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 30 June 2014 is set aside.

b. The applicant is to be reinstated to her weekly payments at the rate applicable at 4 October 2014.

c. The payments are to be back-dated to 5 October 2014.

d. Such payments are to continue until such time as a further work capacity decision is made and comes into effect.

Introduction and background

1. The applicant seeks procedural review of a work capacity decision made by the Insurer on 30 June 2014. The decision advised the applicant that her weekly payments of compensation would cease on 5 October 2014. The applicant sought internal review and Internal Review Decision (IRD) was dated 11 August 2014. The IRD upheld the original work capacity decision. She then sought Merit Review on or about 26 August 2014. The Merit Review Service (MRS) of the Authority issued findings and recommendations on 14 October 2014. MRS confirmed the Insurer's decisions.

2. The applicant sought procedural review by application to this office on 20 October 2014. I am satisfied that the applicant has made the application for procedural review in the proper form and within time.

3. On 19 June 2006 the applicant sustained injury to her left shoulder in the course of her employment promoting and selling window blinds. Liability to make weekly payments of compensation was accepted and as at the date of the work capacity decision the applicant had received 428 weeks of benefits. She currently works part-time as a child-care provider, with payslips reflecting 16 hours per week and $168 in earnings per week as at August 2014.

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4. The applicant was in receipt of weekly payments immediately before 1 October 2012. Accordingly *Clause 8* of *Part 19H* of *Schedule 6* to the *Workers Compensation Act* 1987 (1987 Act) required the Insurer to conduct a work capacity assessment.

5. *Section 44A* of the 1987 Act provides that a work capacity assessment must be conducted in accordance with the *WorkCover Work Capacity Guidelines* (Guidelines).

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 has made submissions which are capable of being construed as relating to procedural matters:

   - The applicant is of the view that only two medical reports, among many, have really been "considered" by the Insurer in the course of work capacity assessment and the consequent work capacity decision[1]; and

   - In the course of a vocational assessment which was conducted at the behest of the insurer "no-one even asked me if I was on pain relief, which I was."

Submissions by the Insurer

7. The Insurer has not provided submissions in response to the application for procedural review. It follows that the second submission made by the applicant at paragraph 6 above is uncontested by the Insurer.

The Decision

8. The *WorkCover Work Capacity Guidelines* relevant to making this work capacity decision came into effect on 11 October 2013. *Schedule 8 Clause 23* of the *Workers Compensation Regulation 2010* (the

[1] Whether or not one of the "considered" documents even qualifies as a "medical report" (as that term is commonly understood) is discussed *infra*.

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Regulation) states that an Insurer must make a work capacity decision as soon as practicable after the work capacity assessment.

9. The Insurer correctly advised the applicant of the date of assessment (25 June 2014) and the outcome of the assessment, which is reflected in the decision to terminate her weekly payments as from 5 October 2014.

10. The legislation was relevantly referenced, as required by Guideline 5.3.2.

11. The entitlement periods for weekly payments were adequately explained and the relevant legislation was both cited and explained in a coherent fashion. The Insurer also correctly explained the effect of section 59A(2) and (3) on the applicant's future entitlement to medical and related expenses.

Procedural matters

12. On page 2 of the decision dated 30 June 2014 reference is made to a "Dr Jennifer," who had produced a Certificate of Capacity with certain restrictions, including a lifting/carrying capacity of 5 kg, "no above head work" and, perhaps most importantly, the applicant could only work 8 hours per day for 2 days per week. The applicant's current work clearly complies with this certificate, even to the extent of working for 16 hours per week.

13. A further reference is made to the mysterious "Dr Jennifer" on page 3 of the same decision. This reference is in a schedule of documents said to have been "considered" by the Insurer in the course of assessment and decision-making. The full extent of the documents given such consideration appears to be:

    - The work capacity certificate of "Dr Jennifer" dated 27 November 2013;

    - An IME report dated 13 September 2012 which found that the applicant had 9% whole person impairment;

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- A bizarre document styled as an "*Injury Management Consultation File Review report*" dated 5 May 2014 which purported to find that the applicant had capacity to work full time "with restrictions confined to the left shoulder";

- A Vocational and Functional Assessment dated 16 December 2013 which purported to find the applicant to have suitable employment options including "Telemarketer," "Customer Service," and "Front Office/Motel Reception" with no reference to the hours to be worked beyond a choice of 16 hours or 38 hours per week; and

- Various payslips, which confirm that the applicant worked 16 hours per week and earned $168 per week as at the date of the documents.

14. Certain limitations seem to arise as a result of the processes adopted by the Insurer in the course of this assessment and decision-making endeavour.

    First, the applicant has never been treated by a Dr Jennifer.

    Secondly, the IME report is dated September 2012 and can scarcely qualify as evidence of the applicant's "current" work capacity as at June 2014, some 21 months later. In addition, while the Insurer notes that this report assesses 9% WPI, it makes no reference to work capacity.

