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 7 November 2013 is set aside.**

b. **The applicant is to be reinstated to her weekly payments at the rate applicable at 7 November 2013.**

c. **The payments are to be back-dated to 3 April 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 7 November 2013. The decision was made to cease weekly payments with the last date for payment to be 13 February 2014. The applicant sought internal review. The internal review decision (IRD) was sent to him on 2 January 2014. The IRD altered the decision. The Insurer as a result stated that the IRD was a new decision which would take effect on 3 April 2014. The applicant sought merit review by an application received by the Authority on 4 February 2014. A recommendation was issued on 9 April 2014. On 8 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 suffered an injury to his back on 13 March 2003. He was employed as a crane operator. The applicant returned to work on suitable duties with the same employer. His condition deteriorated and he was declared unfit for work in August 2004. He has not worked since that time. He underwent a lumbar spine fusion in May 2011. 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 dated 4 October 2013, published on 8 October 2013, and which came into effect on 11 October 2013. 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 section 54(2)(a) of the 1987 Act).

Submissions by the applicant

7. The applicant raised numerous 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."* Some of 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. Many submissions went to the procedural issues and are relevant. The submissions went to 7 pages and were part of the application for Procedural review. It is not realistic to detail the submissions in this

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Review. I have examined the submissions and will deal with them in this decision.

Submissions by the Insurer

8. The Insurer made no submissions. Despite this I have noted the submissions made by the Insurer to the Merit Review Service as recorded in the Merit Review Decision.

The Decision

9. The decision has a heading *"Evidence Considered In Making The Decision(s) and any Key Information".* Only 3 documents are listed. It is unlikely after 10 years that there are not considerably more than 3 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 3 documents it is probable that not all evidence in the possession of the insurer has been considered. This is confirmed by the IRD referring to a further two medical reports held by the Insurer. The decision only referred to one medical report, which unsurprisingly was the report relied upon in the findings of the decision. The IRD came to a different conclusion based on one of those other two reports. The only conclusion that it is possible to come to is that when making the original work capacity decision the Insurer over-looked evidence which did not support the decision reached.

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 did not have regard to all relevant documents before them it is an inevitable conclusion 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. The decision states that the assessment was completed. The date of the assessment is not revealed. 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. 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 which would also reveal the date of the assessment.

14. The decision sets out the entitlement periods, being the first and second entitlement periods, the period after 130 weeks and the period after 260 weeks. None of the sections of the Act are referred to as required by *Guideline* 5.3.2. While the first and second entitlement periods are not relevant to the applicant, the applicant should be referred to section 32A of the 1987 Act and the definition of "*second entitlement period"* as his entitlement is in the period after that period. The applicant is advised that he has received greater than 130 weeks of weekly compensation, and that his weekly benefit is calculated pursuant to section 38(7) of the 1987 Act. It has not been explained that section 39 of the 1987 Act in relation to 260 weeks does not apply to weekly payments made before 1 October 2012, the commencement of the 2012 amendments, pursuant to Clause 13, Part 19H of Schedule 6 to the 1987 Act. The applicant should be told that section 38 of the 1987 Act applies to him and not section 39 of the 1987 Act.

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15. There is some discussion in the IRD that the applicant has a 22% Whole Person Impairment (WPI). That would have been known at the date of the decision. *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."* The applicant should be advised that with a WPI greater than 20% he may have an entitlement to weekly payments of compensation at some stage in the future pursuant to section 39(2) of the 1987 Act.

16. The calculation using the formula in section 38(7) of the 1987 Act is then set out. While that is an interesting exercise and worthwhile practice, it is unnecessary. Section 38 states that an applicant is only entitled to weekly payments after 130 weeks where the criteria in subsection (3) are satisfied. The applicant does not meet either of the 2 criteria in paragraph (3)(b) of section 38: he is not employed for not less than 15 hours per week and is not earning at least $155 per week (as indexed).

