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 self-insured employer on 20 August 2013 which was sent under cover of a letter dated the same day.

2. There is no dispute that the applicant injured his left knee in the course of his employment on or about 22 August 2008 when performing his duties as a Station Assistant. The applicant unsuccessfully sought to return to pre-injury duties and on 27 August 2010 he was medically retired by his employer, *qua* employer. The employer, *qua* insurer, made weekly payments as required under the provisions of the *Workers Compensation Act* 1987 (1987 Act) for all periods of incapacity.

3. Accordingly the applicant was in receipt of compensation by way of weekly payments immediately before 1 October 2012, a circumstance enlivening Clause 8 of Part 19H of Schedule 6 to the 1987 Act requiring the Insurer to conduct a work capacity assessment for the purpose of facilitating the application of the amended weekly benefits provisions to the applicant's claim.

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 gazetted on 9 August 2013.[1] The *Guidelines,* which ostensibly have the force of delegated legislation, are intended to provide instructions and guidance to insurers regarding the appropriate and consistent application of work capacity assessments and decisions.

[1] This is only a reference to the *Work Capacity Guidelines*. The relevant *Review Guidelines* remained those gazetted on 7 December 2012. Both sets of Guidelines were replaced in short order on 11 October 2013 when the *Work Capacity Guidelines* and the *Review Guidelines* gazetted on 8 October 2013 came into effect. The *Work Capacity Guidelines* gazetted on 9 August 2013 came into effect on 12 August 2013 and were superseded on 11 October 2013, making them possibly the shortest-lived set of Guidelines ever in force.

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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 payments payable to the injured worker then the Insurer is required to give proper notice to the worker (Section 54 of the 1987 Act). Notice must also comply with the postal service rule, found in section 76(1)(b) of the *Interpretation Act* 1987.[2]

7. The applicant sought an internal review of the work capacity decision made by the employer *qua* insurer and was advised of the outcome by letter dated 3 October 2013. Since that decision upheld the original decision, the applicant approached the WorkCover Merit Review Service (MRS) for a merit review on 25 October 2013 and on 7 February 2014 the applicant was advised that MRS had also upheld the original work capacity decision.[3] On 11 February 2014 the applicant applied to the WorkCover Independent Review Officer for procedural review of the work capacity decision. I am satisfied that the application was made within time and on the correct form.

THE WORK CAPACITY DECISION

8. The decision states correctly that notice of 3 months 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. This is unfortunate, since the

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[2] In the 9 August 2013 *Guidelines*, the Authority inserted its own somewhat unsophisticated postal service rule, requiring an allowance of "7 days after the document is posted" (see Guideline 6). This must have been an oblique reference to the definition of "Days" found in the iteration of the *Review Guidelines* gazetted on 7 December 2012, which at 1.4.5 said this: "A reference in these Guidelines to a number of days is a reference to a number of calendar days, unless otherwise stated." Cf: s 76(1)(b) *Interpretation Act* 1987 which refers to service "on the fourth working day" and which in section 76(2) says:

> (2) In this section:
> **"working day"** means a day that is not:
> (a) a Saturday or Sunday, or
> (b) a public holiday or a bank holiday in the place to which the letter was addressed.

[3] While the 105 days it took for MRS to conduct their review was clearly in breach of the 30 day requirement set out in *Review Guideline* 10.14 as it was in force as at the date of application, during the course of the merit review the October 2013 *Review Guidelines* amended 10.14 to make the 30 day period more of a fond hope than a mandatory requirement, thus rendering a paper tiger toothless.

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Insurer had certainly given sufficient notice. The letter dated 20 August 2013 advised that "the reduction to your payments [4] of weekly compensation will apply from 29/11/2013," thereby giving three months and nine days by way of notice.

9. *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 says:

> "*Your entitlement to **benefits for** medical or related expenses will continue in accordance with the provisions of the Act.* "

The covering letter, which enclosed the decision, says:

> "*Your entitlement to **compensation in respect of** medical or related expenses will continue in accordance with the provisions of the Act".*

The disparity in the wording of these two sentences is puzzling, particularly to the eye of an informed reader who might conclude that it is a form of words denoting one of that rare breed, the distinction without a difference. An injured worker applying for workers compensation would not necessarily know that the words "*benefits for*" and *"compensation in respect of*" might mean the same thing to the person writing the letters. Such toxic parataxes are inimical to a clear understanding by the applicant and 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 of the relevant legislation. The reference to "*the Act"* does not identify the relevant legislation.

[4] Given that the "reduction" was to "nil," it might have been less misleading to refer to cessation or termination of payments. Reducing a "payment" to "nil" is to make no payment.

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10. Section 59A(3) of the 1987 Act also states that an injured worker may once again become entitled to payments for medical and related expenses for such time as they may in the future become entitled to weekly payments, even following the exhaustion of the 12 month period referred to in s 59A(2). This was not referred to and it follows that this is another instance of the legislation not being properly or fully explained.

11. 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.[5]

12. The decision says:

    "As the injury occurred prior to 01 October 2012 the transitional Pre-Injury Average Weekly Earnings (PIAWE) rate is determined by the operation of Schedule 6, Part 19H, Clause 2(1) of the Savings and Transitional provisions of the Act."

    Even though this sentence contains more demonstrable errors than any other sentence in the entire correspondence between this applicant and the Insurer, I will refer only to the first. There is nothing in the legislation which says that the *date of injury* is relevant to the application of the transitional rate, other than the obvious inference that if a person is receiving weekly payments of workers compensation immediately before 1 October 2012[6] *a fortiori* they must have suffered injury before that date. Clearly the test has been wrongly set out and the applicant has not had the relevant legislation properly explained in a coherent manner.

13. The insurer purported to advise the applicant how to seek internal review of their work capacity decision. They said this:

[5] But see at paragraph 2 above, where this insurer (*qua* employer) had medically retired the applicant in August 2010. It is perhaps an undesirable circumstance causing a genuine conflict for an employer to medically retire a worker and then, acting in the guise of a self-insurer, require that worker to comply with the return to work provisions in section 48 of the *Workplace Injury Management & Workers Compensation Act* 1998.

[6] That being the true test – see Pt 19H Schedule 6, 1987 Act: "**existing recipient of weekly payments** means an injured worker who is in receipt of weekly payments of compensation immediately before the commencement of the weekly payments amendments."

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> "The request for review must be sent to us within 30 days of you receiving this notice."

The legislation does not and has never set a 30 day requirement for lodgement of an application for internal review. Despite this, the ill-fated September 2012 iteration of the Guidelines which came into effect on 1 October 2012 did say at 6.2.2 that there was such a time-limit. There may therefore have been some room for the view that the requirement existed by virtue of delegated legislative instrument between 1 October 2012 and 11 August 2013. However the version of the Guidelines which came into effect on 12 August 2013 removed the former Guideline 6.2.2 and replaced it with a new Guideline 7.2.2 which made no reference to a 30 day time-limit and instead referred to lodgement of an application ""as soon as practicable after receiving the work capacity decision from the insurer." Since the work capacity decision was dated 20 August 2013, the relevant Guidelines are those in force between 12 August 2013 and 10 October 2013.[7] It follows that the applicant was not given the correct information about the internal review process.

FINDING

14. 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

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

16. I recommend that the Insurer pay the applicant the weekly benefit to which he was entitled prior to 20 August 2013 until such time as he is properly transitioned. Those payments should continue from 29 November 2013 being the date on which they ceased.

[7] See footnote 1 *supra*.

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17. 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 November 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
27 February 2014