    Thirdly, the *Guidelines* refer to the "available information" which may be considered in the course of an assessment, and at *Guideline 4* set out what is thought to be a non-exhaustive list of relevant sources of information, including the *Certificate of Capacity*, reports from "the treating doctor, treating specialist or other allied health professionals,"[2] independent medical reports and even "injury management consultant reports." There is no specific reference in the *Guidelines* to "misleading documents containing hearsay evidence constituted by one-sided accounts of alleged conversations held over the phone with other parties who are given no opportunity to confirm or deny the contents of the

[2] Whatever that may mean. Are they required to be "allies" of the applicant worker, or is "allied health professional" meant to be a term of art, undefined by the legislation, somehow denoting a particular class of doctor or paramedical practitioner otherwise unspecified?

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resultant 'report'." Perhaps this is unsurprising. What is surprising is that precisely such a document is what this Insurer has relied upon, to the applicant's detriment, described as an "*Injury Management Consultation File Review report*" dated 5 May 2014. This "report" was written by a medical practitioner, following what is described as a "file review"[3] and an alleged telephone conversation with the applicant's nominated treating doctor (NTD). No effort was made to corroborate the contents of the report by seeking confirmation of the telephone conversation from the NTD. Despite this, the Insurer relied on the report to conclude that the NTD has "agreed" with the report-writer that the applicant could work 38 hours per week. The Insurer went further and "preferred" this report to the opinion expressed by the NTD in the work capacity certificate.

Fourthly, the injustice dealt to the applicant by the conduct of the Insurer in relying on the "*Injury Management Consultation File Review report"* is exposed by a perusal of the Internal Review Decision, during the course of reading which it becomes clear that:

- The illusive "Dr Jennifer" referred to in the work capacity decision was none other than Dr Jennifer P, the applicant's NTD;

- The same doctor wrote to the Insurer on 10 July 2014 disputing that she had ever "agreed" that the applicant could work fulltime, saying only that she had the impression this was the report-writer's opinion. She had said in the course of the telephone conversation that she would "consider upgrading the applicant's work capacity," but after a further examination of the applicant on 6 May 2014, did not make any alteration to the assessment that the applicant could only work two days per week.

- Despite what appears immediately above, the Insurer made the peculiar observation that the NTD "has not provided any clear rationale as to why she believes your capacity is restricted to 8 hours per day, 2 days per week."[4]

[3] Contents of the "file" were not disclosed to the applicant.
[4] The requirement of providing a "rationale" for a medical opinion seems novel.

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- Even though the NTD has clearly contradicted the report-writer, the insurer still "prefers" the opinion of the report-writer. The report-writer has never examined the applicant.

15. While it is true that procedural review may not impugn "*any judg[e]ment or discretion exercised by the insurer,*" it cannot be within the discretion of any party to rely on evidence which is obtained in a way conducive of procedural error. The error may not be the report-writer's – he may well have understood the NTD to have said something and reported it in good faith. But it was incumbent on the Insurer to provide the NTD with the opportunity to confirm or dispute the written account of the conversation *before* making a decision which would adversely affect the rights of the applicant. In a recent Fair Work Commission decision overturning the dismissal of an employee due to procedural irregularity the FWC described the evidence and procedures relied upon by the employer as containing:

> " … a striking level of inaccuracy and a highly regrettable propensity to accept propositions made […] with little or no questioning or testing of those assertions."[5]

Finding that the "factual basis" for the dismissal could not be upheld, the FWC held that the decision to dismiss was invalid by reason of "a highly erroneous procedure."

16. I find the decision of the FWC in *Redden* instructive in the current matter, since the common element is the reliance on uncorroborated hearsay which, in the present case, was actually preferred over the opinion of the NTD. To the extent that the decision was based on the report of 5 May 2014, the decision must have been invalidly made. Given that the only other evidence the insurer had came from a 21 month old IME report and the NTD, there was no reliable evidence before the Insurer to support the decision reached.

17. In the course of Internal Review the Insurer made an observation which, if true, is disturbing. On page 4 this appears:

[5] *Redden –v- Harbour City Ferries Pty Ltd* [2014] FWC 8195 (20 November 2014).

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> "Although Dr K has not examined you in person,[6] his specialty is in determining capacity for work by reviewing the evidence on file and discussing it with the Nominated Treating Doctor."

The status of any report ensuing from such "specialised" practice must be dependent upon the corroboration of the contents with the NTD or other party with whom the report-writer has spoken. Otherwise we are left with no more than an amateurish attempt at 'hot-tubbing' which is all steam and no tub.

FINDING

18. Under the legislation the Insurer can make an assessment of the applicant's work capacity and then a decision about that work capacity, but they must comply with the legislation, the Regulation and the *Guidelines* in order to produce a procedurally correct result. In the current instance there have been breaches of the *Guidelines* which are to be treated as delegated legislation. Accordingly the work capacity decision must be found to be invalid.

RECOMMENDATION

19. The work capacity decision of the Insurer dated 30 June 2014 is set aside.

20. The applicant is to be reinstated to his weekly payments at the rate applicable at 4 October 2014.

21. The payments are to be back-dated to 5 October.

22. Such payments are to continue until such time as a further work capacity decision is made and comes into effect.

Wayne Cooper
Delegate of the WorkCover Independent Review Officer
28 November 2014

[6] Other means of examination are not identified.