WiRO

WorkCover independent review office

Level 4, 1 Oxford Street, Darlinghurst NSW 2010
T: 13 9476
contact@wiro.nsw.gov.au
www.wiro.nsw.gov.au

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.

SUMMARY:

a. **The work capacity decision of the Insurer dated 20 October 2014 is set aside.**

b. **The applicant is to be reinstated to her weekly payments at the rate applicable immediately prior to 27 January 2015.**

c. **The payments are to be back-dated to 27 January 2015.**

d. **Such payments are to continue until such time as a further work capacity decision is made and comes into effect.**

Introduction and background

1. The applicant seeks procedural review of a work capacity decision made by the Insurer on 20 October 2014. The decision informed the applicant that her weekly payments of compensation would cease. The applicant sought internal review and the Internal Review Decision was dated 12 December 2014. The decision remained unchanged. The applicant then sought Merit Review on or about 22 December 2014 and the Authority issued the Merit Review recommendation on 21 January 2015 upholding the Insurer's decision. The applicant made application to this office on 04 February 2015.

2. I am satisfied that the applicant has made the application for procedural review in the proper form and within time.

3. The applicant suffered injury to her cervical spine on or about 4 October 2010 in the course of her employment as an Assistant in Nursing. She continued in that employment on suitable duties until 6 January 2012 when the suitable duties were withdrawn by her (now) former employer. In about august 2013 the applicant stated work as a "Youth Worker." It appears that in around September 2014 the nature of that employment changed and since that time she has been employed as a "Disability

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Worker" with a different employer. At all relevant times the applicant was in receipt of weekly payments of compensation, due to being variably partially or totally incapacitated (as those terms were understood, formerly).

4. The applicant was in receipt of weekly payments immediately before 1 October 2012. Accordingly *Clause 8* of *Part 19H* of *Schedule 6* to the *Workers Compensation Act* 1987 (the 1987 Act) required the Insurer to conduct a work capacity assessment.

5. *Section 44A* of the 1987 Act provides that a work capacity assessment must be conducted in accordance with the *WorkCover Work Capacity Guidelines (Guidelines).*

Submissions by the applicant

6. 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."* The applicant made standard submissions which were in the following terms:

   The insurer failed to:

   i. Correctly reference the legislation;

   ii. Advise the applicant that any documents or information that have not already been provided to the worker can be provided to the worker on request to the insurer;

   iii. Provide a clear explanation as to how the decision was reached;

   iv. Provide information about the effect of the decision on the injured worker's entitlements to medical benefits.

The application form wrongly identified the date of the work capacity decision as 20 September 2014, rather than 20 October 2014.

Submissions by the Insurer

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7. The Insurer has not provided submissions in response to the application.

The Decision

8. The work capacity decision which is the subject of this review certainly complies with the notice provision in section 54(2)(a) and broadly complies with the Guidelines issued by WorkCover. There are, however, at least four errors which collectively make the decision notice invalid.

9. The first submission by the applicant goes to the failure of the Insurer to correctly reference the legislation. This is a requirement imposed by Guideline 5.3.2 of the WorkCover *Work Capacity Guidelines*. In my view, where the legislation was referenced, it was done so with accuracy.

10. However, there is a failure to even cite the legislation in relation to the ongoing liability of the insurer for medical expenses. The applicant was told that the Insurer "will continue to provide reasonable and necessary medical and treatment related expenses for 12 months from your last date of wage payment." First, this does not state that the payments must continue in accordance with the legislation. The reader might think it is a decision made by the insurer to continue payments for a random period of 12 months. Secondly, there is no specific reference to section 59A(2) or (3). Thirdly there is a very confusing reference to the last date of "wage payment." Given that the applicant is currently at work earning wages at the same time as receiving weekly payments of workers compensation it is confusing and confounding to the applicant to refer to the last date when they are paid wages. It is possible for a reasonable worker in this position to conclude from this letter that medical and related expenses will be met for 12 months after they cease earning wages for work, rather than for 12 months following the expiration of entitlement to weekly payments of compensation.

11. The above shortcoming also applies directly to the fourth and final submission of the worker, that the effect of the work capacity decision on the applicant's on-going entitlement to payment for medical expense was not explained. In addition to what appears in paragraph 10 above, I should add that the applicant was never told that she might once again be entitled to payments for medical expenses by virtue of the operation

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of section 59A(3). This would obviously be possible if she were accepted by the Insurer as incapable of working longer hours than her present certification and that certification allowed her to work 15 or more hours per week, earning more than the minimum amount required to satisfy the test in section 38(3) (currently around $183 per week). A further example appears at paragraph 74 of the reasons for decision in the recent case of *Flying Solo Properties Pty Ltd t/as Artee Signs v Collet* [2015] NSWWCCPD 14, where Roche, DP seemed to be of the view that an entitlement to pre-approved medical expenses would arise during the time when a worker is off work undergoing an operation.[1]

12. In the course of the decision the Insurer said this:

> I have determined that you have current work capacity of 8 hours and 5 days per week from **24/04/2013 to 13/11/2014** & from **13/10/2014 to 13/11/2014** – 4 hours and 5 days per week.

Given that the second period is included wholly within the first period, this is confusing and inexplicable. It does little to provide a "clear explanation" of how the decision was reached.

13. On the following page of the decision an attempt was made to clarify what appears in paragraph 12 above, with no success. Here is what appears:

> You were certified fit for work 8 hours and 5 days per week from **08/05/2013 to 13/10/2014**.[2] However we note that from 13/10/2014, you are now certified as having capacity for 4 hours and 5 days per week by your nominated treating doctor, Dr B. This information is inconsistent with your history of capacity for work since May 2013. Hence [the Insurer] has written to Dr B for further clarification on your downgrade.

It is probably permissible for an Insurer to make the enquiry, but it cannot be acceptable for an Insurer to make a work capacity decision without first receiving a reply from the doctor. Making the decision in the absence

[1] How pre-approval could occur *prior* to the worker being off work for the purpose of undergoing the operation more than 12 months after the cessation of weekly payment entitlements was not explained, in the absence of a finding by the WCC that the operation was necessary.
[2] Note that this is different to the earlier cited period of "24/04/2013 to 13/11/2014."

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of an answer from the doctor defeats the purpose of making the enquiry and is of itself an admission by the Insurer that it has made a decision in the absence of a vital piece of information.

14. The final error made by the Insurer occurs in the course of giving the applicant information about internal review. This appears:

    > You must return the request for review form to the Internal Review Team at [the Insurer] within 30 days or [the insurer] may decline to review the decision(s) further.

    This is both misleading and wrong. The Insurer has no right to "decline" to undertake a review simply because a worker is outside a 30 day time period set by the Insurer. If the statement is based on a mis-reading of section 44(1)(a) then it is a further instance of the legislation not being properly explained.

FINDING

15. Under the legislation the Insurer can make an assessment of the applicant's work capacity and then a decision about that work capacity, but they must comply with the legislation, the Regulation and the Guidelines in order to produce a procedurally correct result. In the current instance there have been breaches of the Guidelines which are to be treated as delegated legislation. Accordingly the work capacity decision must be found to be invalid.

RECOMMENDATION

16. The work capacity decision of the Insurer dated 20 October 2014 is set aside.

17. The applicant is to be reinstated to her weekly payments at the rate applicable immediately prior to 27 January 2015.

18. The payments are to be back-dated to 27 January 2015.

19. Such payments are to continue until such time as a further work capacity decision is made and comes into effect.

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Wayne Cooper
Delegate of the WorkCover Independent Review Officer
10 March 2015.