WorkCover independent review office

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RECOMMENDATION FOLLOWING AN APPLICATION FOR REVIEW OF THE INSURER'S WORK CAPACITY DECISION PURSUANT TO SECTION 44BB(1)(c) OF THE *WORKERS COMPENSATION ACT* 1987.

SUMMARY:

a. The work capacity decision of the Insurer dated 13 October 2015 is set aside.

b. The applicant is to be reinstated to her weekly payments at the rate applicable immediately prior to 20 January 2016.

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

Introduction and background

d. On 7 October 2002 the applicant suffered injury to her neck and back when she fell from a ladder whilst in the course of her employment as a sales assistant. The applicant unsuccessfully attempted to return to duties with her pre-injury employer and her employment was eventually terminated in 2007. From 2012 the applicant was self-employed in her own business working up to 20 hours per week. She no longer does that work, having ceased some time in 2015.

e. The applicant seeks procedural review of a work capacity decision made by the Insurer on 13 October 2015. The decision advised the applicant that her weekly payments of compensation at the rate of $794.96 would cease on 20 January 2016. The applicant sought internal review and the Internal Review Decision (IRD) confirmed the original decision and was dated 11 December 2015. While there is some dispute as to the actual date of receipt by the applicant of this decision, she sought Merit Review on or about 14 January 2016 and was found to be within the statutory timeframe. The Authority issued the Merit Review recommendation on 10 February 2016.

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f. On 3 March 2016 application was made to this Office for procedural review. Clearly the applicant had applied within the relevant 30 day period, which would mean that under section 44BC a 'stay' of the original decision remains in place for the duration of the procedural review.

g. Despite the recommendation of the Merit Review Service of the Authority (MRSA) requiring the Insurer to make an assessment as to whether or not the applicant was a high needs worker and to determine the applicant's "entitlement (if any) in accordance with section 38(3A) of the 1987 Act," the Insurer had the effrontery to make the following statement in submissions to this Office in the course of procedural review:

> "Noting that there was no 'stay' applicable as [the applicant's] weekly benefits had ceased on 10/2/2016."

h. There are two problems with the statement: first, it shows that the Insurer terminated payments on the same date as the recommendation was issued by the MRSA and before even conducting the assessment required by the binding recommendation; and secondly, it shows that the Insurer has no understanding whatsoever of the concept of a "stay," or how section 44BC operates.

i. That any Insurer would even admit to so blatant a breach of the legislation is of itself surprising; but to have that misconduct relied upon in submissions as though it were grounds for a continuation of the breach betrays either (i) an ignorance of the law or (ii) a contempt for the law which can fairly be described as profound in the extreme. For the benefit of this scheme agent I hereunder reproduce the relevant sections of the 1987 Act:

> **44BB Review of work capacity decisions**
>
> (3) The following provisions apply to the review of a work capacity decision when the reviewer is the Authority or the Independent Review Officer:
>
> (g) recommendations made by the Authority ***are binding on the insurer and must be given effect to by the insurer***,

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(h) recommendations made by the Independent Review Officer ***are binding on the insurer and the Authority*****.** [Emphasis added]

44BC Stay of work capacity decisions

(1) A review of a work capacity decision in respect of a worker operates to stay the decision that is the subject of the review ***and*** prevents the taking of action by an insurer based on the decision while the decision is stayed. [Emphasis added]

j. Compliance with the recommendation of the Authority is not a discretionary matter, "binding" being a word which brooks no subtlety.

k. Section 44BC has two limbs: the first being the imposition of a stay for the duration of review under section 44BB; the second being the prevention of the taking of any action "based on the decision" during the stay. It is obvious that the withholding of weekly payments is an action "based on the decision" and it is equally obvious that to so act during the course of section 44BB review is a breach of the Act. It is unlikely that legislative amendment could make the meaning any plainer than it is at present.

l. Section 44A of the 1987 Act provides that a work capacity assessment must be conducted in accordance with the *WorkCover Work Capacity Guidelines (Guidelines).* The relevant version of the *Guidelines* came into effect on 11 October 2013.

Submissions by the applicant

m. Section 44BB(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 has made submissions as follows:

- The Insurer failed to respond to a request for internal review within 30 days;

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- The insurer did not make a decision "as soon as possible" after making a work capacity assessment;

- The Insurer based its decision on the suitable employment role of Events Coordinator, which is inappropriate to the applicant's physical limitations. The MRSA agreed with this submission by the applicant and found instead that the role of Telemarketer was appropriate.

