the transitioning process to be completed *"within 18 months"* of 1 October 2012.

4. The relevant version of the WorkCover Work Capacity Guidelines *(Guidelines)* is the one dated 27 September 2012 which came into effect on 1 January 2013. The *Guidelines* provide instructions and guidance to Insurers regarding the appropriate and consistent application of work capacity assessments and decisions.

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."* Some of the applicant's submissions went to 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 applicant made other submissions related to procedural matters. First, the IRD does not refer to the *"Best Practice Decision Making Guide".* Secondly, there is no date given for the assessment.

Submissions by the insurer

7. The Insurer was invited to make submissions but did not do so.

The Decision

8. The decision states that a work capacity assessment was undertaken. No date for the assessment was provided. The Insurer is required to make a decision "*as soon as practicable"* after the assessment is made: see Clause 23, Schedule 8, *Workers Compensation Regulation* 2010. The applicant cannot know whether that has occurred. The decision does not state that the assessment is required pursuant to Clause 8 of Part 19H of

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Schedule 6 to the 1987 Act. As such the legislation has not been properly referenced as *Guideline* 5.4.2 requires.

9. There does not appear to be any legislative requirement to notify the applicant of the outcome of the assessment. However, *Guideline* 5.4.2 stated that the decision must:

    - *state the decision and give brief reasons for making the decision;*
    - *outline the evidence considered in making the decision, noting the author, the date and any key information. All evidence considered should be referred to, regardless of whether or not it supports the decision;*
    - *clearly explain the line of reasoning for the decision.*

    My finding is that the *Guidelines* result in the insurer being compelled to reveal the outcome of the assessment which would involve showing the date of the assessment.

10. *Guideline* 5.1 requires the Insurer to follow the *"Best Practice Decision-Making Guide".* That Guide never existed. The Insurer cannot have been able to satisfy *Guideline* 5.1. It appears that the author of the *Guidelines* failed to consider whether the Guide existed before issuing the *Guidelines*.

11. *Guideline* 5.4.2 required the decision to *"reference the relevant legislation."* This would require any interpretation of the legislation (including delegated legislation) to be accurate. It is clearly inaccurate to say (as this Insurer has said) that the claim *"must transition to the new benefits system in 2013."* What Clause 8(2) of Part 19H of Schedule 6 to the 1987 Act requires is for the Insurer to conduct a work capacity assessment (for the purposes of transitioning a claim) *"no later than 12 months (or such longer period as may be prescribed by the regulations) after the commencement of the weekly payments amendments."* While the amendments commenced on 1 October 2012, the *Workers Compensation Regulation* 2010 says at Clause 17, Schedule 8 that *"a period of 18 months is prescribed for the purposes of Clause 8(2) of Part 19H of schedule 6 to the 1987 Act."* It follows that there was no

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requirement for the Insurer to conduct a work capacity assessment and for the claim to be transitioned *"in 2013."*

12. *Guideline* 5.4.2 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."* Section 59A(2) of the 1987 Act provides that treatment expenses and related expenses are no longer payable 12 months after weekly payments cease. The decision states that *"any entitlement you may have to payment of pre-approved reasonable and necessary medical and other expenses, until 30 October 2014, will not be affected".* The decision does not state what is to happen after 30 October 2014. Are these payments to cease or be restricted in some fashion? As the section has not been referred to the applicant is unlikely to be able to determine what is to happen after 30 October 2014.

13. 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.

14. The decision states that the Notice is given in accordance with section 54 of the 1987 Act. The correct reference is to section 54(2)(a) of the 1987 Act.

15. The decision states that the applicant has a *"current capacity to work"* and reference is made to section 43(1)(a) of the 1987 Act. The correct reference is to the definition of *"current work capacity"* in section 32A of the 1987 Act. That definition means being unable to return to pre-injury employment, but being able to work in *"suitable employment".* That term is also defined in section 32A. It is central to the 2012 amendments. The definition includes, *inter alia*, that suitable employments includes work *"whether the work or the employment is of a type or nature that is generally available in the employment market".* An applicant is unlikely to know from the term suitable employment that it may include work which may not exist.

