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 8 July 2013.

2. There is no dispute that the applicant was injured in the course of his employment on 1 March 2006. After the injury the applicant returned to work briefly, but he has not worked since 2006. 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. 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 a reduction in the weekly benefits payable to the injured worker[1] then the Insurer is required to give proper notice to the worker (Section 54(2)(a) of the 1987 Act).

[1] Or cessation of weekly benefits.

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7. The applicant made 2 points in his application. The first is in relation to the medical evidence. This is a procedural review pursuant to section 44(1)(c) of the 1987 Act. This means that the merits of the matter such as medical evidence are not relevant. A procedural review looks at how the decision was made, it does not review the judgement or discretion exercised by the Insurer. The second issue the applicant raised is that the Insurer had offered to settle his claim some years ago. The Insurer in its submissions correctly stated that whether or not that occurred is irrelevant in a procedural review.

8. *Guideline* 5.4.2 requires the Insurer to reference the legislation. The heading of the Notice refers to section 43 of the 1987 Act. The correct reference is to section 54(2)(a) of the 1987 Act. As such the legislation is not properly referenced.

9. 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".* The correct reference should 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 legislation is being referred to. The decision refers to section 43 and identifies that section as being in the 1987 Act, but the reference to section 54 is silent as to the legislation in which it occurs. As such, the legislation has not been properly identified.

10. The decision states that a work capacity assessment has been made. The decision does not state that this is a requirement 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. The insurer is required to make a decision "*as soon as practicable"* after the assessment is made: 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*

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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.

11. In this case the applicant does not know when the assessment took place. The Insurer made a Fair Notice call on 18 June 2013. There does not appear to be a follow up letter as required by *Guideline* 5.2, although the Insurer in its submissions states that "*written correspondence within the designated timeframes under the Guidelines"* was done. It is not clear when this was done, or if the tautologically described "written correspondence" fulfils the requirement of a follow up letter after the fair notice telephone call. It is also not clear if the applicant was advised in the fair notice call and letter that a work capacity assessment was to take place or had taken place. As such, the applicant cannot know whether the decision was made *"as soon as practicable"* after the assessment.

12. The decision states that "*You have a current work capacity (Section 43(1)(a)).*" Section 43(1)(a) is not the correct section to refer to. Also, the legislation in which section 43(1)(a) is to be found is not referenced. *"current work capacity*" is a term defined in section 32A of the 1987 Act. That section has not been referred to. These are breaches of *Guideline* 5.4.2 and the need to *"reference the relevant legislation".*

13. The decision states that "*You have suitable employment options (Section 43(1)(b)).*" Section 43(1)(b) is not the correct section to refer to. Also, the legislation in which section 43(1)(b) is to be found is not referenced. *"Suitable employment*" is a term defined in section 32A of the 1987 Act. That section has not been referred to. These are breaches of *Guideline* 5.4.2 and the need to *"reference the relevant legislation".*

14. The decision states that:

Weekly payments have been paid to you for more than 130 weeks, and

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I. *You have a current work capacity;*

II. *You are not working 15 hours per week (section 38(3)(b));*

III. *You are not earning $155 pr* (sic) *more per week (section 38(3)(b));*

The decision again does not refer to the definition of *"current work capacity*" in section 32A of the 1987 Act. The reference to section 38(3)(b) does not advise which legislation is being referred to. The decision fails to refer to section 38 of the 1987 Act as being the relevant section and fails to explain the relevance of 130 weeks. A reference to section 32A of the 1987 Act and the definition of "*second entitlement period"* is also necessary in order to explain the relevance of 130 weeks.

15. *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 and related expenses are no longer payable 12 months after a worker ceases to be entitled to weekly payments of compensation. The decision correctly refers to the 12 month period, but refers to section 59. *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 decision fails also to refer to section 59 of the 1987 Act as being the section which has the relevant definitions for treatment and related expenses.

16. To add to the confusion, medical and related expenses includes workplace rehabilitation: see section 59 of the 1987. The decision states that the applicant "*will be provided with the support to assist in your return to increased hours with assistance in rehabilitation if reasonable and necessary."* Section 59A of the 1987 Act is clear that workplace rehabilitation expenses are no longer payable 12 months after a worker ceases to be entitled to weekly payments of compensation.

17. Section 59A(3) of the 1987 Act also states that the applicant will, after the entitlement to compensation for medical expenses ends under section 59A(2), become eligible for further payments for medical expenses if the applicant becomes entitled to compensation for weekly

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benefits at some stage in the future and for such time as weekly payments continue. Again, the legislation is not properly or fully explained.

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 it has provided copies of all documents relied upon. The Insurer does not state that there are no other documents. The insurer's statement suggests to an applicant that there are no other relevant documents. An applicant may well disagree if he has the opportunity to peruse such other documents.

19. The Insurer also states that the copies of documents provided is done pursuant to section 43 of the 1987 Act. Section 43 is not relevant. Documents are provided as required by *Guideline* 5.4.2.

20. The decision then notes that the applicant has provided the Insurer with documents in support of the claim. A table is then set out, but strangely lists no documents. At the very least the applicant will have provided medical certificates or work capacity certificates. The Insurer has not listed any such certificates. *Guideline* 5.4.2 requires that the decision refer to "*All evidence considered ... regardless of whether or not it supports the decision".* There is no evidence that this has occurred.

FINDING

21. 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

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

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23. I recommend that the Insurer pay the applicant the weekly benefit to which he was entitled prior to 8 July 2013 until such time as he is properly transitioned. Those payments should continue from 15 October 2013 being the date on which they ceased.

24. 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 15 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
5 February 2014