WiRO
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 24 July 2013 is set aside.

b. The applicant is to be reinstated to his weekly payments at the rate applicable immediately prior to 1 November 2013.

c. The payments are to be back-dated to 1 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 24 July 2013. The decision stated that payments were to cease on 1 November 2013. The applicant sought internal review. The Internal Review Decision (IRD) was issued on18 September 2013. The applicant sought Merit Review by the Authority on 23 October 2013. The Merit Review was issued on 26 June 2014, 230 days later

2. The applicant was injured on 21 February 2005. The injury was to his back. He returned to suitable employment with the employer. He underwent surgery in November 2006, and was terminated from his job in October 2008. He later found suitable employment elsewhere. 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

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(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 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."* The applicant's submissions went to the merits of his case and as such went to the judgement and discretion of the Insurer and cannot be relevant to a procedural review.

Submissions by the insurer

7. The Insurer made no submissions but did provide copies of correspondence and telephone records with the applicant which was of assistance.

The Decision

8. The decision states that the Insurer is required to make a work capacity assessment. The decision does not say that the assessment has been made. 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* 5.4.2 requires.

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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.

10. The decision states that the applicant has an inability to return to his pre-injury employment but is able to return to suitable employment. The Insurer should refer to section 32A of the 1987 Act and the definitions of *"current work capacity"* and *"suitable employment."* An untutored applicant would not expect *'current work capacity'* to mean being unable to return to pre-injury employment, but being able to work in *"suitable employment."* The latter term is central to the 2012 amendments. The definition holds in part that suitable employment 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 does not exist or is otherwise unavailable "generally."[1]

11. The decision states that there is a deemed pre-injury average weekly earnings as the applicant was in receipt of weekly payments immediately before 1 October 2012. The Insurer refers to Part 19H of Schedule 6 of the 1987 Act. While that is correct the proper reference is to the relevant clauses in Part 19H: clause 1 (the definition of "*existing recipient of weekly payments*"), clause 2 (the transitional amount as indexed - $938.30), and clause 9(3) (the deeming provision).

[1] Technological change may lead to further complications, since work as a toll collector or a train ticket inspector may be drying up as a result of the invention of the transponder and the Opal card.

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12. The applicant is advised that he has received 338 weeks of weekly payments and that this places him in the period after the second entitlement period. Reference is made to section 38(7) of the 1987 Act but the applicant should be referred to the definition of *"second entitlement period*" in section 32A of the 1987 Act. The formula in section 38(7) then requires reference to section 35 of the 1987 Act and the definitions of the terms used in the formula.

13. *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."* The decision states that treatment expenses and related expenses will continue. Section 59A(2) of the 1987 Act states that such expenses cease 12 months after weekly payments cease. The legislation has not been properly referenced. This constitutes demonstrable error.

14. The Insurer failed to advise that section 59A(3) of the 1987 Act provides that the applicant may, after the entitlement to compensation for medical expenses ends, become eligible for further payments for medical expenses if he 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 as clearly the Insurer was not aware of section 59A.

15. Guideline 5.4.2 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. Further, the Insurer has relied upon WorkCover medical certificates the most recent of which is January 2013. Section 44B(3)(b) of the 1987 Act only allows a medical certificate to be valid for 28 days. Section 44B(4) allows for an extended certificate in certain circumstances but it is not stated that those conditions have been met. It is a grave procedural error for an Insurer to rely on certificates more than 6 months old when attempting to assess "current" work capacity.

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16. The decision states that the applicant may seek an Internal Review and that it must be sought *"strictly within 30 days from receipt*" of the decision. That is wrong. Section 44(1)(a) of the 1987 Act does not provide any time limit. *Guideline* 6.2.2 that was in force at the date of the decision also states that there is a 30 day time limit. Later iterations of the *Guideline* refer to *"timely lodgement".* What that phrase would mean is unclear. It may be that 30 days is timely, but it may mean something completely at odds with that proposition.

FINDING

17. 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.

RECOMMENDATION

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

19. I recommend that the Insurer pay the applicant the weekly benefit to which he was entitled prior to 1 November 2013 until such time as he is properly transitioned. Those payments should continue from 1 November 2013 being the date on which they ceased.

20. 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 1 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
1 September 2014

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