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16. The applicant is advised that section 38 of the 1987 Act applies to him as he has been in receipt of weekly payments for in excess of 130 weeks as that is the expiration of the second entitlement period. It should be explained that the *"second entitlement period"* is defined in section 32A of the 1987 Act. It is not merely a concept devised by the Insurer. In relation to calculating weekly payments the correct reference is to section 38(7) of the 1987 Act.

17. The applicant is advised that his Average Weekly Earnings (AWE) is $938.30. Reference is made to section 43(1)(d) of the 1987 Act. The Insurer should have referred to clause 1 (the definition of "*existing recipient of weekly payments*"), clause 2 (the transitional amount as indexed), and clause 9(3) (the deeming provision) of Part 19H of Schedule 6 of the 1987 Act. Section 43(1)(d) states that the Insurer may make *"a decision about the amount of an injured worker's pre-injury average weekly earnings or current weekly earnings".* The Insurer has stated that the transitional amount must be used and that the Insurer can make a decision about average weekly earnings. Which of these 2 options is to be used is left unsaid.

18. The decision states that the applicant's "*entitlement to weekly payments at your current rate must cease within 3 months of this decision – please refer to: Section 43(1)(f) and 54(2)(a) of the Workers Compensation Act 1987".* If the applicant was to read section 54(2)(a) he would see that the 3 month period is the minimum, not a maximum.

19. The decision lists documents which the Insurer has *"reviewed and considered".* At the end of the list of documents the Insurer states that the *"information which supports our decision indicates". Guideline* 5.4.2 states that all evidence considered should be referred to, whether or not it supports the decision. The Insurer by stating *"information which supports our decision"* is a statement that the Insurer has only considered information which supports the decision. Any information which does not support the decision may have been ignored. This is a demonstrable error.

20. The applicant is advised that he may request an internal review. The Insurer has not referred to section 44(1)(a) of the 1987 Act. This is a breach of *Guideline* 5.4.2 and the need to *"reference the relevant legislation."* The Insurer states that the request can be made by facsimile

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or email. The Insurer does not say that such a request can be made by post. This error by omission is the more unusual for the decision itself being only capable of service either in person or by post.

21. The application for internal review is said to be required to be lodged within 30 days of receipt of the decision. That is not correct. Section 44(1)(a) of the 1987 Act does not set any time limit in which the application for internal review is to be made. *Guideline* 6.2.2 states that there is a 30 day time limit. *Guideline* 7.1.2 of the *Guideline* which came into effect on 11 October 2013 correctly refers to *"timely lodgement"* and that the application should be lodged *"as soon as practicable after receiving the work capacity decision".* A time frame of 30 days may well be appropriate, but no assistance is given as to what may constitute *"timely lodgement."*

22. The decision states that "*frivolous and vexatious applications may be rejected."* An Insurer cannot refuse to carry out an internal review even where it decides that an application is frivolous or vexatious. The Authority and WIRO may decline to review a matter where the application is frivolous or vexatious (not frivolous <u>and</u> vexatious as the decision says) pursuant to section 44(3)(c) of the 1987 Act.

23. The decision states that it was made by a *"Technical Specialist."* The nature of this technical specialist's specialization is not stated and would not be apparent to the applicant.[2] It is then stated that the decision was reviewed and confirmed by the *"Work Capacity Team."* No names are given. The decision is signed by the "*Work Capacity Team*", not the Technical Specialist who is said to have made the decision. The applicant cannot know who made the decision. This is important as the IRD must be made by someone who was not involved in the decision: *Guideline* 6.2.6.[3] When the decision-maker cannot be identified by the applicant, he cannot know whether the IRD was undertaken by someone not involved in the decision. This is a breach of the requirement that the assessment, decision-making and review processes be conducted and communicated to injured workers in a transparent manner.[4]

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[2] Arguably a "technical" objection in every sense.
[3] See also 7.2-7.5 of the *Review Guidelines*.
[4] See for instance *Work Capacity Guideline* 2.3.

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FINDING

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

RECOMMENDATION

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

26. I recommend that the Insurer pay the applicant the weekly benefit to which he was entitled prior to 30 October 2013 until such time as he is properly transitioned. Those payments should continue from 30 October 2013 being the date on which they ceased.

27. 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 30 October 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
30 July 2014