WiRO
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 17 December 2013. The applicant sought internal review and the Internal Review Decision was issued on 16 January 2014. She then sought Merit Review and applied to the Authority on 14 February 2014. The Authority issued the Merit Review recommendation on 28 March 2014, 42 days later.[1] Following receipt of the Merit Review Service (MRS) recommendation, the applicant made application to this office on 28 April 2014. 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 2 June 2006. She returned to suitable employment with the employer. She underwent surgery to her injured shoulder in September 2008. Following recovery she returned to suitable employment with the employer. 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. Accordingly 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] *Guideline* 10.14 of the *Guidelines for work capacity decision Internal Reviews by insurers and Merit Review by the WorkCover Authority (Review Guidelines)*, 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 11 October 2013.[2] 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 regards the decision as *"unjust, unreasonable, unnecessary and in favour of 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 a chronology and copies of correspondence, such as the Fair Notice letter of 20 November 2013, and notes kept with respect to telephone calls between it and the Insurer (including the Fair Notice telephone call of 20 November 2013).

The Decision

9. *Guideline* 5.2 requires the Insurer to make a *"Fair Notice"* telephone call and to send a letter setting out the same advice. These both occurred on 20 November 2013. The Insurer's notes of the telephone call comply with *Guideline* 5.2. The letter fails to comply. Guideline 5.2 states that the Insurer must *"advise the potential outcome of this review and detail the information that has led the insurer to their (sic) current position."*

[2] The same date as the *Review Guidelines*, see footnote 1 *supra*.

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The notes of the telephone call reflect this, but the subsequent letter does not. An Insurer cannot assume that all that is said in the telephone call will be remembered by an applicant which is why the same information needs to be confirmed in a letter.

10. The decision states that a work capacity assessment was made on 17 December 2013. 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 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.

11. Curiously, a document listed in the decision as being relied upon is also called a *"Work Capacity Assessment"* dated 6 November 2013, created by a private external work assessment provider. It is unclear as to whether there are 2 assessments. The Insurer has advised that the assessment was made on 17 December 2013. If so, what is the status of this earlier Work Capacity Assessment? This is a matter which the Insurer should have made clear in the decision. Is the provider making an assessment as agent for the Insurer (i.e. in lieu of the Insurer), or is the provider's assessment a provisional report forming part of the overall documents on which an ultimate assessment was actually made by the Insurer itself? If the former, then the following question arises: Since the Insurer is an agent of the employer, is the agent of an agent capable of making an assessment under the Act? A work capacity assessment

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must be made by an Insurer[3] and while the anglicised Latin maxim that "a person who acts through an agent acts himself" remains the law, it might be stretching a point to say that a person who acts through an agent who in turn acts through another agent acts himself. That the self-insuring employer has retained the services of a licensed scheme agent to manage the claim and conduct the transitional process adds yet a further layer to the hierarchy of decision-making in this case.

12. The decision states that the applicant's weekly payments are to cease. Appropriate notice is given, but reference is made to section 54 of the 1987 Act. The correct reference is to section 54(2)(a) of the 1987 Act. *Guideline* 5.3.2 requires the Insurer to reference the relevant legislation.

13. *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 but refers to *"section 59A(2) of the Act"* without specifying that it is the 1987 Act.

14. 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. This was not disclosed by the Insurer.

15. Section 43 of the 1987 Act is referred to and it is stated that the Insurer may make decisions about *"current work capacity", "suitable employment", "the amount that a worker is able to earn in suitable employment",* and *"the amount of an injured workers pre-Injury weekly earnings or currently (*sic*) weekly earnings".* Both *"current work capacity" and "suitable employment"* are defined in section 32A of the 1987 Act. The decision fails to refer to section 32A. The definition of *"current work capacity"* means an applicant who cannot return to her pre-injury employment. That would not be obvious from the usual meaning of the phrase. That definition is qualified by the term *"suitable employment"*. That phrase bears little resemblance to a usual understanding of it. For

[3] See section 44A(1) of the 1987 Act.

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example, *"suitable employment"* includes employment *"regardless of whether the work or the employment is available."*

16. The reference to *an injured workers pre-Injury weekly earnings or currently (*sic*) weekly earnings"* is not of assistance in a matter where the applicant is being transitioned and the average weekly earnings is a statutory rate set by Clause 2, Part 19H of Schedule 6 of the 1987 Act *(transition amount).* Under the heading *"Reason(s) for decision"* the applicant is advised that she was receiving weekly payments as at 1 October 2012 and as a result she has a *"deemed pre-injury average weekly earnings ("PIAWE") of $948.50."* This would perhaps leave the applicant ruminating on why the Insurer would claim that it may make decisions about "*pre-Injury weekly earnings"* but then state that it is bound to use a set figure. Also, 1 October 2012 is irrelevant. What is relevant is that the applicant was in receipt of weekly payments *immediately before* 1 October 2012.

17. A heading in the decision states *"Evidence considered in making the work capacity decision."* Two documents are then listed and it is noted that those documents have been sent to the applicant. The decision refers to a further two documents (being medical reports) in the body of the report. They were also sent to the applicant. The decision states that the documents were provided pursuant to section 74 of the *Workplace Injury Management and Workers Compensation Act* 1998 and clause 37 of the *Workers Compensation Regulations (*sic) 2003. Section 74 deals with claims in dispute and is not relevant. In any event, the 2003 *Regulation* was repealed on 1 February 2011. The relevant provision would be clause 46 of the *Workers Compensation Regulation* 2010.

18. The end of the decision advises as to assistance that may be available to the applicant. It states that one place to seek assistance is her *"union or Solicitor (at your expense)."* If the applicant seeks assistance from a solicitor it cannot be at her expense. Pursuant to section 44(6) of the 1987 Act a solicitor cannot charge for any work done in relation to an internal review. The applicant would need to find a solicitor prepared to work for no fee. The same mistake is made at the end of the Internal Review Decision (IRD).

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19. The IRD also states that the applicant may seek internal review of the IRD by completing the attached form and posting it to the Insurer. The applicant is then advised that if she is not satisfied with the outcome of the internal review she has requested she may lodge an application for Merit Review. The applicant is being told in the IRD that a further internal review is required. That would be a view assisted by the decision having been made by the employer as a self-insurer, while the IRD was issued by a named insurer. That in itself should have been explained in the IRD. To the likely confusion of the applicant the IRD begins with a sentence that refers to *"our Work Capacity Decision."* As the decision by the employer advises that that an Internal Review may be sought by sending the application to the employer, receiving an IRD from an Insurer would be anomalous and contrary to expectations.

FINDING

20. 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.*[4]

RECOMMENDATION

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

22. I recommend that the Insurer pay the applicant the weekly benefit to which she was entitled prior to 17 December 2013 until such time as she is properly transitioned. Those payments should continue from 24 March 2014 being the date on which they ceased.

23. Whether or not the applicant can now be transitioned is unknown. 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*." Clause 17 of

[4] The *Regulation* 2010, not the repealed *Regulation* 2003.

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Schedule 8 to the *Regulation* 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. Clause 17 ceased to have effect on and from 1 April 2014.

24. 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 24 March 2014 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
9 May 2014