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 July 2013 is set aside.

b. The applicant is to be reinstated to his weekly payments at the rate applicable at 30 July 2013.

c. The payments are to be back-dated to 5 November 2013.

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 has applied for procedural review of a work capacity decision made by the Insurer on 30 July 2013. The decision was made to cease weekly payments with the last date for payment to be 5 November 2013. An internal review decision (IRD) was sent to the applicant on 24 September 2013 and the applicant sought merit review by an application received by the Authority on 15 October 2013. A recommendation was issued on 11 April 2014, being 178 days later. On 2 May 2014 the applicant sought procedural review by this office. On 7 May 2014 the applicant lodged an amended application for procedural review. I am satisfied that the amended application is within time and on the correct form.

2. There is no dispute that the applicant was injured in the course of his full-time employment on 20 April 2007. The applicant returned to work on restricted duties with the same employer. That work activity by the applicant ceased in October 2008 as the employer could not maintain suitable duties. The applicant's employment was formally terminated in 2009. The Insurer made weekly payments as required under the provisions of the *Workers Compensation Act* 1987 (1987 Act).

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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's claim. Clause 17 of Schedule 8 to the *Workers Compensation Regulation* 2010 (the Regulation) required the transitioning process to be completed *"within 18 months"* of 1 October 2012.

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* is the one published on 27 September 2012 which applied to all claims from 1 January 2013.[1] 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 or cessation of the weekly benefits payable to the injured worker then the Insurer is required to give proper notice to the worker (see, relevantly, section 54(2)(a) of the 1987 Act).

Submissions by the applicant

7. The applicant raised certain matters in the amended 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 submitted that the decision should be reconsidered and also sought to have the decision reviewed to see *"whether the Insurer has complied with all the procedural requirements".* For this review the relevant issues are whether the Insurer has complied with all procedural requirements.

[1] To add to the confusion, they are said on their face to "come into effect on 1 October 2012."

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8. The first application for procedural review raised matters in relation to the merits of the matter and as such are not relevant.

Submissions by the Insurer

9. The Insurer made submissions which dealt with the original application of 2 May 2014. The Insurer points out correctly that the issues raised only relate to the merits and are not relevant. The remainder of the submissions go to the provision of a chronology and relevant correspondence and notes of conversations with the applicant. Many medical reports and vocational assessments were also provided, but they go to the merits of the claim. Those documents do provide some useful background to the matter.

10. The Insurer did not specifically address the amended application.

The Decision

11. *Guideline* 5.2 is the fair notice provision. The fair notice letter was sent on 8 July 2013. There was no fair notice telephone call as the applicant was overseas on family business. The letter advises that a decision *"may impact on your entitlement to weekly benefits, or may change the rate of weekly benefit that you are paid."* *Guideline* 5.2 requires the Insurer to *"advise the potential outcome of this review and detail the information that has led the insurer to their current position."* Using phrases such as *"may impact"* and *"may change"* the rate of weekly payments does not assist the applicant to know the potential outcome of the review. There is also no detail of the information that has led the Insurer to an outcome. As the Insurer has not made any prediction as to the outcome, it is unsurprising that no information is referred to in the fair notice letter.

12. The fair notice letter refers to an assessment then being undertaken by the Insurer. The decision does not refer to an assessment having been made. It refers to *"a review of your ongoing entitlement to weekly payments."* The fair notice letter appears to state that the assessment was underway, but the decision does not state that it was ever completed. The Insurer was required to make an assessment pursuant

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to Clause 8 of Part 19H of Schedule 6 to the 1987 Act. The applicant cannot know from the decision whether or not it was completed.

13. There does not appear to be any legislative requirement to notify the applicant of the outcome of the assessment, assuming it was completed. However, *Guideline* 5.4.2 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.*

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

15. The decision does not state that as the applicant was in receipt of weekly payments immediately before 1 October 2012 that he must be transitioned. [2] The legislation has not been properly referenced as required by *Guideline* 5.4.2.

16. The decision states that weekly payments *"will cease from 6/11/ 2013".* It then states that in *"accordance"* with section 54 weekly payments will continue at the current rate until 5 November 2014. Perhaps that is the day upon which payments will cease. It is not stated that section 54 is to be found in the 1987 Act. In any event, the correct reference is to section 54(2)(a) of the 1987 Act. The legislation has not been properly referenced as required by *Guideline* 5.4.2. The decision also states that weekly payments will cease *"effective 6/11/ 2013".* The applicant would rightfully have been confused by having 2 dates for the cessation of the payments.

