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 23 July 2013.

2. There is no dispute that the applicant was initially injured in the course of his employment on 20 September 1999. Subsequent to the initial injury, aggravations occurred and in 2007, the applicant undertook suitable employment. Following surgery in 2011 the applicant was medically terminated from his employment and is now employed in suitable employment in a family business. The Insurer made weekly payments as required under the provisions of the *Workers Compensation Act* 1987 (1987 Act). Those payments are now in dispute and before the Workers Compensation Commission. It is unclear when payments stopped although it was not before 1 October 2012.

3. Since 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

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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).

7. The heading of the decision fails to mention section 54(2)(a) of the 1987 Act. No legislation is referred to in the heading. *Guideline* 5.4.2 requires the Insurer to "*reference the relevant legislation".* Section 54(2)(a) is central to a work capacity decision and must be referred to in the decision, preferably in the heading.

8. The applicant raised a number of matters in the Application for Procedural Review. 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*[2] *or discretion exercised by the insurer".* The issues raised by the applicant go to the merits of the decision and thereby challenge the judgement or discretion of the insurer. Those issues cannot be relevant to this review.

9. *Guideline* 5.2 requires the Insurer to make a *"fair notice"* telephone call to the applicant "*at least two weeks prior to the decision.*" That occurred on 27 June 2013. A pentalogue of procedural bullet-points are then set out, thus:

    - *inform the worker that a review of their current work capacity is being undertaken and that a work capacity decision is going to be made*

    - *explain that this review may include further discussions with other parties such as their employer, nominated treating doctor or other treatment providers*

    - *advise the potential outcome of this review and detail the information that has led the insurer to their current position*

    - *provide an opportunity for the worker to supply any further information to the insurer for further consideration and the date that this information is to be provided by*

[1] Or cessation of weekly benefits.
[2] Judgement is given the wrong spelling "judgment" in the Act.

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- *tell the worker when this decision is expected to be made.*

10. The Insurer states that both the assessment and decision were discussed. Even if I were to infer that the other points were also covered, a problem immediately arises. *Guideline* 5.2 also requires that "*This information should also then be confirmed in writing to the worker.*" It does not appear that this has been done. This is an important requirement as many applicants will not remember all that they are told in the telephone call, or there may be a language barrier, and an applicant will be assisted by having the information confirmed in writing. The failure to comply with *Guideline* 5.2 must constitute a demonstrable error.

11. The decision states that "*this assessment was conducted in accordance subdivision 3 of the Workers Compensation Act 1987.*" The 1987 Act has 2 "*subdivision 3*" headings in different places in the Act. An applicant would not know which *"subdivision 3"* is being referred to by this statement. The decision does not state that the assessment is a requirement pursuant to Clause 8 of Part 19H of Schedule 6 to the 1987 Act. The legislation has not been properly referenced as required by *Guideline* 5.4.2.

12. 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. The Insurer has provided a document called a "*Work Capacity Assessment Worksheet".* A worksheet is a preliminary document which may not bear much

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relationship to the findings in the final assessment. It is unclear why a worksheet would be provided to the applicant but not the full assessment.

13. The decision states under the Heading "*Work Capacity Decision"* that the applicant "*currently* [has] *some capacity for work."* "*Current work capacity"* is defined in section 32A of the 1987 Act. That definition refers to "*suitable employment*" which is also defined in section 32A of the 1987 Act. These parts of the 1987 Act are not referenced, as required by *Guideline* 5.4.2. An applicant is unlikely to understand that these terms have a specific meaning in the 1987 Act and do not necessarily convey what their ordinary meaning may suggest.

14. The applicant is advised in the decision that he has been "*deemed to have been incapacitated for a total of 246 weeks, as at the date of the assessment."*[3] No suggestion is given and no legislation is referred to explain why the applicant would be "deemed" to have such a precise number of weeks of incapacity or whether the weeks of incapacity relate to any type of payment that may have been made to the applicant. Further into the decision it is stated that the applicant has been "*receiving workers compensation benefits for 246 weeks".* Again, what benefits have been paid is not clear, particularly for an applicant not being paid any weekly benefits at the time of the decision.

