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 26 July 2013 is set aside.

b. The applicant is to be reinstated to his weekly payments at the rate applicable at 3 November 2013.

c. The payments are to be back-dated to 3 November 2013.

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

1. The applicant seeks procedural review of a work capacity decision made by the Insurer on 26 July 2013. The applicant sought internal review. The Internal Review Decision (IRD) was issued on 23 September 2013. The applicant sought Merit Review by the Authority. That application was received by the Authority on 23 October 2013. The Merit Review decision was issued on 15 April 2014, some 182 days later.[1] The applicant sought procedural review on 15 May 2014.

2. The applicant was injured on 21 May 1992. He returned to suitable employment with his employer but that employment was terminated in February 1993. From that time until about 2009 the applicant obtained some casual suitable employment. 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. 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

[1] Cf: *Review Guideline* 10.14 (as amended).

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Regulation) required the assessment 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 27 September 2012 which came into effect on 1 January 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 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

6. 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* (sic)[2] *or discretion exercised by the insurer."* The applicant's submissions go to the merits of the decision, that is, the judgement or discretion of the Insurer and are to that extent not relevant to a procedural review.

Submissions by the insurer

7. The Insurer was invited to make submissions, but did not do so.

The Decision

8. The decision states that a work capacity assessment was completed. It is unclear when the assessment took place. The Insurer is required by Clause 23 of Schedule 8 to the Regulation to *"make a work capacity decision in respect of an existing recipient of weekly payments as soon as practicable after the first work capacity assessment of the worker is*

[2] Incorrectly spelt as 'judgment' in the Act.

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conducted by the insurer." The applicant does not know when the assessment was made and cannot know if the decision was made "as soon as practicable" after the assessment. There does not appear to be any legislative requirement to notify the applicant of the outcome of the assessment. However, *Guideline* 5.4.2 stated[3] 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.*

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

9. The decision does not state that the assessment is required 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* 5.4.2 required.

10. *Guideline* 5.4.2 required the decision to *"reference the relevant legislation."* This would require any interpretation of the legislation (including delegated legislation) to be accurate. It is clearly inaccurate to say (as this Insurer has said) that the claim *"must transition to the new benefits system in 2013."* What Clause 8(2) of Pt 19H of Schedule 6 to the 1987 Act requires is for the Insurer to conduct a work capacity assessment (for the purposes of transitioning a claim) *"no later than 12 months (or such longer period as may be prescribed by the regulations) after the commencement of the weekly payments amendments."* While the amendments commenced on 1 October 2012, the *Workers Compensation Regulation* 2010 says at Clause 17, Schedule 8 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."* It follows that there was no

[3] As at 26 July 2013 the relevant guideline was numbered 5.4.2, but it was re-numbered as 5.3.2 in the iteration of the *Guidelines* published in the Gazette on 9 August 2013, which post-dated the work capacity decision but preceded the internal review.

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requirement for the Insurer to conduct a work capacity assessment and for the claim to be transitioned *"in 2013."*[4]

11. *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 states that "*any entitlement you may have to payment of pre-approved reasonable and necessary medical and other expenses, until the 3rd of November 2014, will not be affected."* This statement gives no information to the applicant about the effect of section 59A(2) on such entitlements beyond 3 November 2014. The effect of section 59A(2) of the 1987 Act has therefore been disguised, if not misrepresented.

12. In addition, section 59A(3) of the 1987 Act states that the applicant may, after the entitlement to compensation for medical expenses is extinguished by the effluxion of 12 months, relumine that very entitlement to medical expenses if the entitlement to compensation for weekly benefits resumes at any stage in the future and for such time as those weekly payments continue. This was not disclosed by the Insurer.

13. The decision does not state the number of weeks for which the applicant has received weekly payments. It is a safe assumption that he has received more than 130 weeks of payments. The decision should explain the *"second entitlement period"* and that it is defined in section 32A of the 1987 Act. *Guideline* 5.4.2 requires the Insurer to *"reference the relevant legislation",* which has not occurred.

14. The decision states that *"we can confirm that you have a current capacity to work."* It is then said that the applicant has skills and experience *"to allow you to secure suitable employment."* No legislation is referred to as required by *Guideline* 5.4.2. Reference should be made to section 32A of the 1987 Act. That section defines "*current work capacity",* which is itself defined by reference to *"suitable employment*." These are very important definitions. Current work capacity refers to the applicant not being able to return to his *"pre-injury employment but is*

[4] See paragraph 27 *infra*.

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able to return to work in suitable employment". Suitable employment is a term with a specific meaning which may have little relationship to an understanding of the term in common parlance. 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 definition should be explained clearly by the Insurer.

