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 1 July 2013.

2. There is no dispute that the applicant was injured in the course of his full-time employment with the insured on 6 August 2010. The applicant returned to work, but resigned from that employment in February 2011. In January 2012 the applicant found suitable employment in a number of part-time jobs which he has maintained. 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

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worker[1] then the Insurer is required to give proper notice to the worker (Section 54(2)(a) of the 1987 Act).

7. The applicant raised certain 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 or discretion exercised by the insurer".* Most issues raised by the applicant go to the merits of his matter which are matters for the judgement and discretion of the insurer. They are therefore not relevant to this review. The applicant raised the issue of delay in the Merit Review. The application for Merit Review was lodged on 10 September 2013. The Merit Review Decision was made on 31 January 2014, 143 days later. While very late, it is not something I can take into account.

8. The Insurer made submissions. Many documents were provided and a useful timeline provided.

9. *Guideline* 5 and 5.1 requires the Insurer to use something described as the *"Best Practice Decision-Making Guide".* This is a difficulty which faced the Insurer in making its work capacity decision. *Guideline* 5 and 5.1 is in the following terms:

"Clause 5

> **Work capacity decisions should be made in line with the *Best Practice Decision- Making Guide.*"**

and then:

"Clause 5.1

> **When making a work capacity decision the insurer should follow the *Best Practice Decision-Making Guide.*"**

10. That Guide did not exist and has never existed. It follows that through no fault of its own the Insurer has not followed the *Guidelines.*

[1] Or cessation of weekly benefits.

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11. The decision does not state that a work capacity assessment has been made. A work capacity assessment 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. Guideline 5.2 requires the Insurer to make a "*fair notice"* telephone call to the applicant *"at least two weeks prior to the decision."* The Insurer is then required to confirm the information in writing. The Insurer made a fair notice telephone call and sent a letter on 7 June 2014. Neither of these advises the applicant that a work capacity assessment is to take place. The Insurer only states in the letter that it is "*currently assessing information from your file."* 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 was no evidence that a work capacity assessment took place. The Insurer advised in the Internal Review Decision (IRD) of 6 September 2013 that "*we are required to conduct a work capacity assessment."* The Insurer does not state that one took place.

12. In this case the applicant from the decision and IRD did not know whether the work capacity assessment took place. As such, the applicant cannot have known whether the decision was made "*as soon as practicable"* after the assessment. The Insurer's submissions to this Review stated that the assessment began on 1 March 2013 and was concluded on 3 June 2013. The applicant cannot have known that from the decision or IRD.

13. Where a work capacity assessment did take place 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;*

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•clearly explain the reasoning for the decision.

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

15. The heading to the decision states that the decision is made pursuant to section 43 of the 1987 Act. The correct reference is section 54(1) and (2)(a) of the 1987 Act. As such, the legislation has not been properly referred to as required by *Guideline* 5.4.2.

16. The decision states that weekly payments will cease 3 months and 1 week, being 7 October 2013 pursuant to section 54 of the 1987 Act. The correct reference is to section 54(2)(a) of the 1987 Act. Two paragraphs later the decision states that payments will cease on 8 October 2013. The IRD states that payments will cease on 8 October 2013, and that this is an amended date from the original date of 1 October 2013 in accordance with section 53(3)(b) and the *Guidelines*. Section 53(3)(b) of the 1987 Act is not correct and again the legislation has not been properly referenced. The correct reference to the *Guidelines* should be to *Guideline* 5.4. Any reasonable worker in the position of applicant would have been quite confused by these varying dates.

17. *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 states that the Insurer *"will continue to approve"* treatment expenses as defined by section 60 of the 1987 Act but that such expenses will expire 12 months later. The date given is 8 October 2014, not 7 October 2014, and the decision refers to section 59 of the 1987 Act. The correct reference is to section 59A(2) of the 1987 Act.

