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 27 September 2013. The Insurer decided to cease weekly payments. The applicant sought internal review. The Internal Review Decision was issued on 20 November 2013. The applicant sought Merit Review by the Authority. That application was received by the Authority on 20 December 2013. The Merit Review decision was issued on 10 March 2014, some 80 days later.[1]

2. The applicant was injured on 5 August 2004. She returned to suitable employment but that employment was soon terminated. She attempted a return to work for a few days in early 2012, but that was unsuccessful. 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.[2]

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*).*

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

[1] Cf: *Review Guideline* 10.14 (as amended).
[2] See also clause 17, schedule 8, *Workers Compensation Regulation* 2010 which sets an 18 month time-limit. For more on this, see paragraph 24 *infra*.

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a reduction or, as in this case, a cessation 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, that is, the judgement or discretion of the Insurer and are to that extent not relevant to a procedural review.

Submissions by the insurer

8. The Insurer was invited to make submissions, but did not do so.

The Decision

9. The decision does not state that a work capacity assessment was undertaken. It makes reference to a "review" of the applicant's claim has been made. If that review was the assessment it should say so. The Insurer sent a Fair Notice letter as required by *Guideline* 5.2 on 6 September 2013. A Fair Notice telephone call took place also, but the date of that is unclear. The Fair Notice letter advises that the assessment will take place. I will assume that the assessment took place, but failing to clearly state that fact is unsatisfactory. There does not appear to be any legislative requirement to notify the applicant of the 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;*

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- *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 does not state that the assessment is required pursuant to Clause 8 of Part 19H of Schedule 6 to the 1987 Act. The legislation has not been properly referenced as *Guideline* 5.3.2 requires. The Fair Notice letter refers to the assessment being conducted pursuant to Part 3, Division 2, Subdivision 3 of the 1987 Act. This may be a reference to section 44A of the 1987 Act, but it is unlikely to be of help to the applicant.

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 a worker ceases to be entitled to weekly payments of compensation. The decision is silent as to the effect of the decision on payment of treatment expenses. This silence is aggravated by the Internal Review Decision which states that the decision *"has no effect on your entitlement to reasonably necessary medical treatment in accordance with Section 60 of the 1987 Act."*

12. In addition, section 59A(3) of the 1987 Act states that the applicant may, after the 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 and for such time as those weekly payments continue. As cessation of treatment expenses after 12 months was not mentioned in the decision, it cannot be expected that any right to have such payments restored would be mentioned.

13. *Guideline* 5.3.2 requires the Insurer to *"reference the relevant legislation."* The decision states that weekly payments cease as the applicant has been paid more than 130 weeks of weekly payments. The decision does not attempt to explain the relevance of 130 weeks. To do so would have required the decision to refer to the definition of *"second entitlement period*" in section 32A of the 1987 Act. The decision sets out

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the criteria to be applied pursuant to section 38(3)(b) and (c) of the 1987 Act for entitlements to weekly payments after the second entitlement period, but the legislation has not been properly referred to as required by *Guideline* 5.3.2 as it refers simply to section 38.

14. *Guideline* 5.3.2 requires the Insurer to *"detail any support, such as job seeking support, which will continue to be provided during the notice period".* The decision says nothing as to any support which may be available.

15. The decision states that the applicant has *"current capacity for work and* [you] *are able to return to suitable employment".* Section 32A of the 1987 Act defines "*current work capacity",* which is itself defined by reference to *"suitable employment*." These are very important references and, in particular, *"suitable employment"* is a term with a specific meaning which may have little relationship to an understanding of the term in common parlance.

16. The decision states that the Insurer has "*considered the following documents"* and then sets out 11 documents. *Guideline* 5.3.2, which has not been referred to, 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. The Insurer also does not state that there are no other documents. The insurer's statement suggests to an applicant that there are no other relevant documents. An applicant may well disagree if she has the opportunity to peruse such other documents.

17. The commentary in relation to one document dated 28 March 2013 refers to section 48 of the *"WIMA*". For those well versed in acronyms for workers compensation legislation, this well-known reference is to the *Workplace Injury Management and Workers Compensation Act* 1998. An applicant is unlikely to have much idea as to the meaning of this acronym.

18. 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".*

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19. The decision states that the request for internal review must be *"sent to us"* within 30 days of receiving the decision. Section 44(1)(a) of the 1987 Act does not impose any set time limit. The *Guideline* 6.5 of *Guidelines for work capacity decision Internal Reviews by insurers and Merit Review by the WorkCover Authority (Review Guideline)* which came into effect on 11 October 2013 sets out that there is no time limit, and that the application for internal review must be lodged *"as soon as practicable after receiving"* the decision. The lack of a set time limit leaves what is an appropriate time most unclear.

20. The decision does not state that the Internal Review will be *"undertaken by a person who was not involved in the making of the original work capacity decision"* as required by *Review Guideline* 7.2. Making this clear to an applicant may give some comfort to an applicant that an internal review will attended to by a person with an open mind.

FINDING

21. 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 *Workers Compensation Regulation* 2010.

RECOMMENDATION

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

23. I recommend that the Insurer pay the applicant the weekly benefit to which she was entitled prior to 27 September 2013 until such time as she is properly transitioned. Those payments should continue from 26 December 2013 being the date on which they ceased.

24. 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*

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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. The regulator might be well advised to take urgent remedial action, if still possible.

25. 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 12 October 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
1 May 2014