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 18 September 2013. The applicant sought internal review. That decision was issued on 18 October 2013. He sought Merit Review by the Authority. That application was received by the Authority on 30 October 2013. The Merit Review Decision was issued on 24 February 2014, some 117 days later.[1]

2. The applicant injured his lower back on 27 May 1989. The applicant returned to his pre-injury employment with the employer after 2 days off work. On 18 December 1998, 6 April 2000, and 25 August 2000 the applicant aggravated his injury. In 2002 and 2003 the applicant underwent surgery to his back. The applicant returned to suitable duties with the employer and eventually returned to full hours. He was medically retired in June 2011. The Insurer made weekly payments as required under the provisions of the *Workers Compensation Act* 1987 (1987 Act) for all relevant periods.

3. The applicant was in receipt of compensation by way of weekly payments immediately before 1 October 2012. Thus he was an "existing recipient of weekly payments" at the relevant time and 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).*

5. The relevant version of the *Guidelines* came into effect on 12 August 2013. That publication stated that the *Guidelines* provide instructions

[1] Cf: *Review Guideline* 10.14 (as amended). But see paragraph 7 *infra*.

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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 largely 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. He submits that he was not properly informed of the Merit Review Decision (MRD). It appears that the MRD was posted to the applicant, but he did not receive it. The Insurer accepts that the applicant did not receive the MRD. He received it soon after 8 April 2014 when he contacted the Merit Review Service seeking advice as to when the MRD would issue. The application for Procedural Review was received on 14 April 2014. Section 44(3)(a) of the 1987 Act requires that the applicant seek review within 30 days of receiving the MRD. He has done that.[2]

Submissions by the insurer

8. The Insurer made submissions. The submissions note that the applicant's submissions which deal with the merits are not relevant to a Procedural Review. The submissions refer to when the MRD was sent to the applicant. The Insurer does not dispute that the applicant did not receive the MRD when it was first posted to him. The submissions also provide a helpful time line in relation to the assessment and decision.

[2] In fact, section 44(3)(a) of the 1987 Act requires the Notice of the MRD to be in the *"the form approved by the Authority."* As no form has been approved by the Authority the applicant would still be within time, as time has not commenced to run.

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The Decision

9. The decision states that a work capacity assessment has taken place. The Insurer's timeline demonstrates that the fair notice provisions as set out in *Guideline* 5.2 have been followed. It would have been of assistance to the applicant to know the date of the assessment. The Insurer is required to make a decision "*as soon as practicable*" after the assessment is made: see Clause 23, Schedule 8, *Workers Compensation Regulation* 2010. The date of the assessment would assist in knowing whether this occurred. 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;*

   - *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. As such the legislation has not been properly referenced as *Guideline* 5.3.2 requires.

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 the applicant's *"entitlement for medical and related expenses will continue in accordance with the provisions of the Act."* While completely accurate, this statement fails to advise as to the effect of section 59A(2). The

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reference to the "*provisions of the Act*" fails to advise the applicant which of the two relevant Acts is being referred to.

12. The applicant might understandably assume that medical expenses continue into the future. Such a view would be confirmed by the decision on its last page stating that *"we remain committed to providing ongoing support and assistance to you."* This sentence makes it appear that assistance is open-ended.

13. 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. This was not disclosed by the Insurer.

14. The decision sets out the definitions of *"suitable employment"* and *"current work capacity"* but fails to refer to section 32A of the 1987 Act in which these terms are so defined.

15. The applicant is advised that his weekly payments are to be determined by section 38 of the 1987 Act. He had also been advised that he has received 150 weeks of weekly payments. The Insurer should advise the applicant as to the *"second entitlement period"* as defined in section 32A of the 1987 Act, and that (as he is past the 130 week point) his payments are determined by section 38. Section 38(3) of the 1987 Act is then referred to in the decision. Having these 2 different references could cause confusion for an applicant who may have not had to deal directly with legislation before.

16. The decision lists *"Evidence Considered in Making the Decision"* and then sets out 8 documents and that these documents have been sent to the applicant. *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 he has the opportunity to peruse such other documents.

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17. In 2011 the employer retired the applicant on medical grounds but that fact is not revealed in the decision. One may assume that as at 2011 the employer had information that the applicant was unfit to continue in the suitable employment he had enjoyed since about 2000. The employer is a self-insurer. There are no documents from 2011 or before listed in the 8 documents referred to in the decision. Guideline 5.3.2 requires the Insurer to consider all evidence "*regardless of whether or not it supports the decision.*" Clearly, other documents and evidence exist. In such a matter the objective observer might wonder why the Insurer has ignored that evidence, or at least failed to refer to it.

18. The applicant is advised that he 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 sent to us within 30 days of you receiving this notice."* 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[3] states that the application *"should be lodged by the worker with the insurer as soon as practicable after"* receiving the decision. There is no 30 day time limit. In the previous iteration of the *Guidelines* some attempt had been made to impose a 30 day limit, but as the mediaeval theologians who concocted the ontological argument eventually found to their cost, it is a futile exercise to attempt to define something into existence.[4]

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 *Workers Compensation Regulation* 2010.

RECOMMENDATION

[3] The iteration which came into effect on 11 October 2013.
[4] Keen students of unicorns, gryphons and poltergeists might also take note.

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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 he was entitled prior to 18 September 2013 until such time as he is properly transitioned. Those payments should continue from 27 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 31 March 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 27 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
7 May 2014