- The Insurer informed the applicant of an incorrect number of weekly payments received, in breach of Guideline 5.3.2. In the decision the number of weeks quoted is 610, whereas at paragraph 51 of the MRSA recommendation the following bizarre sentence appears:

  > "The Insurer has submitted and no dispute has been raised that [the applicant] has received 1,224 weeks of weekly payments of compensation."

  It is obvious that both figures cannot be correct, but both are supplied by the insurer. I described the sentence as "bizarre" because the date of injury is 7 October 2002, meaning that 1,224 weeks will not have elapsed since the date of injury until a time in April 2026. That the submission might have been made in error is understandable, that no effort was made to correct it is not.

- The Insurer found at the same time in the same decision that the applicant could work for (i) at least 20 hours per week and (ii) "up to" 38-40 hours per week. This is not in compliance with the Guidelines or the Act.

- The Insurer cited section 38, without specifying which sub-sections were relevant to the applicant's case.

  The last submission is of particular importance in light of the recommendation by MRSA that the Insurer make an assessment for the purposes of section 38(3A), despite the applicant's non-compliance with 38(3).

Submissions by the Insurer

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n. The Insurer has provided submissions in response to the application which included a chronology. Erroneously, the chronology alleges that the MRSA recommendation was dated "10/1/2016," whereas it was in fact dated 10 February 2016. The totality of submissions might be accurately summarised as follows:

- The insurer does not believe or accept that it made any procedural errors; and

- The worker has been through the review process previously.

It has to be said that the substance of the first submission is slight, whereas the point of the second is not obvious.

The Decision

o. This is the second application by this worker for procedural review, a previous recommendation having issued from this Office reported and numbered as 21914 (219 of 2014).

p. It is possible that the internal review decision was communicated to the applicant more than 30 days following receipt of the request, but nothing turns on this point, since the applicant successfully applied for merit review in any event, which is the only known remedy for a slow response to internal review.

q. *Schedule 8 Clause 23 of the Workers Compensation Regulation* 2010 (the Regulation) states that an Insurer must make a work capacity decision as soon as practicable after the work capacity assessment. Here the applicant is advised that the assessment commenced on 30 June 2016 and a fair notice call was made on 24 August 2015. The assessment was not completed until 13 October 2015, being the same day on which the notice issued informing the applicant of the decision. It is true that this an inordinately long time to conduct an assessment, however the Regulation only requires the decisions to be made as soon as practicable after the assessment. Since it appears to have been made instantaneously with the conclusion of the assessment, there is no breach.

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r. The applicant is right to say that Events Coordinator is an unsuitable role, but that error was a matter for MRSA, which corrected it.

s. It is concerning that the Insurer has told the applicant she received 610 weeks of payments but told MRSA it was 1,224 weeks. There is no way to reconcile the two figures. The applicant has definitely received in excess of 130 weeks of payments, which is probably the only relevant fact. It is relevant because it makes section 38 the relevant section. However, the applicant cannot possibly know which part of section 38 affects her claim absent information from the insurer on this.

t. It is not strictly true that the Insurer did not explain section 38 to the applicant. The following appears:

The decision has been made because:
……
……
……

- You are not working 15 hours or more per week (section 38(3)(b) of the Workes Compensation Act 1987);

- You are not earning $176 or more per week (section 38(3)(b) of the Workers Compensation Act 1987).

But nowhere does it say that the applicant has to be both working 15 hours and earning $176 ad have to have received in excess of 130 weeks of compensation. I fact, it says the opposite. Just before the two sentences in bullet points above, the following appears:

- Weekly payments have been paid or are payable to you for ***up to*** 130 weeks.(Emphasis added)

The last bullet point is a clear misstatement of the law. It would lead the applicant to wonder what happens after 130 weeks. And that is precisely what the Insurer is supposed to be telling her.

u. The finding by the Insurer that the applicant can work for a minimum of 20 hours “up to” 38-40 hours per week is too imprecise

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to be any finding at all. A specific finding of work capacity does not give a range with a variance of "up to" 18-20 hours difference. This does not comply with the Guidelines.

v. It follows that the first submission of the Insurer is wrong and the second of no consequence.

FINDING

w. 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

x. The work capacity decision of the Insurer dated 13 October 2015 is set aside.

y. The applicant is to be reinstated to her weekly payments at the rate applicable immediately prior to 20 January 2016.

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

Wayne Cooper
Delegate of the WorkCover Independent Review Officer
21 April 2016