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*.***

1. The applicant, an injured worker, has applied for procedural review of a work capacity decision (the decision) made by the Insurer on 3 June 2013 which was sent under cover of a letter dated the same day (the covering letter).

2. There is no dispute that the applicant was injured in the course of his employment on or about 9 February 2008 when he sustained injury to the lumbar spine while changing a brake shoe on a train. An MRI post-dating the injury by one month showed posterior disc prolapse at L3/4 and at L4/5, together with multiple degenerative changes at those levels. The applicant returned to work on light duties in mid-March 2008 and stayed with the Employer, working as an Administration Assistant, until he was medically retired on 1 February 2012. The Insurer made weekly payments as required under the provisions of the *Workers Compensation Act* 1987 (1987 Act) for all periods of incapacity.

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.

4. Section 44A of the 1987 Act provides that a work capacity assessment is an assessment of the injured worker's current work capacity and must be conducted in accordance with the *WorkCover Work Capacity Guidelines (*Guidelines*)*.

5. The relevant version of the *Guidelines* is the one published on 27 September 2012 which applied to all claims from 1 January 2013. That publication stated that the *Guidelines* provide instructions and guidance to Insurers regarding the appropriate and consistent application of work capacity assessments and decisions.

6. Once the Insurer has conducted an assessment then the Insurer is required to make a work capacity decision. Where that decision involves

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a reduction in the weekly payments payable to the injured worker then the Insurer is required to give proper notice to the worker (Section 54 of the 1987 Act).

7. The applicant has been in receipt of weekly payments for more than 130 weeks as at the date of the decision and therefore Section 38 of the 1987 Act applies.

8. The decision states correctly that 3 months notice is required prior to reducing benefits as a result of a work capacity decision. The decision refers to *"section 54 of the Act".* The correct reference would be to section 54(2)(a) of the 1987 Act. The more pressing issue for an applicant is that the decision does not state which Act is being referred to. As such, the legislation has not been properly identified.

9. The letter states that a work capacity assessment has been made. The insurer is required to make a decision "*as soon as practicable"* after the assessment is made: see Clause 23, Schedule 8, *Workers Compensation Regulation* 2010. There does not appear to be any legislative requirement to notify the applicant of the outcome of the assessment. However, *Guideline* 5.4.2 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 reasoning for the decision.*

    My finding is that the *Guidelines* result in the insurer being compelled to reveal the outcome of the assessment.

10. In this case the applicant cannot know the actual date of the assessment. No date is nominated by the Insurer for a Fair Notice Call having been made, nor is any letter produced confirming such notice in

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writing, or seeking submissions from the applicant.[1] The applicant might infer that the decision was made *"as soon as practicable"* after the assessment, but he is as likely to be wrong as he is to be right in drawing such an inference and cannot be certain.

11. The decision states that "*it has been determined that you have a current capacity for work." "Current work capacity*" is a term defined in section 32A of the 1987 Act. That section has not been referred to. This is in breach of *Guideline* 5.4.2 and the need to *"reference the relevant legislation".*

12. *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".* Section 59A(2) of the 1987 Act states that treatment expenses are no longer payable 12 months after a worker ceases to be entitled to weekly payments of compensation. The decision states that "*Your entitlement to benefits for medical or related expenses will continue in accordance with the provisions of the Act".* The covering letter states that "*Your entitlement to compensation in respect of medical or related expenses will continue in accordance with the provisions of the Act".* The difference in the wording of these two sentences is puzzling. An applicant would not necessarily know that the words "*benefits*" and *"compensation*" are the same thing and it is not even clear that the Insurer knows.[2] Such statements are in breach of the *Guidelines.* Further, *Guideline* 5.4.2 requires the insurer to "*reference the relevant legislation".* The decision does not refer to section 59A(2) of the 1987 Act which is the relevant subsection. The reference to the *"Act"* does not identify which Act is being referred to.