17. Consequently, the transitional amount is not strictly required to be explained, although it is useful information for the applicant to know. He may at some stage return to employment, and having information as to how weekly payments are calculated would be of assistance. The decision fails to properly reference the legislation in relation to the transitional amount. Reference is made to clause 9(3) of Part 19H of Schedule 6 to the 1987 Act. Reference should also be made to clause 1, the definition of *"existing recipient of weekly payments",* and clause 2, which sets out the transitional amount. It should then be explained that for an *"existing recipient of weekly payments"* the commencement date of the amendments was 1 October 2012: the applicant must have been in receipt of weekly payments immediately before that date.

18. In that regard, the Insurer has stated that the transitional rate *"applies to all injuries received with claims for compensation made before 1 October 2012."* That is incorrect. What is relevant is being in receipt of weekly payments immediately before 1 October 2012.[1]

19. *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*

[1] By necessity the claim for compensation must be made before 1 October 2012 in order to be in receipt of weekly payments immediately before that date.

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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 applicant is advised that the decision *"has no effect on your entitlement to receive, and have paid, reasonably necessary medical treatment as allowed by Sections 59 and 60"* of the 1987 Act. The decision then states that *"time limits on accessing treatment now apply."* The applicant is referred to the *"previously supplied WorkCover fact sheets sent to you with our Notice of an Impending Work Capacity Decision or contact our office."* The type of time limits is not set out. An applicant may consider it means accounts for treatment must be presented to the Insurer within certain time frames or they will not been paid. Telling the applicant to look elsewhere for an explanation as to time limits does not satisfy the requirement to state the impact of the decision within the decision. 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.

20. Additionally, section 59A(3) of the 1987 Act states that the applicant may become eligible for further payments for medical expenses, after the entitlement to compensation for medical expenses ends, if the applicant becomes entitled to compensation for weekly benefits at some stage in the future. This entitlement[2] was not disclosed by the Insurer and the non-disclosure constitutes a further breach of *Guideline* 5.3.2.

21. The decision states that the applicant has a *"current work capacity pursuant to subsection 43(1)(a) of the Workers Compensation Act 1987."* 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 his pre-injury employment but who is able to return to *"suitable employment."* The latter term is also defined in section 32A. The definition requires the Insurer to have regard to, *inter alia*, the applicant's *"work experience,"* but then to have no regard to *"the nature of the worker's pre-injury employment."* This should be explained clearly by the Insurer. The decision has failed to refer to the legislation as required by *Guideline* 5.3.2.

[2] Albeit sylphic, at most.

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22. The IRD altered the decision, and states that it is a new decision. The IRD issued on 2 January 2014. It states that payments will cease after 3 months and 1 week and that payments will cease on 3 April 2014. The innumeracy evident on the face of the IRD means that 4 working days have not been allowed as required by section 76(1)(b) of the *Interpretation Act* 1987.

23. The original work capacity decision is signed by a manager, who is also the same person who signed the IRD. The IRD states that the manager is *"independent of the original work capacity decision."* The Merit Review notes the Insurer's submission that the decision *"was conducted by* [assessor] *and the notice was signed by* [manager]…*Any suggestion that* [manager] *had any involvement with the initial assessment and the making of the work capacity decision as a result of the assessment is refuted."*[3] *Guideline* 7.1.6 requires the Insurer to undertake an internal review by *"a party independent to"* the decision. *Review Guideline* 7.2 requires that the internal review be undertaken by *"a person who was not involved in the making of"* the decision. It is disingenuous to state that a person who signed a decision was not "involved" in the making of the decision. If they have done nothing else they have authorised the decision. No one would accept that a manager would sign a document without being satisfied that it was correct. That would involve, at the very least, an admission that the signature was worthless, signifying nothing. An Insurer can scarcely rely on such an admission as a defence to an allegation of procedural breach.

FINDING

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

[3] It may be denied, but is hardly refuted. To refute an argument is to defeat it, to refute an assertion is to disprove it. Mere denial cannot constitute refutation, except in the basest slang usage. Clearly the Insurer would not be writing slang.

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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 he was entitled prior to 7 November 2013 until such time as he is properly transitioned. Those payments should continue from 3 April 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 3 April 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
30 May 2014