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 13 August 2013. He was advised that his weekly payments of workers compensation would "reduce to nil" with the decision being effective "immediately." Two sentences later he was told that the decision would be "effective from 15 November 2013."[1]

2. The applicant subsequently sought internal review. That decision was issued on 11 October 2013. The original decision was reaffirmed. The applicant consequently sought Merit Review by the Authority. That application was received by the Authority on 29 October 2013. The Merit Review decision was issued on 27 February 2014, some 121 days later.[2] Once again the original decision survived scrutiny.

3. The applicant made his application to this office on the correct form and within 30 days of receipt of the Merit Review Service recommendation, in accordance with the legislation and guidelines.

Background

4. The applicant was injured on 12 March 1997 in the course of his occupation as a Fitter. He returned to suitable employment with the same employer until 30 April 2005, when his employment was terminated. The Insurer made weekly payments as required under the provisions of the *Workers Compensation Act* 1987 (1987 Act) for all relevant periods.

5. The applicant was in receipt of weekly payments immediately before 1 October 2012. Accordingly he was an "existing recipient of weekly payments" as defined in division 1, clause 1, Part 19H of Schedule 6 to the 1987 Act. Clause 8 of Part 19H therefore required the Insurer to conduct a work capacity assessment for the purpose of "facilitating the

[1] That is, three months and two days later, *contra* the notice requirements in section 54(2)(a) of the 1987 Act and section 76(1)(b) the *Interpretation Act* 1987.
[2] Cf: *Review Guideline* 10.14 (as amended).

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application of the weekly payments amendments [introduced in 2012] to" the applicant.[3]

6. 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*).*

7. The relevant version of the *Guidelines* came into effect on 12 August 2013, one day prior to the work capacity decision notice being issued. That publication states that the *Guidelines* provide instructions and guidance to Insurers regarding the appropriate and consistent application of work capacity assessments and decisions.

8. 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).[4]

Submissions by the applicant

9. 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 primarily go to the merits of the decision, that is, the judgement or discretion of the Insurer and are to that extent not relevant to a procedural review. However there remains one issue which was raised at the merit review stage but was not dealt with there, since it concerns procedural fairness. The applicant alleges that the Insurer has relied on the reports of a Doctor 'K' who the applicant alleges did not conduct a proper assessment. In the merit review process (but not repeated here) he also alleged that he was not provided with copies of documents forwarded to Dr K, nor was he given any opportunity to

[3] Per division 2, clause 8(1) of Part 19H schedule 6 to the 1987 Act. See also clause 17, schedule 8, *Workers Compensation Regulation* 2010 which sets an 18 month time-limit. For more on this, see paragraphs 12 & 30 *infra*.
[4] See footnote 1, *supra*.

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participate in discussions between the Insurer's doctor and his own treating doctor, Dr Y. In addition to the above, he was not provided with descriptions of the jobs that Dr K alleges he could perform. Since the merit reviewer was not concerned with procedures, this is what they said:

> I acknowledge that [the applicant] makes various submissions in relation to the Insurer's conduct in procuring the assessment and report from Dr [K], that the handling of his matter by the Insurer has been procedurally unfair and that the Insurer did not provide him with proper information. However, this review is not a review of the Insurer's processes and procedures.[5]

10. The MRS did not deal with the procedural objections, and therefore they remain undetermined. It is therefore appropriate that they be considered by this office.

Submissions by the insurer

11. The Insurer made the following submission:

> We make the following submission.
>
> [The] application for procedural review of the work capacity decision contains a statement in which [the applicant] asserts that he has been unfairly treated by Dr K whom he accuses of fabricating the assessment, of not referring to radiology and being biased. He does not provide a reason or support in respect to the grounds for seeking the review. None of the issues raised in the statement are in relation to the Insurer's procedures in making the WCD decision and we contend that [the] application does not meet with WIRO's terms of reference.

The Decision

12. The decision correctly outlines the relevant entitlement periods and accurately describes the effect of section 38. There can be no dispute

[5] MRS recommendation 27 February 2014, at paragraph 22.

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that the applicant is covered by section 38, having received weekly payments for the best part of a decade. It was determined that the applicant was actually working for 18 hours per week and earning $393.38 gross per week, although for an earlier period he was working only for 15 hours per week.