17. *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,*

[2] See paragraph 3 supra.

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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 the Insurer *"will continue to approve"* treatment expenses as defined by section 60 of the 1987 Act but that such expenses will no longer be payable 12 months later being 6 November 2014, rather than 5 November 2014.The decision refers to section 59 of the 1987 Act. The correct reference is to section 59A(2) of the 1987 Act. In a strange move the IRD states that the *"decision only relates to your entitlements to weekly benefits and does not affect other entitlements that you may be entitled to under the Act."*

18. Additionally, 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.

19. The applicant is advised that he has been in receipt of weekly payments for more than 130 weeks and, accordingly, section 38 of the 1987 Act applies. Section 38(3)(b) is then set out. The Insurer has failed to explain the relevance of 130 weeks and the *"second entitlement period"* which is referred to in Section 38(3)(b). It would assist the applicant to be referred to section 32A of the 1987 Act and the definition of *"second entitlement period"* therein.

20. Section 38(3)(b) also refers to *"current work capacity*". That is a term also defined in section 32A of the 1987 Act. The definition means an applicant who cannot return to his pre-injury employment but is able to return to *"suitable employment".* That term is also defined in section 32A and it is unlikely to bear much relationship to how most people would understand that term in normal usage. The definition includes the Insurer taking into regard the applicant's *"age, education, skills and work experience",* but not taking into regard *"the nature of the worker's pre-injury employment".*

21. *Guideline* 5.4.2 also 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

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the Insurer. The Insurer has failed to so advise the applicant. The decision lists 11 documents that are relied upon. Those documents were sent to the applicant. The Insurer does not state that there are no other documents. The insurer's statement suggests to an applicant that there are no other documents or at least no other relevant documents. The applicant may well disagree if he has the opportunity to peruse any other documents held by the Insurer.

22. Guideline 5.4.2 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".* The IRD lists 5 documents, all of which are also in the decision. The other documents listed in the decision are not referred to in the IRD. Ignoring what are very relevant documents would lead the applicant to assume that only documents which support the Insurer are relied upon and documents that do not support the Insurer have been ignored

23. *Guideline* 5.4.2 requires the Insurer to *"clearly explain the line of reasoning for the decision".* As the decision maker may not have had all relevant documents before them it can possibly be considered that there is a fundamental error in the reasoning of the decision and a breach of *Guideline* 5.4.2.

24. 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* 5.4.2 and the need to *"reference the relevant legislation".*

25. The applicant is advised that the application for internal review must be sent within 30 days of receiving the decision. That is not what the 1987 Act says. Section 44(1)(a) of the 1987 Act allows for the applicant to seek an internal review, but with no time limit. The *Guidelines for work capacity decision Internal Reviews by insurers and Merit Reviews by the WorkCover Authority* 6.5 which came into effect on 1 January 2013 stated that the application for internal review must be lodged within 30 day of receipt of the decision. This was in conflict with the Act. The Insurer may have been comforted by that *Guideline*, but the next iteration of *Guideline* 6.5 which came into effect on 11 October 2013 corrected itself and that guideline now states that the applicant should

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lodge the application "*as soon as practicable after receiving*" the decision.

26. The advice as to the internal review states that the application form should be completed and returned and *"include any extra information, reports and documents to support you request for review. Any new or additional matters that you would like us to consider will need to be provided as part of this application."* This statement conveys the impression that an applicant must provide further evidence or information in order to make an application for internal review. That is misleading. The applicant may request an internal review pursuant to section 44 of the 1987 Act whether or not further evidence or information is available or submitted. The applicant is only required to provide "*grounds"* in an application for internal review as required by section 44(2) of the 1987 Act and *Guideline* 6.2 of *Guidelines for work capacity decision Internal Reviews by insurers and Merit Review by the WorkCover Authority*.

FINDING

27. 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

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

29. 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*

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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. In order to remove this impediment it may be necessary for the regulator to perform a legislative lithectomy by delegation.

30. I recommend that the Insurer pay the applicant the weekly benefit to which he was entitled prior to 30 July 2013 until such time as he is properly transitioned. Those payments should continue from 5 November 2013 being the date on which they ceased.

31. 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 5 November 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
23 May 2014