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 made by the Insurer on 21 July 2013.

2. There is no dispute that the applicant was injured in the course of her employment on or about 17 January 2005 when she was lifting a patient while working as a Carer. The applicant unsuccessfully sought to return to work and remains unemployed. 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. The insurer purported to make a work capacity decision on 21 June 2013 and confirmed that decision with a subsequent internal review, the outcome of which was communicated to the applicant by letter dated 15 August 2013. The gravamina of those decisions were:

    - that the applicant would lose her entitlement to weekly payments, since they would be terminated on and from 29 September 2013;
    - her entitlement (if any) to payment of pre-approved reasonable and necessary medical and "other expenses"[1] until 29 September 2014 "will not be affected;"[2]
    - if the applicant sought review of these decisions by the WorkCover Merit Review Service, "WorkCover will provide a response to you within 30 days of receipt of your request;"[3]

[1] These would more usually, and correctly, be described as "related expenses." The term "other expenses" connotes an unspecified class of expenses beyond the narrow compass of medical and related expenses.
[2] Not quite the same thing as saying that after 29 September 2014 they will cease entirely, which is the true effect of the decision.

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- if the applicant sought subsequent procedural review by the WorkCover Independent Review Officer (WIRO), the Insurer advised that "WIRO will provide a response within 30 days of receipt of your request."[4]

5. 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*[5] *or discretion exercised by the insurer".* The issues raised by the applicant go to the merits of her matter which are matters for the judgement and discretion of the insurer. They are therefore not relevant to this review.

6. 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: 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.*

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[3] Likely said more in hope than expectation – the Merit Review Service took from 12 September 2013 until 17 January 2014 (which comes to a total of 127 days) to issue a decision. At the time of application, *Review Guideline* 10.14 required a merit review decision to issue "within 30 days." After an amendment in October 2013, this became more of an aspirational goal than a mandated deadline.

[4] This has never been a requirement of the *Review Guidelines*, however (perhaps somewhat ironically) this is one prediction made by the Insurer which was accurate.

[5] Judgement is given the wrong spelling "judgment" in the Act.

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

7. In this case the applicant does not know when the assessment took place. The decision was made on 21 June 2013 and the applicant could infer that the decision was made "*as soon as practicable"* after the decision. What is not clear is whether the applicant was told in the course of a Fair Notice call and letter the "*potential outcome of this review and detail the information that has led the insurer to their current position"* as required by *Guideline* 5.2.

8. *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 "*any entitlement you may have to payment of pre-approved reasonable and necessary medical and other expenses, until 29 September 2014, will not be affected".* This statement gives no information to the applicant about the effect of section 59A(2) on such entitlements beyond that date. The effect of section 59A(2) of the 1987 Act has therefore been disguised, if not misrepresented.

9. 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.

FINDING

10. 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*.* The full effect of the decision has not been explained to the applicant and this clearly comes within the description of what would normally be understood as demonstrable error. Accordingly the work capacity decision is invalidly made.

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11. In this matter another unusual anomaly arose, which ought not become common practice. The letter dated 21 June 2013 was unsigned and instead of a signature had the words: “Work Capacity Team” as though no person had made the decision. In the body of the same letter the applicant was told that the original decision was made by “the Work Capacity Team” and reviewed and confirmed by “a Work Capacity Review Specialist” working for the same insurer. No individual is ever named. In the letter advising the outcome of internal review, an individual’s signature appears over an individual name and their title of “Technical Specialist – Independent Review Officer Work Capacity – Independent Review Team.” How the worker (or anyone reviewing these decisions) is to be assured that there is any arms-length review of the original decision in circumstances where no names are given to those making the decisions and internally scrutinizing them is unknown. It is certainly not true that I can confirm this to be the case.

RECOMMENDATION

12. I recommend that the Insurer conduct a new work capacity assessment and make a new work capacity decision in accordance with the WorkCover *Guidelines,* and the relevant legislation and regulations.

13. I recommend that the Insurer pay the applicant the weekly benefit to which she was entitled prior to 21 June 2013 until such time as she is properly transitioned. Those payments should continue from 29 September 2013 being the date on which they ceased.

14. 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 29 September 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.

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