15. The applicant may well have been further confused when he read the Internal Review Decision (IRD) which "deemed" him to have been "*incapacitated for a total of 244 weeks as at the date of this assessment".* The IRD is dated 22 August 2013, 4 weeks later, but the number of weeks of incapacity has decreased.[4]

16. On the assumption that the number of weeks relates to section 38(3)(b) and (c) of the 1987 Act and payments after the "*second entitlement period"* the decision should have referred to section 38(3)(b) and (c). Further, the definition of "*second entitlement period"* in section 32A of the 1987 Act should also have been referred to. To add to the already

[3] In the 1987 Act "deemed" workers are different to workers *simpliciter* and it follows that the term has a particular meaning when used in conjunction with the 1987 Act, beyond the everyday dictionary definition of "to form or have an opinion, to judge." Counting the number of weeks of compensation paid is scarcely a matter of opinion or judgement.

[4] Since the Insurer is likely to have computerized records of all payments, the aggregation of weekly benefits should be precise.

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considerable confusion, the decision states that the applicant is to "*be transitioned to the third entitlement period of weekly compensation payments".* The 1987 Act does not use the term "*third entitlement period"* but rather "*the expiry of the second entitlement period"* in section 38(1) of the 1987 Act.

17. Section 38 of the 1987 Act is referred to further into the decision. The decision sets out section 38 in full. That of itself would confuse an applicant since parts of the section are not relevant to the decision. However, that problem may be minor compared to the heading above the text of section 38 which is "*38 Special requirements for continuation of weekly payments after the second entitlement period (after week 130)".* An applicant could be kept very busy trying to find the 38 special requirements hidden in the text of section 38, and be left wondering what a "*second entitlement period"* is. The applicant having already been confused by the number of weeks of incapacity, which appear to diminish with the effluxion of time, would again be confused as to the relevance of *"week 13."*

18. *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. Section 59A(2) of the 1987 Act is not referred to. The decision states that medical expenses will continue to be paid.

19. In addition, section 59A(3) of the 1987 Act states that the applicant may, after the entitlement to compensation for medical expenses ends, become eligible for further payments for medical expenses if the applicant becomes entitled to compensation for weekly benefits at some stage in the future. This was not disclosed by the Insurer.

20. *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 analysed the relevant documents. Fifteen documents are listed. The insurer's statement suggests to an applicant

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that there are no other relevant documents. An applicant may well disagree if he has the opportunity to peruse such other documents. The applicant would also be concerned to see that the IRD lists 23 relevant documents, and still no suggestion that there may be more documents. *Guideline* 5.4.2 has not been referred to in the decision.

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. There is therefore a multiplicity of errors, all clearly demonstrable.

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,* the relevant legislation and the *Regulation*.

23. 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. Accordingly he remains entitled to his former weekly payments until he is validly transitioned and a section 54 notice issues and the relevant period of notice therein has expired.

24. Because the review process does not operate as a stay of the original decision, the applicant has not received weekly payments since they were terminated by the Insurer. Therefore it cannot be said that he "is receiving" compensation. This means that clause 21 of schedule 8 to the *Workers Compensation Regulation* 2010 cannot apply. It follows that he may be restored to the correct pre-transition amount forthwith and back-

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dated to the date when the last payment was made, since there is no need for the expiration of any notice period.[5]

25. Noting the binding nature of these recommendations[6] I recommend that the Insurer takes my views into account, and I recommend that the Insurer immediately gives effect to them.

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

[5] To the extent that clause 21 of schedule 8 of the *Regulation* conflicts with section 9 ("A worker ... shall receive compensation") and section 33 ("compensation... shall include a weekly payment ***during the incapacity***") it is *ultra vires.*
[6] See section 44(3)(h) of the 1987 Act – recommendations made by the Independent Review Officer are binding on the insurer and the Authority.