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 31 December 2013 is set aside.

b. The applicant is to be reinstated to his weekly payments at the rate applicable immediately prior to 7 April 2014.

c. The payments are to be back-dated to 7 April 2014.

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 31 December 2013. The decision stated that payments were to cease on 7 April 2014. The applicant sought internal review. The Internal Review Decision (IRD) was issued on 10 February 2014. The applicant sought Merit Review by the Authority. The Merit Review was issued on 22 May 2014.

2. The applicant was injured on 14 October 2011. The injury was to his right hip. He returned to suitable employment. 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 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 4 October 2013, published on 8 October

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2013, and which came into effect on 11 October 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."* The applicant's submissions went to the procedural issues in the case. He raised the issue that he has not been transitioned correctly as the assessment was done incorrectly. Further, weekly payments had ceased on 20 November 2013, rather than 7 April 2014 as the decision states.

Submissions by the insurer

7. The Insurer's "submissions" consisted of a time-line, which did not assist greatly. No mention is made of the two Notices issued pursuant to section 74 of the *Workplace Injury Management and Workers Compensation Act* 1998 (1998 Act). The first Notice, of which I do not have a copy, was apparently issued on 18 November 2013. The second, of which I have a copy, was issued on 27 March 2014. The second Notice is called a *"Revised Notice"* and states that it confirms the decision of 18 November 2013 to deny all liability for weekly payments and treatment expenses as of 18 November 2013. As a result it is not clear why the Insurer issued a decision when it appears it issued a section 74 Notice on 18 November 2013. The Insurer made no attempt to explain what has occurred.

The Decision

8. The decision states that a work capacity assessment was undertaken on 31 December 2013. The decision does not state that the assessment is required pursuant to Clause 8 of Part 19H of Schedule 6 to the 1987

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Act. As such the legislation has not been properly referenced as *Guideline* 5.3.2 requires.

9. There does not appear to be any legislative requirement to notify the applicant of the outcome of the assessment. However, *Guideline* 5.3.2 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.

10. The decision states that notice is given pursuant to section 54 of the 1987 Act. The correct reference is to section 54(2)(a) of the 1987 Act. An appropriate time for 3 months notice is then given to 7 April 2014. It should be explained that the 3 months notice takes into account the time for delivery of the notice by post which is governed by section 76(1)(a) of the *Interpretation Act* 1987 which allows for service by post to be effected on the 4th working day after the day of posting. A decision may only be served in person or by post. In this time it is peculiar that a document cannot be served, when appropriate, electronically.

11. Section 43 of the 1987 Act is then set out as to decisions which may be made, including *"a decision about the amount of an injured worker's pre-injury average weekly earnings or current weekly earnings"* (section 43(1)(d)). For a claim which is being transitioned to the new legislation, as this claim is, the Insurer cannot make a decision about "*pre-injury average weekly earnings"* (PIAWE). The PIAWE is the transitional rate as set out in Clause 2, Part 19H, Schedule 6 to the 1987 Act. The decision states that on the following page. An applicant would be rightly concerned that there are two methods to determine PIAWE and would

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be under the impression that the Insurer has chosen one method in preference to the other. This is misleading, to say the least.

12. The reason given for choosing the transition rate is that it applies to the applicant as he was in receipt of weekly payments *"as at 14 October 2012"* pursuant to clause 2 of Part 19H of Schedule 6 of the 1987 Act. Whether or not the applicant was in receipt of weekly payments on 14 October 2012 is irrelevant. The test is being in receipt of weekly payments immediately before 1 October 2012. The Insurer should have referred to clause 1 (the definition of "*existing recipient of weekly payments*"), clause 2 (the transitional amount as indexed which is why the figure used is $948.50), and clause 9(3) (the deeming provision) of Part 19H of Schedule 6 of the 1987 Act. The test as incorrectly stated is a demonstrable error.

