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.

SUMMARY:

a. The work capacity decision of the Insurer dated 30 October 2013 is set aside.

b. The applicant is to be reinstated to her weekly payments at the rate applicable at 30 October 2014.

c. The payments are to be back-dated to 6 February 2014.

d. The payments are to continue until such time as a further work capacity decision is made and comes into effect.

Introduction and background

1. The applicant seeks procedural review of a work capacity decision made by the Insurer on 30 October 2013. The applicant sought internal review and the Internal Review Decision (IRD) was issued on 8 January 2014. She then sought Merit Review and applied to the Authority on 31 January 2014. The Authority issued the Merit Review recommendation on 4 April 2014, 63 days later.[1] Following receipt of the Merit Review Service (MRS) recommendation, the applicant made application to this office on 1 May 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 30 May 2008. She injured her right ankle. She returned to suitable employment with the employer with some time off work following operations on her right ankle. The Insurer made weekly payments as required under the provisions of the *Workers Compensation Act* 1987 (1987 Act).

[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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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).

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'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 submissions. The Insurer submitted that the fair notice telephone call and letter of 9 October 2013 were properly undertaken. That matter is dealt with later. The Insurer submits that appropriate notice was given pursuant section 54 of the 1987 Act. That

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

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matter will be dealt with in this decision. The Insurer also provided a useful chronology and copies of correspondence.

The Decision

9. *Guideline* 5.2 requires the Insurer to make a fair notice telephone call and letter. The letter fulfils the requirements of the Guideline. The telephone call does not. The Insurer states that the applicant's *"weekly benefits may be affected."* The letter correctly states that a preliminary determination indicates that weekly benefits may be reduced or discontinued. The Insurer, in its notes of the call, said that the applicant's *"weekly benefits may be affected."* The call is vague. Having benefits that *"may be affected"* could mean anything from payments increasing to payments ceasing. A comment like this is of no assistance to the applicant.

10. Proper notice was given as to the cessation of payments. 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.

11. The decision states that a work capacity assessment was made on 30 October 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.*

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

12. *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. Section 59A(2) is not referred to as required by *Guideline* 5.3.2. The decision states that the decision *"does not affect your entitlements to medical and related treatment expenses."* The Insurer in its submissions accepts that this is incorrect, but adds that the applicant was advised that treatment *"continued at the time the notice was issued".* While that is true, the effect of section 59A(2) has been misrepresented because while treatment expenses do continue, such payments must cease after 12 months. The Insurer's submission is that while section 59A(2) was not referred to in the decision that was remedied in the IRD. The IRD cannot remedy a fault in the decision. In addition, the IRD itself fails to advise the applicant as to section 59A(3) of the 1987 Act. Hence, the attempt to supply the lack of information in the earlier letter with extra information in the later letter failed not only because one notice cannot remedially amend another but also because such remedial information as was included was incomplete.

13. 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.

14. 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"*.

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That phrase bears little resemblance to a usual understanding of it as defined by section 32A. For example, *"suitable employment"* includes employment *"regardless of whether the work or the employment is available."* It also requires the Insurer to have regard to the applicant's *"age, education, skills and work experience"* while having no regard to her *"pre-injury employment."* This requires an Insurer to walk something in the way of a linguistic and conceptual tight-rope, which exercise tends to result in serious consequences for injured workers as well as Insurers if any missteps occur.

15. 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.

16. The decision states that documents are enclosed which *"support the decision to dispute liability."* A decision to *"dispute liability"* is made pursuant to section 74 of the *Workplace Injury Management and Workers Compensation Act* 1998. A work capacity decision does not dispute liability.[3] It affects the rate at which weekly payments are to be made. Only one document is listed despite using the words *"following documents."* The decision states that the document was 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. As already noted, 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.

[3] Section 43(2)(a) of the 1987 Act clearly states that a decision to dispute liability for weekly payments is not a work capacity decision.

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17. *Guideline* 5.3.2 requires the Insurer to "*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."* By stating that "*documents which support the decision to dispute liability"* are enclosed, and then only enclosing one document, would lead the applicant to the ineluctable conclusion that only one document exists that assists the Insurer in reaching its decision. She might make the deduction that documents which do not support the Insurer's conclusion have been ignored. The applicant would have her conclusion confirmed by the IRD which has a heading *"Information, reports and documents supplied by the worker or obtained/received by the insurer which are relevant to the decision."* There are two documents listed. The one document referred to in the decision is not present in that list. The phrase *"relevant to the decision"* again suggests that inconvenient documents have been ignored. Neither the decision nor the IRD state that there are no other documents, including documents which may not support the Insurer's decision and IRD. This qualifies as an error by omission.

18. *Guideline* 5.3.2 states that the Insurer must *"advise that any documents or information that have not already been provided to the worker can be provided to the worker on request to the Insurer."* The decision has failed to so advise the applicant.

19. The decision was issued by the employer. It appears, therefore, that the employer is a self-insurer. The IRD as provided to the procedural review is a file copy which has no letterhead, although it has at the start of the IRD, *"YOUR REF: XXX:XXX:YYYY".* The reference does not appear to relate to the applicant, so one must assume the IRD was sent to the employer, perhaps by an agent or contractor employed by the employer. The submissions made for this Procedural Review are on letterhead which names an Insurer (a licensed scheme agent). Has the self-insurer outsourced the decision-making function to a licensed scheme agent? At what stage did the licensed scheme agent become involved in the process? It should be made clear from the outset which body has made the work capacity decision and IRD. This is important if, for example, the applicant sought to have the decision judicially reviewed by the Supreme Court as referred to in section 43(1) of the 1987 Act.

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20. 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 *"You have 30 days from the date of this letter to request an internal review"* of the decision. 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.

21. 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. Section 44(1)(b) of the 1987 Act is clear that the applicant, if dissatisfied with the IRD, can seek a merit review.

22. 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."* It would help the applicant to be advised that a solicitor is unable to charge for any such assistance due to section 44(6) of the 1987 Act. The IRD states that assistance can be obtained from a *"Lawyer (at your own expense)."* If the applicant seeks assistance from a solicitor it cannot be at her expense. Section 44(6) of the 1987 Act applies again with respect to advice given with respect to seeking a Merit Review.

FINDING

23. 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.*[5]

RECOMMENDATION

[4] The iteration which came into effect on 11 October 2013.
[5] The *Regulation* 2010, not the repealed *Regulation* 2003.

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

25. I recommend that the Insurer pay the applicant the weekly benefit to which she was entitled prior to 30 October 2013 until such time as she is properly transitioned. Those payments should continue from 6 February 2014 being the date on which they ceased.

26. 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 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.

27. 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 6 February 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
15 May 2014