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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 10 December 2013 is set aside.

b. The applicant is to be reinstated to her weekly payments at the rate applicable at 10 December 2013.

c. The payments are to be back-dated to 16 March 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 has applied for procedural review of a work capacity decision made by the Insurer on 10 December 2013. The decision was made to cease weekly payments with the last date for payment to be 16 March 2014. The applicant sought internal review. The internal review decision (IRD) was sent to her on 3 February 2014. The applicant sought merit review by an application received by the Authority on 3 March 2014. A recommendation was issued on 10 April 2014. On 2 May 2014 the applicant sought procedural review by this office. I am satisfied that the application is within time and on the correct form.

2. There is no dispute that the applicant was injured on 29 August 1998 when she was assaulted in the course of her full-time employment. The applicant returned to work on restricted duties with the same employer. She was medically retired in 2006. She found suitable duties with another employer in 2007, but was unable to maintain that work after a short period. 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 8 October 2013, which came into effect on 11 October 2013. That publication states 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 various issues 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 went to the merits of the case, that is, the very object of judgement or discretion of the Insurer excluded by section 44(1)(c) and therefore could not be relevant to this review.

Submissions by the Insurer

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8. The Insurer's first submissions referred to the applicant's submissions. Its other submissions also deal with the merits of the case. Since all the submissions only deal with the merits they are not relevant to a procedural review.

The Decision

9. The decision states that the assessment was completed on 10 December 2013. The Insurer was required to make an assessment pursuant to Clause 8 of Part 19H of Schedule 6 to the 1987 Act. This has not been referred to as required by *Guideline* 5.3.2. It is stated that the assessment used *"all available evidence on your claim."* The decision later states that the "*documents relied upon to make the decision are:"* Only 4 documents are listed. It seems unlikely after 15 years that there are not considerably more than four documents. *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 only referring to 4 documents it seems probable that not all evidence has been considered. Stating that the 4 documents are the ones *"relied upon to make the decision"* 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.

10. *Guideline* 5.3.2 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 by the Insurer upon request. The Insurer has failed to so advise the applicant.

11. *Guideline* 5.3.2 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* 5.3.2.

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12. 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.*

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

14. The decision states that the Insurer *"is obliged to initially assess and regularly review your work capacity under your workers compensation claim."* The decision does not state that as the applicant was in receipt of weekly payments immediately before 1 October 2012 that she must be transitioned. [1] The legislation has not been properly referenced as required by *Guideline* 5.3.2.

15. The decision refers to the applicant having been in receipt of 401 weeks of weekly payments. The relevance of a number of weeks is not explained. The decision should refer to 130 weeks and refer to the *"second entitlement period"* and its definition in section 32A of the 1987 Act.

16. Rather than then refer to section 38 of the 1987 Act, the decision relies on section 39 of the 1987 Act. That section deals with cessation of payments after 260 weeks of weekly payments. The applicant has received more than 260 weeks of payments, but section 39 does not apply to periods of payments made before the commencement of the 2012 amendments: see Clause 13, Part 19H of Schedule 6 to the 1987 Act.

[1] See paragraph 3 *supra*.

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17. Having relied on section 39, the decision states that the formula to determine the amount of weekly payments is pursuant to section 38 of the 1987 Act. The only way in which section 39 weekly payments are payable pursuant to the section 38 formula is where the applicant has a greater than 20% whole person impairment (WPI). The decision does not state that the applicant has a greater than 20% WPI. As none of the 4 documents is a medical report it would be courageous of the Insurer to make a finding as to WPI. The alternative possibility is that there may be in the Insurer's possession a medical report to this effect; if so the Insurer has not referred to any such report in the correspondence, which would be a breach of the *Guidelines* in any event.

18. *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, 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 section 59A. The Insurer should have advised the applicant of this provision, since it is an inescapable consequence of the cessation of weekly benefits that section 59A(2) must come into effect after 12 months and no further decision is required at that later time.

19. 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.

20. The decision states that pursuant to *"subsection 43(1)(a)* [of the 1987 Act]*, I have determined that you have a current work capacity".* The phrase "*current work capacity*" is a term defined in section 32A of the 1987 Act. The definition describes an applicant who cannot return to her pre-injury employment but who 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 requires the Insurer to have

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regard to the applicant's *"age, education, skills and work experience,"* but then to have no regard to *"the nature of the worker's pre-injury employment."* The decision has failed to refer to the legislation as required by *Guideline* 5.3.2.

21. The appropriate notice is given pursuant to section 54(2)(a) of the 1987 Act, but the decision only refers to section 54 of the 1987 Act. The required 3 month period is said to be extended by a week to allow for delivery by post in accordance with section 76(1)(b) of the *Interpretation Act* 1987, and *Guideline* 6. Section 76(1)(b) does not refer to a period of a week. It states that service by post is taken to be effected on the 4th working day after the day of posting. The iteration of *Guideline* 6 which came into effect on 12 August 2013 states that service is taken to have occurred 7 days after the document is posted, which may not always be effective.[2] The iteration which came into effect on 11 October 2013 states that service is taken to be effected 4 days after the document is posted. This *Guideline* may well lead to a breach of section 76(1)(b) of the *Interpretation Act* 1987. By way of example, the 4th *calendar* day after the Thursday before Easter would be Easter Monday, a public holiday. The 4th *working* day is the following Friday.

22. 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."*

23. 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 11 October 2013 states that the applicant should lodge the application "*as soon as practicable after receiving*" the decision.

FINDING

[2] By way of example, at Christmas time the 4th working day after 24 December is 2 January, 9 days after the day of posting. The 4th working day after 17 April 2014 was 28 April 2014, 11 days later, due to Easter and ANZAC Day falling in consecutive weeks..

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24. 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

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

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."* 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 lithotomy by delegation.

27. I recommend that the Insurer pay the applicant the weekly benefit to which she was entitled prior to 10 December 2013 until such time as she is properly transitioned. Those payments should continue from 16 March 2014 being the date on which they ceased.

28. 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 16 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.

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