18. The Insurer later in the decision states that it "*will continue to approve reasonable and necessary treatment expenses as defined by section 60"* of the 1987 Act. The 2 explanations as to how treatment

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expenses are to be dealt with cannot be reconciled. The matter is not assisted by the IRD advising that the "*work capacity decision only relates to your entitlements to weekly benefits and does not affect other entitlements that you may be entitled to under the Act."*

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. The decision refers to work capacity by reference to section 43(1)(a). It is not stated that this section is in the 1987 Act. Further, the decision does not state that section 43(1)(a) refers to "*current work capacity"* and that the phrase is defined in section 32A of the 1987 Act. The decision then refers to "*suitable employment"* by reference to section 43(1)(b) and (c). Again, the 1987 Act is not mentioned. The decision does not state that this phrase is also defined in section 32A of the 1987 Act. The same issue arises in relation to the decision referring to the amount that the applicant can earn. Section 43(1)(d) is then referred to. The decision does not state that the phrase "*current weekly earnings"* is defined in section 44I of the 1987 Act. An applicant could not be expected to know that these 3 phrases do not necessarily carry the meaning which their normal usage in language may suggest. An applicant could therefore be misled as to what the decision is attempting to explain.

21. The applicant is advised that a vocational assessment found that he had a capacity to work in certain jobs which are set out. The decision states a figure for average potential earnings. How this is arrived at is not explained. An Insurer cannot assume that an applicant could work this out for himself by reading the vocational assessment. The Insurer has an obligation to explain a decision in plain language as required by Guideline 5.4.1 which states, *inter alia*:

    Plain language communication requires:
    - *being considerate of the nature of the worker's circumstances*
    - *communicating respectfully*

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- *communicating a clear message*
- *presenting concise information*
- *adapting communication style to meet the worker's needs.*

22. The decision states that weekly payments are to be calculated pursuant to section 38 of the 1987 Act. The proper reference is to section 38(7) of the 1987 Act. The decision states that the applicant has been in receipt of weekly payments for more than 130 weeks but does not attempt to explain the relevance of 130 weeks or refer to section 38(1) of the 1987 Act. Such a reference would then require a reference to "*second entitlement period",* which is not mentioned in the decision, and its definition in section 32A of the 1987 Act.

23. The decision states that the applicant's average weekly earnings (AWE) is $938.30. The decision explains that the AWE is the transitional amount, and refers to clause 9, Part 19H, of Schedule 6 to the 1987 Act. That clause provides that the transitional rate applies. The decision should also refer to clause 2, Part 19H, of Schedule 6 to the 1987 Act which gives the transitional amount. The decision states that the transitional amount applies to all claims "*lodged"* prior to 1 October 2012. That is incorrect. The transitional rate applies to claims where weekly payments were being made immediately prior to 1 October 2012. Clauses 1 and 9, Part 19H, of Schedule 6 to the 1987 Act are the relevant legislation. Clause 1 defines "*existing recipient of weekly payments".*

24. *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 decision lists 5 documents that are 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 documents. An applicant may well disagree if he has the opportunity to peruse other documents. The IRD lists 6 documents, the extra one being a report from a medical specialist. An applicant could at this stage genuinely be concerned that there may be other documents that have not been disclosed. *Guideline* 5.4.2 states that "*All evidence*

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considered should be referred to, regardless of whether or not it supports the decision". An applicant cannot know from the decision as to whether there is any such evidence. I note that in the Insurer's submissions to this Review a number of other documents were provided. As a procedural review I will make no comment on their relevance but the applicant may consider these documents as relevant.

FINDING

25. 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

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

27. I recommend that the Insurer pay the applicant the weekly benefit to which he was entitled prior to 1 July 2013 until such time as he is properly transitioned. Those payments should continue from 8 October 2013 being the date on which they ceased.

28. 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 applicant is not required to produce work capacity certificates for the period from 23 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
18 February 2014

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