13. *Guideline* 5.3.2 requires the decision to *"reference the relevant legislation."* This would require any interpretation of the legislation (including delegated legislation) to be accurate. It is clearly inaccurate to say (as this Insurer has said) the transitional amount used to calculate the pre-injury average weekly earnings of this applicant "applies to all injuries received before 1 October 2012 and disregards any actual pre-injury earnings." The transitional rate only applies in fact to those injured claimants who were existing recipients of weekly payments "immediately before" 1 October 2012. While it follows that such "existing recipients of weekly payments" must have been injured prior to 1 October 2012, it does *not* follow that all claimants injured prior to that date are yoked inexorably to the transitional amount set out in division 1, clause 2 of Part 19H of Schedule 6 to the 1987 Act. The statement by the Insurer that the transitional amount applies "to all injuries received before 1 October 2012" appears on page 4 of the letter dated 13 August 2013, and is repeated by way of emphasis on page 5, thereby compounding the error. It may be that little turns on this, since it is clear that the transitional amount does apply to this applicant, however clumsily he was informed.

14. *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 and related expenses are no longer payable 12 months after a worker ceases to be entitled to weekly payments of compensation. The decision states that:

> This decision has no effect on your entitlement to receive, and have paid, reasonably necessary medical treatment as allowed by the Act.

This statement is not only untrue, it is based on the false premise that the reduction of weekly payments to "nil" might constitute an ongoing

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entitlement (albeit to no monetary payment) which entitlement would forestall the operation of section 59A(2) indefinitely. There was possibly a time when the WorkCover Authority advised Insurers that this was a correct interpretation of the law. Even so, it is now acknowledged to be incorrect and was always incorrect, whether or not the Authority believed this to be the case. Accordingly this is a demonstrable error and is sufficient to invalidate the decision. The applicant has not been advised as to the time limitation on his rights to ongoing medical expenses and *Guideline* 5.3.2 has therefore been breached.

15. In addition, section 59A(3) of the 1987 Act states that the applicant may, after the entitlement to compensation for medical expenses is extinguished by the effluxion of 12 months, relumine that very entitlement to medical expenses if the entitlement to compensation for weekly benefits resumes at any stage in the future and for such time as those weekly payments continue.[6] This, too, was not disclosed by the Insurer.

16. The allegations made concerning the incomplete set of documents sent to the applicant, particularly with reference to those materials supplied to Dr K, would also suffice to have the decision of the Insurer set aside. There is no basis on which the Insurer can justify refusing to give copies of all documents relied upon to the injured worker and this is a blatant breach of *Guideline* 5.1 which requires an insurer to "evaluate all available and relevant evidence" and to follow "a robust and transparent decision-making process." There is nothing transparent about withholding documents from an injured worker.

17. The decision is dated 13 August 2013 and purports to take effect "immediately"[7]. If so, this would be in clear breach of section 54(2)(a) which requires three months notice to be given for a reduction or cessation of weekly payments. Shortly after the applicant is told something different, namely that the decision will take effect from 15 November 2013, which is three months and two days subsequent to the date of the letter giving the notice. While this might ostensibly comply with section 54(2)(a), it fails to allow four working days in addition to three months, as required by section 76(1)(b) of the *Interpretation Act*

[6] Some uncertainty still attends the definition of "week" or "weekly" in this context.
[7] See page 5 of the decision itself and paragraph 1, *supra*.

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1987. Accordingly the failure to provide adequate notice must be fatal to the validity of the decision.

FINDING

18. 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.

RECOMMENDATION

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

20. I recommend that the Insurer pay the applicant the weekly benefit to which he was entitled prior to13 August 2013 until such time as he is properly transitioned. Those payments should continue from 15 November 2013 being the date on which they ceased.

21. 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 31 March 2014. As this can no longer be achieved it is difficult to see how the applicant can now be transitioned. This may be an issue for the regulator to address.

22. 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 15 November 2013 to date by virtue of the operation of section 44B(2) of the 1987 Act. These

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recommendations are binding on the insurer: see section 44(3)(h) of the 1987 Act.

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Delegate of the WorkCover Independent Review Officer
30 April 2014