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 seeks procedural review of a work capacity decision made by the Insurer on 1 October 2013. The applicant sought internal review and the Internal Review Decision was issued on 22 November 2013. She then sought Merit Review and applied to the Authority on 19 December 2013. The Authority issued the Merit Review recommendation on 20 February 2014, a mere 63 days later.[1] Following receipt of the Merit Review Service (MRS) recommendation, the applicant made application to this office on 19 March 2014, received on 24 March. Accordingly I am satisfied that the application has been made within the designated time and on the correct form.

2. The applicant was injured on 18 January 2003. She returned to suitable employment with the employer until her employment was terminated on 13 July 2006. The applicant obtained some further suitable employment in August 2009, but it is unclear as to how long that employment lasted. That suitable employment had ended no later than early 2011. 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. 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*).*

[1] The *Guidelines for work capacity decision Internal Reviews by insurers and Merit Review by the WorkCover Authority* 10.14, which came into effect on 11 October 2013, states that "*The Authority will write to the worker and insurer as soon as practicable and preferably within 30-days of receiving the application advising of the outcome of the merit review."*

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5. The relevant version of the *Guidelines* came into effect on 12 August 2013. That publication stated that the *Guidelines* provide instructions and guidance to Insurers regarding the appropriate and consistent application of work capacity assessments and decisions.

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 benefits payable to the injured worker then the Insurer is required to give proper notice to the worker (Section 54(2)(a) of the 1987 Act).

Submissions by the applicant

7. The applicant raised various 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 or discretion exercised by the insurer".* The applicant's submissions go to the merits of the decision and are therefore not relevant to a procedural review.

Submissions by the Insurer

8. The Insurer made no submissions despite advising that it would do so. The Insurer provided what appears to be a print out of its correspondence to the applicant with respect to the decision, together with its file records of telephone calls to the applicant. No attempt was made to draw my attention to any part of these documents which may be thought relevant, beyond a bare cataloguing of a series of events which clearly describe in laborious detail the various phases of what might be described as "claims management."

The Decision

9. The decision states that a work capacity assessment was 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* 5.3.2 requires. There does not appear to be any legislative requirement to notify the applicant of the

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outcome of the assessment. However, *Guideline* 5.3.2 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 line of reasoning for the decision.*

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

10. The decision states that the applicant's weekly payments are to cease. Pursuant to section 54(2)(a) of the 1987 Act the Insurer is required to give 3 months notice that the applicant's payments are to cease. The decision was made on 1 October 2013. The decision states that weekly payments will cease on 31 December 2013. This is an egregious error.[2] The proper time frame is to allow the decision to be received by the applicant 4 working days after being posted pursuant to section 76(1)(b) of the *Interpretation Act* 1987 which would be Tuesday 8 October 2013 as Monday 7 October 2013 was a public holiday pursuant to section 4(i) of the *Public Holidays Act* 2010. The 3 month notice period would then run until 8 January 2014.

11. *Guideline* 5.3.2 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 weekly payments cease. The decision states that fact. In addition, section 59A(3) of the 1987 Act states that the applicant may, after the

[2] To remove doubt, note that *"egregious"* is used here in the modern pejorative sense rather than the traditional meaning which has the correct etymological sense from the Latin "*egregius*" meaning to tower above the flock in an excellent or renowned way. See the following: "*Egregiously*: *in an egregious manner, remarkably; in 17th c. occasionally in a good sense, remarkably well, excellently; now exclusively in bad or ironical sense, grossly, monstrously, shamefully."* – in *Oxford English Dictionary,* Oxford University Press, 1971.

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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.

12. The decision states that the applicant has received 459.58[3] weeks of weekly payments. This places the applicant beyond the second entitlement period. *Guideline* 5.3.2 requires the Insurer to *"reference the relevant legislation."* The decision does not attempt to explain the second entitlement period, or refer to its definition in section 32A of the 1987 Act.