13. The decision states that weekly payments are divided into three entitlement periods. A fourth period is the period after 5 years pursuant to section 39 of the 1987 Act although there is little need to point that out to the applicant in this matter. The applicant has *"received between 14-130 weeks of weekly compensation."* The applicant should have been referred to section 32A of the 1987 Act and the definitions of *"first entitlement period"* and *"second entitlement period."*

14. It is then stated that section 37 of the 1987 Act applies. Section 37(2) provides the test of working for not less than 15 hours. The calculation is then set out as AWE x 95% - E + D. The decision does not state that the terms of the calculation (AWE, E and D) are defined in section 35 of the 1987 Act. The decision then states that the applicant is *"currently working and earning $*[XXX] *in suitable employment which exceeds your s 37(3) entitlement of $758.80."* As the transitional rate is $948.50, 95% of that is $901.08. The applicant would have little idea as to why the Insurer has jumped between two subsections of the 1987 Act and as to how 95% of $948.50 can equal $758.80. If the applicant read the section himself[1] he may be capable of understanding what has occurred, but even someone with a good knowledge of legislation may be justifiably confused. Applying the wrong calculation is a demonstrable error.

[1] Used here as an emphatic pronoun.

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15. The confusion continues with the next sentence which states that the applicant is *"currently unfit."* As the applicant has also been told that he is currently working 15 hours per week, the applicant would by this stage have little faith that the Insurer has applied any consistency of thought to reaching the work capacity decision. Various differing sections are used, 95% in one sentence does not mean the same thing as 95% in another sentence, and (perhaps most anomalously) he is both working and not working at the same time.

16. *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 Section 59A(2) of the 1987 Act provides that treatment expenses and related expenses are no longer payable 12 months after weekly payments cease although the reference is only to *"the Act".* The legislation has not been properly referenced.

17. The Insurer failed to point out that 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.

18. Guideline 5.3.2 requires the Insurer to *"advise that any documents or information that have not already been provided to the worker can be provided to the worker on request to the insurer".* The decision states that the applicant has been sent copies of the 3 documents listed in the decision. He is not told that he may request copies of other documents. The decision also states that the documents have been provided pursuant to section 74 of the *Workplace Injury Management and Workers Compensation Act* 1998 and clause 37 of the *Workers Compensation Regulation* 2003. Section 74 deals with claims in dispute and is not relevant. In any event, the 2003 *Regulation* was repealed on 1 February 2011. The relevant provision would be clause 46 of the *Workers Compensation Regulation* 2010. This is a demonstrable error.

19. The decision states that it was made by Person A, but the decision is signed by Person B, a *"Case Specialist".* It is peculiar that one person is

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said to have made the decision but another person signs the decision. This is not assisted by the decision being made by the employer (as a self-Insurer) while the IRD is under the letterhead of both the employer and an Insurer (a scheme agent). The *"Revised Notice Under Section 74"* has also been issued under the letterhead of both the employer and an Insurer (a scheme agent).

20. It is tolerably clear that either of two alternatives were the motivation behind the issuing of both a section 74 Notice and a work capacity decision: (a) it is possible that the work capacity decision was made as a fail-safe mechanism in case the *section 74 Notice* issued on 18 November 2013 was overturned in the Workers Compensation Commission; and/or (b) it is equally possible that the *section 74 Notice* issued on 27 March 2014 was itself[2] issued in order to cover the possibility of the work capacity decision being overturned by either Merit Review or Procedural Review. Whatever the motivation, the result was unsatisfactory. A work capacity decision is not a section 74 Notice *manqué*, and *vice versa*. It is an attempt to confound and conflict, which may entitle the applicant to pray in aid the defence of *exceptio lis alibi pendens* against the work capacity decison, by virtue of the first section 74 Notice, and against the second section 74 Notice by virtue of the work capacity decision.

FINDING

21. 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

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

[2] Another emphatic pronoun, but in the passive voice.

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23. I recommend that the Insurer pay the applicant the weekly benefit to which he was entitled prior to 31 December 2013 until such time as he is properly transitioned. Those payments should continue from 7 April 2014 being the date on which they ceased.

24. 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 7 April 2014 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
31 July 2014