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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*.*

SUMMARY:

a. The work capacity decision dated 15 October 2014 is set aside.

b. The applicant is to be reinstated to her weekly payments at the rate applicable immediately prior to 22 January 2015.

c. The payments are to be back-dated from 22 January 2015.

d. Such payments are to continue until a new work capacity decision is made.

Introduction and background

1. The applicant suffered injury to both forearms in May 2006 as a result of her employment as a TAFE instructor. Her employment continued, but was ultimately terminated in 2010. She now works as a Nutritional Consultant.

2. For all relevant periods the Insurer accepted liability and made weekly payments of compensation.

3. The applicant seeks procedural review of a work capacity decision made by the Insurer on 15 October 2014. The decision advised the applicant that her weekly payments of compensation would cease from 21 January 2015. The applicant sought internal review of the decision and the Internal Review Decision (IRD) was dated 26 November 2014. The IRD confirmed the initial work capacity decision.

4. The applicant then sought Merit Review from the Authority on 21 December 2014 and a recommendation was made dated 20 January 2015 confirming the original work capacity decision. The applicant subsequently applied to this office for procedural review.

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

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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's submission to this Office merely seeks scrutiny of the Insurer's decision-making processes. She does not specifically repeat the submissions made earlier to the Merit Review Service or to the Insurer in the course of IRD. Since the both the Insurer and the Merit Review Service have referred at length to the earlier submissions by the applicant, they remain to that extent relevant and available for consideration.

   - The insurer itself refers to submissions by the applicant in relation to a report by one particular doctor thus:

     "Independent Medical Consultation Stage[1] - Dr K – 20/08/2014, [the applicant] indicates that the report from Dr K states: "*It should be noted that this is a file review and I have not examined the worker. The opinion offered is within the constraints of a file review and this should be borne in mind when reviewing this report*." [The applicant] has stated that given that this doctor has not made contact to ask questions or examine her in person, she feels that there is no new information from his report that can be contributed to assist [the Insurer] or herself in this case review."

7. It is clear that the Insurer has relied upon this report. Two pages prior to the commendable insertion of the applicant's submissions in the work capacity decision notice the Insurer had this to say of the very report in question:

[1] A "stage" peculiar to this Insurer which persists with the practice of getting doctors to not examine patients/workers, then relying on "reports" of the doctors, which reports appear to be given no less weight (and in some cases considerably more weight) than reports and certificates of the Nominated Treating Doctor (NTD). This is despite the WorkCover *Guidelines* saying that the WorkCover Certificate of Capacity produced by the NTD is the "**primary tool**" for communication with all parties involved in the return to work process. (See Guideline 3 – *WorkCover Work Capacity Guidelines* which came into effect on 11 October 2013.)

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> "An Independent Medical Consultation file review[2] took place on the 20/08/2014. Dr K states in his report that he is unable to explain [the applicant's] lack of progress on organic grounds. She has had several Independent Medical Examinations that have failed to reveal any notable or significant pathology. Dr K further states that there is certainly no evidence on file[3] as to why [the applicant] could not return to work 5 days a week."

8. Despite the last sentence in the preceding paragraph the Insurer did not conclude that there might be evidence which was not "on file," which might have been discovered had the doctor taken the trouble to actually examine the applicant.

9. In the course of the IRD the Insurer made the following observations:

> "Dr K. File review 20/08/2014. In discussion with [the NTD], [the applicant] is currently certified for 3 hours per day 3 days per week after a recent upgrade and the intention was further upgrade."

10. This would have been news to the applicant, who in the course of the work capacity decision dated 15 October 2014 was told nothing of a "discussion" between Dr K and her NTD. There was also no reference to a proposed "further upgrade" by the NTD in the work capacity decision.

11. A further twist arises in the course of Merit Review, where the merit reviewer says at paragraph 28:

> "28. Dr K was called upon by the Insurer to conduct an onsite[4] file review and produce a report. The report of 20 August 2014 states that Dr K is unable to explain [the applicant's] lack of progress on organic grounds. He felt there was no evidence on file as to why she could not return to work for 5 days per week, noting her certification for 3 hours per day."[5]

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[2] Whether it was a "consultation" or a "file review" appears to be an unresolved issue. They are scarcely the same thing.
[3] Precisely which "file" is not specified.
[4] The venue was not previously disclosed.
[5] Again there is no reference to discussion with the NTD. In light of the final sentence, Dr K seems to have created the impression that the NTD's certification was completely without discoverable foundation.

