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(C) OF THE *WORKERS COMPENSATION ACT 1987.*

1. The applicant seeks a review of a work capacity decision of the Insurer.

2. The applicant was injured in the course of his employment on 12 January 2009 when he suffered injury to his right shoulder. He subsequently underwent surgery on the shoulder. There is no dispute about the injury having occurred in the course of employment.

3. Once the applicant ceased work, approximately four weeks following the date of injury, payments of weekly compensation were commenced. Medical expenses were also paid. I am not informed as to whether or not any claim was ever made for lump sum compensation under sections 66 and 67 of the *Workers Compensation Act 1987* ("1987 Act").

4. The applicant was an existing recipient of weekly benefits at the time of the 2012 legislative amendments. He was being paid $628 per week pursuant to the former section 40. The Insurer completed an assessment of the work capacity of the applicant and purported to issue a notice of a work capacity decision pursuant to Section 43 of the Act on 27 March 2013.

5. The Insurer also purported to give the applicant notice pursuant to Section 54 of the *1987 Act* of the reduction of his weekly benefit to "nil." This information was contained within a letter to the applicant dated 27 March 2013, which letter enclosed a purported notice pursuant to Section 43 of the 1987 Act.

6. On 24 May 2013 the Insurer wrote to the applicant advising of the outcome of an internal review of the decision dated 27 March 2013. The internal review upheld the original decision.

7. A WorkCover Merit Review was completed and a Statement of Reasons issued on 25 June 2013. The Reviewer upheld the determination of the Insurer.

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8. On 10 July 2013, the applicant requested the Independent Review Officer to undertake a review of the decision of the Insurer pursuant to Section 44(c) of the *1987 Act*. I am satisfied that the applicant has made that application within the time provided by that section.

9. The grounds on which the applicant seeks review are stated to be as follows:

   (a) He was not contacted by the Insurer within the 30 day time limit set for internal reviews;

   (b) He alleges that the Insurer "change their letterheads to suit themselves";

   (c) He was not examined by a doctor as part of the work capacity assessment;

   (d) The Insurer is alleged to have gone "doctor shopping"; and

   (e) The Insurer sent a report from the rehab provider to the applicant with details of a different person, possibly another worker.

The Legislative Framework

10. The legislative framework which governs the entitlement to and the transition from the previous benefits is complex and must be difficult for an injured worker without legal assistance to navigate through and to understand its impact. Similarly, insurers and employers may have difficulties with making and issuing notice of valid decisions.

Process of the Insurer

11. The decision reached by the Insurer appears to be appropriate in the circumstances of the case. The decision maker had regard to vocational assessments and medical evidence in addition to an accurate post-injury work history of the applicant. As far as the process undertaken by the Insurer in reaching the work capacity decision is concerned, I am satisfied that there was no breach of procedural fairness and that the

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rules of natural justice were fully complied with. There were a large number of reports considered by the Insurer.

12. The grounds sought to be relied upon by the applicant for procedural review show some cause for disquiet.

(a) The alleged failure of the Insurer to meet the 30 day deadline for internal review (ground (a)) is not relevant for the purposes of a procedural review, although I note the Insurer received the application for internal review on 23 April 2013 and sent a letter advising of the outcome of that review dated 24 May 2013.

(b) No evidence has been provided for ground (b) (the changing letterhead allegation) and nothing turns on it.

(c) A report was provided to the Insurer by a particular doctor, who apparently had access to documents from the Insurer's file and who had a telephone conversation with the applicant's nominated treating doctor. The reporting doctor did not examine or even speak with the applicant. *Prima facie* this seems unfair, since the applicant does not and cannot know what documents were before that doctor, nor can he know the true content of any conversation between that doctor and his own nominated treating doctor. However, while the medical report produced as a result of this process may have some considerable weight with the Insurer, it is not of itself a document which contains binding recommendations. Only the claims branch of the Insurer can make the work capacity decision and this document forms merely a part of that decision making process. Accordingly, while the applicant is perhaps entitled to feel aggrieved by the process in which the report from that doctor was obtained, it is not grounds for overturning the work capacity decision.

(d) There is no evidence for what the applicant refers to as "doctor shopping".

(e) The applicant has sent to my office part of a document said to be a "Vocational Rehabilitation Plan" prepared by a rehab provider and addressed to the Insurer. At the foot of the page the applicant's name appears in typescript as "the applicant" whereas the heading of the document says this:

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"**Vocational Rehabilitation Plan for: Mr X (not the applicant)**."
The same "Mr X" is referred to in the body of the document, specifically under the heading "RTW Goal". The applicant was upset to receive this document. He annotated the document with the following words: "This is not me. They have sent personal information of Mr X in my internal review. So how can you trust anything they say or do?" Once again, there is no doubt that the applicant has been the subject of a vocational assessment.. While the applicant clearly has fair cause to be upset by the provision of inaccurate or irrelevant information, this document has no more binding force than the medical report of another doctor. Therefore it cannot form the basis of any recommendation to overturn the work capacity decision based on procedural grounds.

My Reasons:

13. Despite this, I remain unsatisfied on the question of notice given to the applicant under section 54.

14. In the letter to the applicant dated 27 March 2013 the Insurer advised that under section 54 of the 1987 Act the applicant's weekly payments of compensation would be reduced to "nil" as of 27 June 2013. Section 54 requires that applicants in the position of this applicant should be accorded three months clear notice prior to having their payments changed. By virtue of the postal service rule (Section 76(1)(b) of the *Interpretation Act 1987)*, the Insurer was required (Section 54(4) of the 1987 Act) to give the applicant notice personally or by post.

15. Therefore in order to comply with the requirements of Section 54 of the 1987 Act a notice posted on 27 March 2013 would not permit the reduction in payments until the expiry of four working days (not including the day of posting) which would set an earliest possible date of Wednesday 3 July 2013.

16. The question which arises is whether strict compliance with the provision of the proper notice is required such as to render a non compliant notice invalid. In my view strict compliance is required for three reasons:

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(a) The effect of a Work Capacity Decision to reduce weekly benefits payable to the injured worker has the potential to impact on that worker's ability to meet financial obligations and the time period was important to ensure that the worker could reorganise his or her affairs.

(b) Failure to give the proper notice is regarded so seriously in the legislation that it is an offence.

(c) There is no provision in the legislation which enables an insurer to amend the notice.

My Recommendation:

17. I recommend that the Insurer issue a valid section 54 notice, which gives the applicant three clear months notice of variation of his weekly benefits. Such notice should include four clear working days for service by post.

18. Since the applicant was an existing recipient as at 1 October 2012, he remains entitled to receive his pre-transition rate of weekly benefits until such time as he is validly transitioned under the Act. This cannot happen until a valid notice under section 54 is issued.

19. I recommend that the insurer take my views into account, and I recommend that the insurer immediately give effect to them.

KA Garling
WorkCover Independent Review Officer
6 August 2013