13. Section 59A(3) of the 1987 Act also states that an injured worker may become eligible for further payments for medical expenses if they are entitled to compensation for weekly benefits at some stage in the future, despite such entitlements having been exhausted due to the effluxion of

[1] Cf *Guideline* 5.2, which requires notice of the decision making process, including confirmation in writing.
[2] The applicant is not a native English speaker and submits that his poor English affects his employment prospects. The Employer's inconsistent use of language is unlikely to assist in the circumstances.

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12 months under section 59A(2). Again, the legislation is not properly or fully explained.

14. The decision refers to section 48 of the *Workplace Injury Management and Workers Compensation Act* 1998 (the 1998 Act). Section 48 is of little relevance to the applicant, since it refers to return to work obligations of a worker.[3] Relevantly, the decision refers to section 32A of the 1987 Act and includes a reference to *"suitable employment".* As above, however, no reference is made to the definition of *"current work capacity*" in section 32A of the 1987 Act. The reference to both the 1987 Act and the 1998 Act is confusing and the failure to refer to the definition of *"current work capacity*" means that the legislation is not properly referenced as required.

15. The decision states that the applicant's average weekly earnings are deemed to be $938.31 "*under schedule 6 Part 19H Clause 2(1)".* There is a schedule 6 in both the 1987 Act and the *Workers Compensation Regulation* 2010. The 1998 Act still notes a schedule 6 which has been repealed. The *Workers Compensation Legislation Amendment Act* 2012 also has a schedule 6 which has been repealed. Such a reference does not assist an applicant. Clearly, the legislation has not been properly referenced.

16. The decision contains the following erroneous assertion: "*We note that you are not working 15 hours per week....*" This must be untrue for at least two reasons: first, in the subsequent Internal review letter dated 2 August 2013 the Insurer notes that the worker submits he is working 16 hours per week and, secondly, the Insurer itself submitted to the Merit Review Service that the applicant works 16 hours per week and earns $16.50 per hour (see paragraph 20, bullet-point 6 on page 3 of the decision of the Merit Review Service dated 17 December 2013).

17. Both the Insurer and the Merit Review Service appear to dispute the applicant's assertions that his limited English is an impediment to

[3] But see at paragraph 2 above, where this employer (a self-insurer) had medically retired the applicant in 2012. It is perhaps an unusual circumstance for an employer to medically retire someone and then, acting in the guise of a self-insurer, expect them to comply with the return to work requirements of section 48 of the 1998 Act. This is particularly so when the Insurer insists, as in this case, that "suitable employment" for the worker includes the very type of work from which he was medically retired in the first place.

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employment. Further, the Merit Review Service even purports to cast doubt on the applicant's assertions that he has linguistic difficulties, relying on the statement of a person whose qualifications are not stated.[4]

18. *Guideline* 5.4.2 also states that the work capacity decision notice must advise the applicant that any documents or information that have not already been provided to the applicant can be provided on request to the Insurer. The Insurer has failed to so advise the applicant. The Insurer states that "*4. Copies of all information, reports and documents listed in Point 4 that have not been previously provided are attached."* As this statement is point 4, and no documents are listed,[5] this would leave an applicant to ponder which part of the decision is being referred to. Lists of documents are provided in points 2 and 3 of the decision.

## FINDING

19. 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

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

21. I recommend that the Insurer pay the applicant the weekly benefit to which he was entitled prior to 3 June 2013 until such time as he is properly transitioned. Those payments should continue from 11 September 2013 being the date on which they ceased.

[4] See MRS decision, at paragraph 20, bullet point 3.
[5] If the applicant were familiar with the theory of descriptions, concerning the invalidity of self-referential statements which exclude themselves from the set of all things referred to, it would not assist the insurer, since "Point 4" is clearly being referred to in Point 4 in a way which is misleading and confounding to the reader (i.e. any reader, not only one with limited English skills).

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22. 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 worker is not required to produce work capacity certificates for the period from 17 October 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(h) of the 1987 Act.

Wayne Cooper
Delegate of the WorkCover Independent Review Officer
04 February 2014