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12. It might usefully be borne in mind that the short term "on file" qualifies everything appearing in the report of Dr K. He does not say there is no evidence to support the applicant's current certification – he only says there is no such evidence "on file."

Submissions by the Insurer

13. The Insurer has not made submissions in response to this application.

The Decision

14. Section 54(2)(a) of the 1987 Act requires at least three months and four working days' notice be given if payments are being reduced or ceased having regard to Section 76(1)(b) of the *Interpretation Act* 1987. In this decision the notice period complied with the legislation.

15. Guideline 2.3 states that the Insurer's decision should be *"timely, informed and evidence based."* The current decision appears to be, at least to an extent, "no evidence" based.

16. The insurer has referenced Section 59A(2) and (3) of the 1987 Act and informed the applicant that her entitlement to treatment expenses will cease 12 months after her entitlement to weekly payments of compensation ceases. The insurer also explained how the applicant may become re-entitled to medical treatment expenses by virtue of Section 59A(3). The insurer has thereby complied with the legislation and Guidelines.

17. Guideline 5.3.2 requires the insurer to explain the relevant entitlement periods. The insurer has informed the applicant that her ongoing entitlements would be assessed pursuant to Section 38 of the 1987 Act. The insurer has thereby complied with the Guideline.

18. The decision generally has displayed a careful consideration of the requirements of the Guidelines and legislation. However there are two elements which might require scrutiny. First, the submission by the applicant in relation to the report of Dr K was never responded to adequately or at all by the Insurer. While the Insurer repeated verbatim the submission made by the applicant, nothing was said in response. This process was repeated in the course of Merit Review, where the reviewer noted the submission of the applicant concerning the report of Dr K and the insurer made no submission in reply. Secondly, the Insurer

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at the very beginning of the work capacity decision made a statement which seems to be at odds with section 54. Relevantly, the insurer said this:

> "[y]our weekly payments at your current rate will continue to be paid until 21/01/2015 provided certificates of capacity cover you until that date."

19. This is odd. The Insurer has already advised the applicant of termination of payments on a date three months in the future. This is the minimum time allowed for under section 54(2)(a). Section 54(6) allows for an exception if payments are reduced due to the change over from one entitlement period to another, but does not allow for cessation of payments in the absence of the correct notice, which has already been given. The utility of providing further certification is therefore questionable. However it is acknowledged that section 44B(1)(a) seems to require a certificate for all periods "in respect of which the worker is entitled to weekly payments." This is yet another anomaly appearing in the legislation, but cannot be held against the Insurer.

20. One thing which can be held against the insurer is the selective, inconsistent and possibly misleading reportage appearing in both the work capacity decision and the IRD concerning the report of Dr K. The work capacity decision did not disclose any conversation between Dr K and the NTD. It did not say that the doctor attended the premises of the Insurer to inspect a file "onsite," which was only revealed in the course of merit review. It did not describe or advise exactly which documents formed the "file" read by Dr K and it nowhere referred to any potential "upgrade" in the applicant's work capacity – this only appeared in the IRD. It is clear that the Insurer has withheld information from the applicant which ought to have been disclosed prior to the work capacity decision being made. This is a clear breach of the Guidelines.

21. Further it is unacceptable for an Insurer to merely recite the submissions of a worker without responding to them in any way. The applicant's very reasonable objections to the report of Dr K were completely ignored by the Insurer in the course of the work capacity decision, IRD and Merit Review. It further appears that no effort was made by the Insurer to corroborate the assertion by Dr K that the NTD would "upgrade" the

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applicant's work capacity in the future, something which did not eventuate in any event.

Finding

22. The Guidelines require Insurers to consider representations made by workers prior to decisions being made. This applicant's representations concerning the report dated 20 August 2014 by Dr K were completely ignored at every stage. Despite this, reliance was placed on the report, even in the course of merit review. The applicant was told new information about that report in the course of IRD. The information should have been disclosed in the original decision. This constitutes a serious breach of the *Guidelines* and the decision must be overturned.

Recommendation

23. The work capacity decision dated 15 October 2014 is set aside.

24. The applicant is to be reinstated to her weekly payments at the rate applicable immediately prior to 22 January 2015.

25. The payments are to be back-dated from 22 January 2015.

26. Such payments are to continue until a new work capacity decision is made.

Wayne Cooper
Delegate of the WorkCover Independent Review Officer
27 March 2015