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 19 December 2013 is set aside.**

b. **The applicant is to be reinstated to his weekly payments at the rate applicable immediately prior to 28 March 2014.**

c. **The payments are to be back-dated to 28 March 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 19 December 2013. The decision stated that payments were to cease on 28 March 2014. The applicant sought internal review. The Internal Review Decision (IRD) was issued on 13 February 2014. The applicant sought Merit Review by the Authority. The Merit Review was issued on 26 May 2014.

2. The applicant was injured on 18 July 2010. The injury was to his head and shoulder. He initially returned to suitable employment and then returned to full duties. In 2011 his employment was terminated. 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.

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4. The relevant version of the *WorkCover Work Capacity Guidelines (Guidelines)* is the one dated 4 October 2013, published on 8 October 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 go to the merits of the case, that is, the judgement or discretion of the Insurer and as such are not relevant.

Submissions by the insurer

7. The Insurer's submissions set out the powers of this Office and a simple timeline from the date of the fair notice letter to the date of the decision.

The Decision

8. The decision states that a work capacity assessment was undertaken on 19 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 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;*

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- *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 takes the form of a covering letter and a Notice of decision. The two documents must be read together but that is unlikely to be understood by the applicant. The decision does not state that the Notice is given pursuant to section 54(2)(a) of the 1987 Act, but the covering letter refers to section 54. An appropriate time for 3 months notice is then given to 28 March 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. At this time it is peculiar that a document cannot be served, when appropriate, electronically.

11. The decision states that *"the following decisions were made"* which are that the applicant *"currently* [has] *some capacity to work"* and that his weekly compensation will cease. The decision does not explain that *"current work capacity"* is defined in section 32A of the 1987 Act. The definition is that the applicant is not able to work in his pre-injury employment but is able to work in *"suitable employment."* That term is also defined in section 32A and includes having regard to *"the worker's age, education, skills and work experience",* but having no regard to *"the nature of the worker's pre-injury employment".* How these are to be reconciled is unclear, but the definition would not be obvious to any applicant.

12. The applicant is then advised that he is *"deemed to have been incapacitated for a total of 94 weeks, as at the date of assessment."* How many weeks of weekly payments have been made is not stated. The relevance of being *"deemed"* to have been "incapacitated" (as

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opposed to being in receipt of payments) for a certain number of weeks is also not explained.[1] The decision then states that the *"relevant entitlement period deemed to apply is 14-130wks working less than 15 hours per week."*[2] The decision should explain that the entitlement periods are defined in section 32A of the 1987 Act and are not merely a device used by the Insurer. They are certainly not part of any deeming provision. There is nothing in the Act that says a person is only entitled to compensation in the "relevant entitlement period" of 14-130 weeks if they are working for less than 15 hours per week. It may be that the Insurer meant to say that following the 130th week a person will only receive weekly payments if at the same time they are working for 15 hours per week and earning the statutorily indexed minimum of $173 per week; but meaning to say one thing and saying something completely at odds with it are not the right way to explain the legislation to the applicant. This is a demonstrable error.

13. The decision states that until such time as he transitions to another entitlement period his weekly payments are as follows: *"(Transitional Rate x 80%) – (Earnings + Non-Pecuniary Benefits/Deductions)"*. There is no attempt to explain entitlement periods. There is no attempt to explain what the transitional rate is. The rate is stated to be $948.50 but again no attempt is made to explain how this figure is arrived at. 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 decision should also refer to section 37(3) of the 1987 Act which is where the calculation as set out is to be found. In addition the Insurer should also refer to section 35 of the 1987 Act which is where the terms in the calculation are defined. By this stage an applicant may believe that the Insurer has simply made up calculations and figures to suit its own purposes rather than what has been set out has some basis in legislation.

[1] Nor is the concept of "deeming," or the mechanism by which this purported "deeming" is executed.

[2] Here the word "deemed" seems to be used in a completely different sense. I take it the Insurer thinks "deemed" is a synonym for "considered," or even "decided" but it raises the question of how an insurer would deal with a "deemed worker" (as that term is defined in the legislation).

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14. *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 states that treatment expenses will continue to be paid. It is not stated 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. The legislation has not been properly referenced. This is a demonstrable error.

15. 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.

16. 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 documents listed in the decision. He is not told that he may request copies of other documents. This is a demonstrable error.

17. The covering letter states that the applicant may seek an Internal Review and that it must be sought within 30 days from the date of the decision. That is wrong. Section 44(1)(a) of the 1987 Act does not provide any time limit in which to seek Internal review. *Guideline* 7.1.2 refers to making the application *"as soon as practicable"* after receiving the decision.

FINDING

18. 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

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

20. I recommend that the Insurer pay the applicant the weekly benefit to which he was entitled immediately prior to 28 March 2014 until such time as he is properly transitioned. Those payments should continue from 28 March 2014 being the date on which they ceased.

21. 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 28 March 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
12 August 2014