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 November 2013 is set aside.

b. The applicant is to be reinstated to his weekly payments at the rate applicable immediately prior to 2 March 2014.

c. The payments are to be back-dated to 2 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 22 November 2013. The decision stated that payments were to cease on 3 January 2014. The applicant sought internal review and then Merit Review by the Authority.

2. The applicant was injured on 31 January 1999. The injury was to his right upper limb, otherwise known as an arm. He returned to suitable employment with the employer but that employment ended in February 2002. 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 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 8 August 2013 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.

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 were brief and 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.

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 completed on 14 November 2013. There does not appear to be any legislative requirement to notify the applicant of the outcome of the assessment. However, *Guideline* 5.3.2 states 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.*

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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.

9. *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."* 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 "*any entitlement you may have to payment of pre-approved reasonable and necessary medical and other expenses* ***will be limited for up to 12 months*** *after your entitlement to weekly payments cease. Please refer to: Section 59A of the Workers Compensation Act 1987".* In what fashion the payments are to be "limited" is not explained. It may be by type of treatment or the cost of treatment, or on some other basis, but the words do not convey the true effect of the section, which is to bring any entitlement to and end after 12 months, subject to section 59A(3),(4).

10. The next statement is the following: "*this means that your entitlement to medical and related expenses will cease on 2 March 2015. Please refer to: Section 59A of the Workers Compensation Act 1987".* By this stage the applicant may believe that his payments for medical treatment are limited in some way (which is not described) for 12 months and then cease. The uncertainty generated by this ambiguous language does not provide clear and accurate information to the applicant.

11. The decision states that the applicant has no entitlement to weekly payments after the second entitlement period unless he has a *"current work capacity."* No reference is made to the definition of *"second entitlement period"* in section 32A of the 1987 Act. The definition of *"current work capacity"* means being unable to return to pre-injury employment, but being able to work in *"suitable employment."* This is not explained. The term is also defined in section 32A. It is central to the 2012 amendments. The definition includes, *inter alia*, that suitable employments includes work regardless of *"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 is not available.

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12. 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, in this case 809.8 weeks. The decimal point suggests an unlikely calculation of 809 weeks, 5 days, 14 hours, 9 minutes and 36 seconds. Such a precise calculation seems improbable. The applicant would be concerned that the decision has not been properly considered. Again 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.

13. Section 38(3)(b) and (c) of the 1987 Act is then set out but the decision does not state that it is that section. The applicant would be left to the view that it is a policy of the Insurer. Why 15 hours is relevant and where the figure of $168 comes from must remain a mystery to the applicant. The Insurer is required to explain the section pursuant to *Guideline* 5.3.2 and that, for instance, $168 is an indexed figure and that the figure to be found in the section is $155.

14. The decision then states that payments ***must cease within 3 months***. The correct reference is made to section 54(2)(a) of the 1987 Act. Tjhis is a serious error, since the reference to "3 months" within the section denotes a minimum notice period and not a maximum entitlement period. This is a demonstrable error and would be sufficient grounds on its own to invalidate the decision.

15. The applicant is advised that as he has received more than 130 weeks of weekly payments and is not employed that he does not satisfy the criteria in section 38 of the 1987 Act. It is then stated that he is able to earn in excess of the transitional rate. Where the transitional rate comes from is not explained. 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. In reality, as the applicant did not satisfy the test in section 38(3)(b) and (c) of the 1987 Act there is no need to set out the transitional rate.

16. 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* 5.3.2 states that all evidence considered should be referred to, whether or not it

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supports the decision. The Insurer by referring to *"information which supports our decision"* is making a statement[1] that the Insurer has *only* considered information which supports the decision. Any information which does not support the decision may well have been ignored. In the circumstances, this misleading (and likely inculpating) statement is a demonstrable error.

17. 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. It is then stated that the decision was reviewed and confirmed by the *"Work Capacity Team."* No names are given. The decision is block signed by the "*Work Capacity Team*,"[2] 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 "a person"[3] who was not involved in the decision: see *Guideline* 6.2.6.[4] When the decision-maker cannot be identified by the applicant, he cannot know whether the IRD was made by a person[5] not involved in the original 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.[6]

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

[1] At least by implication.
[2] No names disclosed.
[3] On no sane reading of either word is a "team" a "person."
[4] See also 7.2-7.5 of the *Review Guidelines*.
[5] Again, the suggestion being an individual, rather than turning the process into a team sport.
[6] See for instance *Work Capacity Guideline* 2.3.

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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 prior to 2 March 2014 until such time as he is properly transitioned. Those payments should continue from 2 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 2 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
22 August 2014