13. The decision refers to the definition of "*suitable employment"* in section 32A of the 1987 Act. There is no attempt to describe the terms of that definition which is not a definition of those words as would be commonly understood.

14. The applicant is advised that as she was in receipt of weekly payments immediately before 1 October 2012 that the Insurer is required to transition her claim. This is correct but the legislation has not been referred to in the decision which is Clause 8, Part 19H of Schedule 6 of the 1987 Act.

15. The decision states that a determination has been made pursuant to section 43 of the 1987 Act. That is correct, but the decision then sets out the criteria from section 38(3)(b) and (c) of the 1987 Act without referring to that section. Again, the legislation has not been referred to in the decision. Another issue which may confuse the applicant is that rather than state that the applicant is not earning $168 per week (section 38(3)(b) of the 1987 Act), it is stated that *"You are currently earning $168 per week*." For an applicant who has no employment this is a remarkable feat.

16. The decision states that *"In making our Work Capacity Decision, we have considered all available and relevant evidence, including the*

[3] While perhaps little turns on it, if what the Insurer is trying to say is that the applicant has been paid for 459 weeks and 4 days, then the correct decimal description would be 459.571428571428 weeks, which might be more commonly rounded to the second decimal point as 459.57 rather than 459.58. A small issue, but one which arises due to the Insurer trying to "round" the aggregation of payments to 100th of a week.

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evidence listed below". Five documents are then listed. The use of the phrase "*including the evidence listed below" suggests* that there are other relevant documents which the Insurer has but may not wish to disclose to the applicant. The applicant is told that she may request copies of any of the 5 listed documents. *Guideline* 5.3.2 states that the work capacity decision notice must advise the applicant that any documents or information that have not already been provided to the applicant can be provided on request to the Insurer. The Insurer has failed to so advise the applicant, and stated instead that the applicant may have copies of the 5 listed documents, without reference to any other documents held by the Insurer.

17. The applicant is advised that she may request an internal review. The Insurer has not referred to section 44(1)(a) of the 1987 Act. This is a breach of *Guideline* 5.3.2 and the need to *"reference the relevant legislation."* It is stated that the application for internal review *"must be received strictly within thirty (30) days from receipt of this letter".* Section 44(1)(a) of the 1987 Act does not provide any time frame for making an application for internal review. The *Guidelines for work capacity decision Internal Reviews by Insurers and Merit Reviews by the Authority* 6.5[4] states that the application *"should be lodged by the worker with the insurer as soon as practicable after"* receiving the decision.

18. At the end of the decision and purporting to form part of the decision is a page of extracts from the 1987 Act under the heading *"Important information about weekly payment entitlements".* This page has little relevance to the applicant. By way of example sections 36 and 37 of the 1987 Act are included, which are not relevant to the applicant's case.

FINDING

19. 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 *Regulation.*

RECOMMENDATION

[4] The iteration which came into effect on 11 October 2013.

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

21. I recommend that the Insurer pay the applicant the weekly benefit to which she was entitled prior to 1 October 2013 until such time as she is properly transitioned. Those payments should continue from 31 December 2013 being the date on which they ceased.

22. Whether or not the applicant can now be transitioned is a vexed issue. Clause 8(2) of Part 19H of Schedule 6 to the 1987 Act states *"The insurer who is liable to make weekly payments of compensation to an existing recipient of weekly payments must conduct a work capacity assessment of the worker no later than 12 months (or such longer period as may be prescribed by the regulations) after the commencement of the weekly payments amendments*". The *Workers Compensation Regulation* 2010 Clause 17 of Schedule 8 states that *"A period of 18 months is prescribed for the purposes of clause 8 (2) of Part 19H of Schedule 6 to the 1987 Act".* This means that the assessment must be made by 1 April 2014. As this can no longer be achieved it is difficult to see how the applicant can now be transitioned.

23. 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 applicant is not required to produce work capacity certificates for the period from 31 December 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(3)(h) of the 1987 Act.

Wayne Cooper
Delegate of the WorkCover Independent Review Officer
22 April 2014

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