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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 5 September 2013 is set aside.

b. The applicant is to be reinstated to her weekly payments at the rate applicable at 5 September 2013.

c. The payments are to be back-dated to 12 December 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 5 September 2013. The decision was made to cease weekly payments with the last date for payment to be 12 December 2012. The applicant sought internal review. The internal review decision (IRD) was sent to him on 21 October 2013. The applicant sought merit review. A recommendation was issued on 6 May 2014. On 13 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 on 27 July 2010. He was employed as a storeman. It appears that the applicant did not return to his pre-injury employment. It is unclear as to whether the applicant was in any employment immediately prior to 1 October 2012, or at the date the decision was made. In any event 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

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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. The relevant version of the *WorkCover Work Capacity Guidelines (*Guidelines*)* is the one dated 8 August 2013, which came into effect on 12 August 2013. The *Guidelines* provide instructions and guidance to Insurers regarding the appropriate and consistent application of work capacity assessments and decisions.

5. Once the Insurer has conducted an assessment the Insurer is then 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

6. 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."* 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

7. The Insurer made no submissions.

The Decision

8. The decision begins with the heading *"WORK CAPACITY DECISION NOTICE. NOTICE OF VARIATION TO PAYMENTS UNDER SECTION 54".* That heading is clear that the decision is a decision. A few lines into the decision is a heading *"Work Capacity assessment-Capacity Decision (Section 43(1))."* The Insurer has conflated into one an

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assessment and a decision by use of the heading *"Work Capacity assessment-Capacity Decision (Section 43(1))."* The Insurer is required to make an assessment, and then to make a decision. This heading leaves the applicant unclear as to whether he is reading an assessment or a decision. He may well conclude that he is reading a decision as it states that his weekly payments will cease, but that assumes that the applicant is well versed in the intricacies of workers compensation legislation.

9. The applicant cannot know when the assessment was undertaken, assuming that the decision is a decision and not the assessment. 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.*

10. 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.

11. The next heading is *"Evidence considered in making the decision:-see attachment A".* Only 4 documents are listed in attachment "A." *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. The IRD does not refer to any further documents. The

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merit review refers to documents attached to the application and the Insurer's reply including two medical reports of December 2011 and January 2012. Those two medical reports are not referred to in the decision. What other documents were received during the merit review process appears to be a closely guarded secret.

12. *Guideline* 5.3.2 requires the Insurer to *"clearly explain the line of reasoning for the decision."* As the decision maker did not have all relevant documents before them it is an inevitable conclusion that there is a fundamental error in the reasoning of the decision since it was clearly not based on all available evidence; as such, this constitutes a breach of *Guideline* 5.3.2.

13. The reference to "*work capacity and current earnings"* does not explain that *"current work capacity"* is 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.

14. The decision states that the applicant is not working. He has the ability to work in suitable employment. The decision then states that his entitlement is calculated pursuant to section 38(7) of the 1987 Act. As the applicant is not working he has no entitlement to weekly payments as he fails the test in section 38(3)(b) of the 1987 Act as he has not "*returned to work (whether in self-employment or other employment) for a period of not less than 15 hours per week and is in receipt of current weekly earnings (or current weekly earnings together with a deductible amount) of at least $155 per week"* (as indexed). The calculation undertaken in the decision is therefore supererogatory, to say the least.

15. In contrast to the decision the IRD states that the applicant is working not less than 15 hours per week and earning in excess of $155 per week (as indexed). How many hours are being worked, and how much is being earned is not said. That leaves the Insurer to then consider

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section 38(3)(c) of the 1987 Act and whether the applicant is capable of undertaking further work. Further into the IRD it is stated that the applicant is not working. These conflicts in the Insurer's mind amply illustrate the confused nature of the decision and IRD. All of this is confused by the merit review finding that the applicant *"is currently not working."* As the merit review fails to say what documents it considered it is impossible to be certain as to the work status of the applicant.

16. *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 a worker ceases to be entitled to weekly payments of compensation. The applicant is advised that the decision *"does not affect any ongoing entitlements to related medical, hospital, rehabilitation, and travel expenses that are reasonably necessary due to the injury".* 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.

17. 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.

18. Appropriate notice is given pursuant to section 54(2)(a) of the 1987 Act, but the decision does not refer to that section. The required 3 month period is said to be extended by 1 week in accordance with the *Guidelines*. Which *Guideline* is not mentioned. A relevant *Guideline* is *Guideline* 6. It states that for a postal address the decision is taken to have been received 7 days after the document is posted. Section 76(1)(b) of the *Interpretation Act* 1987 states that service by post is taken to be effected on the 4th working day after the day of posting. This *Guideline* may well lead to a breach of section 76(1)(b) of the *Interpretation Act* 1987. By way of example, 7 days after the Thursday before Easter would be the following Thursday. The 4th *working* day is the following Friday.

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19. To confound the Insurer, *Review Guideline* 2.4.2 states that delivery is taken to be effected at a postal address on a day 4 days after the document is posted. This is clearly in breach of section 76(1)(b) of the *Interpretation Act* 1987, since it fails to specify "working" days. A letter posted on a Tuesday is deemed to be received the following Monday pursuant to the *Interpretation Act* 1987, but on Saturday pursuant to *Review Guideline* 2.4.2.

20. *Guideline* 5.3.2 requires the Insurer to *"detail any support, such as job seeking support, which will continue to be provided during the notice period."* The decision does not refer to any assistance that may be available.

21. The applicant is advised that he may request an internal review. The Insurer refers to section 44(2) of the 1987 Act rather than 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 the request must be made within 30 days of receiving the decision. That is incorrect. No time limit is given in the 1987 Act. *Guideline* 7.2.2 states that the application should be lodged *"as soon as practicable."*

FINDING

22. 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

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

24. I recommend that the Insurer pay the applicant the weekly benefit to which he was entitled prior to 5 September 2013 until such time as he is properly transitioned. Those payments should continue from 12 December 2013 being the date on which they ceased.

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25. 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 12 December 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
3 June 2014