15. What then follows is a statement that as the applicant is *"not currently working for at least 15 hours per week, not working to your maximum capacity, and not earning at least $155 gross per week, you do not have an entitlement to ongoing weekly payments."* No reference is made to section 38(3) of the 1987 Act which is where this test is found. The applicant would have been unaware of the relevance of a number of hours, gross income, and maximum capacity. In particular, the last phrase would be very confusing. Section 38(3)(c) does not refer to maximum capacity, but to being capable *"of undertaking further additional employment or work that would increase the worker's current weekly earnings."* That is a very different test. Maximum capacity may refer to being able to earn more for the same period of work, which is different to undertaking further additional employment. In any event, Section 38(3)(c) is irrelevant in this matter. Once the applicant fails to meet the test of 15 hours and $155 that paragraph does not need to be considered.

16. The decision only refers to 2 documents, a medical report and a vocational report. *Guideline* 5.4.2 states that *"All evidence should be referred to, whether or not it supports the decision."* The decision is silent as to whether there is evidence that does not support the decision. It may be that there is no contrary evidence, but the decision is silent as to that matter. The IRD refers to 11 documents, including medical reports and rehabilitation reports. On the face of the decision, the decision maker has over-looked or ignored a number of documents.[5] It appears that only evidence which supports the decision has been relied upon by the decision maker.
17. The decision states that the applicant may seek further copies of documents already provided to him. *Guideline* 5.4.2, which has not been referred to, states that the work capacity decision notice must advise the

[5] At least nine of them.

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applicant that any documents or information that have not already been provided to the applicant can be provided on request to the Insurer. The Insurer has failed to so advise the applicant. By only referring to two documents the decision is suggesting that no other documents are relevant. Since we know following the IRD that there were at least 11 documents thought to be relevant by the Insurer, there was a clear breach of *Guideline* 5.4.2 in only listing two in the work capacity decision notice.

18. The decision states that a request for internal review must be sent within 30 days of receiving the decision. *Guideline* 6.5 of *Guidelines for work capacity decision Internal Reviews by insurers and Merit Review by the WorkCover Authority (Review Guideline)* dated 2 December 2012, gazetted 7 December 2012, and which came into effect on 1 January 2013 states that the application for internal review must be lodged within 30 days of receiving the decision. *Work Capacity Guideline* 7.2.2 states that the application for internal review should be lodged within 30 days. The iteration of the *Guideline* which came into effect on 11 October 2013 correctly says that there is no time limit, and that the application for internal review must be lodged *"as soon as practicable after receiving"* the decision.[6] Section 44(1)(a) of the 1987 Act does not impose any set time limit.

19. The decision states that "*frivolous and vexatious applications may be rejected". Review Guideline* 6.7 supports this view. The next iteration of the *Guideline* which came into effect on 11 October 2013 is silent on this point, for the very reason that an Insurer cannot refuse to carry out an internal review even where it decides that an application is frivolous or vexatious. The Authority and WIRO, but not an Insurer, may decline to review a matter where the application is frivolous or vexatious (not frivolous and vexatious as the decision says) pursuant to section 44(3)(c) of the 1987 Act.

20. The applicant is advised that if he is dissatisfied with the internal review he may seek a merit review from WorkCover. Again, the Insurer has not referred to section 44(1)(b) of the 1987 Act. The applicant is also

[6] To the extent that the delegated instrument is inconsistent with the Act, the former must be *ultra vires*. Accordingly there is not *and there has never been* a 30 day time limit.

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advised that WorkCover will *"provide a response to you within 30 days of receipt of your request."* *Review Guideline* 10.14 states "*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."* The Authority took 182 days. It seems that *Guideline* 10.14 is one for the breach of which there exists no current (or currently proposed) remedy.[7]

21. The decision states that the decision was made by the *"Technical Specialist"* and reviewed and confirmed by the *"Work Capacity Team."* The "*Work Capacity Team"* is the signature block for the decision. This leaves it quite unclear as to who made the decision. *Review Guideline* 7.2 states that the *"internal review is to be undertaken by a person who was not involved in the making of the original work place decision."* As this is the case it is important for the robustness of the appeal system that the person [or people] who made the decision is [or are] identifiable so that an applicant can see that the internal review is being undertaken by someone "*who was not involved in the making of the original work capacity decision."* In this case the party who made the decision is not identifiable. As it is the Work Capacity Team which "signed" the decision, it may be that it was a decision by a committee.[8]

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*.

[7] See footnote 1.
[8] A committee need only be one person, but in this instance the use of the word *"team"* must mean two or more people comprise the committee.

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24. I recommend that the Insurer pay the applicant the weekly benefit to which he was entitled prior to 26 July 2013 until such time as he is properly transitioned. Those payments should continue from 3 November 2013 being the date on which they ceased.

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 3 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
5 June 2014