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 8 July 2013 is set aside.**

**b. The applicant is to be reinstated to her weekly payments at the rate applicable at 8 July 2013.**

**c. The payments are to be back-dated to 14 October 2013.**

**d. Such 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 seeks procedural review of a work capacity decision made by the Insurer on 8 July 2013. The applicant sought internal review and the Internal Review Decision (IRD) was issued on 22 August 2013. She then sought Merit Review on 30 September 2013 and the Authority issued the Merit Review recommendation on 20 January 2014 some 82 days later.[1] Following receipt of the Merit Review Service (MRS) recommendation, the applicant made application to this office on 13 May 2014.

2. *Section 44 (3)* of the *Workers Compensation Act* 1987 (*the* 1987 *Act)* requires the applicant to make an application for review to the Independent Review Officer within 30 days of receipt of a decision in the form *approved by the Authority*. I note that at the time of the decision by the Authority there was no such approved form, therefore time could not commence to run. In light of that consideraiton I am satisfied that the applicant has made the application for review in the proper form and within time.

[11] *Guideline* 10.14 of the *Guidelines for work capacity decision Internal Reviews by insurers and Merit Review by the WorkCover Authority (Review Guidelines)*, which came into effect on 27 September 2012, states that "*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."*

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3. The applicant was injured on 6 May 2002. The applicant made an unsuccessful attempt to return to her pre injury duties and was terminated from her employment. The applicant is presently employed with Coles Hardware & Glass as an Administration Officer in 2007 and remains in this role.

4. The applicant was in receipt 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.

5. *Section 44A* of the 1987 Act provides that a work capacity assessment must be conducted in accordance with the *WorkCover Work Capacity Guidelines (Guidelines).*

6. The relevant version of the *Guidelines* came into effect on 27 September 2012.[2] That publication stated that the *Guidelines* provide instructions and guidance to Insurers regarding the appropriate and consistent application of work capacity assessments and decisions.

**7.** 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**

8. The applicant raised various matters 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 go to the merits of the decision and are therefore not relevant to a procedural review.

**Submissions by the Insurer**

[2] The same date as the *Review Guidelines*, see footnote 1 *supra*.

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9. The Insurer has not made any submissions in response to the application.

**The Decision**

10. The decision is dated 8 July 2013. *Section 54(2)(a)* of the 1987 Act requires 3 months notice be given when weekly payments are to be reduced or ceased. The decision states that payments of weekly compensation would cease effective from 14 October 2013.

11. The decision does not advise of the date the work capacity assessment was made. The decision does not state that this is a requirement 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* 5.3.2 requires. 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.*

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

12. *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."*

13. *Section 59A(2)* of the 1987 Act states that treatment expenses and related expenses are no longer payable 12 months after weekly payments cease.

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14. The present decision advises the applicant that any entitlement to pre-approved reasonable and necessary medical and other expenses, until 14 October 2014, will not be affected. The decision **fails** to advise the applicant that her entitlements to medical expenses will actually cease on that day and also fails to advise as to *Section 59A (3)* of the 1987 Act.

15. *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.

16. The description of the effect of section 54(2)(a) is a complete misrepresentation of the notice provision, and incorrectly states that payments must cease "within 3 months" of the work capacity decision, whereas the true effect of the section is to say that the payments may not cease until three months have elapsed following the provision of notice. That is, the Insurer has styled the section as a maximum payment provision, rather than a minimum notice provision.

17. The decision states 'we have reviewed and considered the following information'. Ten documents are listed. The decision states that '*further copies of documents previously provided'* are available upon request. The decision does not enclose the documents listed.

18. *Guideline* 5.3.2 states that the Insurer must *"advise that any documents or information that have **not** already been provided to the worker can be provided to the worker on request to the Insurer".* The decision has failed to so advise the applicant.

19. *Guideline* 5.3.2 also 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 decision merely refers to the *'information which supports our decision'.* It does not take the applicant to the individual documents which support the work capacity decision.

**FINDING**

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20. Under the legislation the Insurer can make an assessment of the applicant's work capacity and then a decision about that work capacity, but they must comply with the legislation, the Regulation and the *Guidelines* in order to produce a procedurally correct result. In the current instance there has been more than one breach of the *Guidelines* which are to be treated as delegated legislation. Accordingly the work capacity decision must be found to be invalid.

**RECOMMENDATION**

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

22. I recommend that the Insurer pay the applicant the weekly benefit to which she was entitled prior to 8 July 2013 until such time as she is properly transitioned. Those payments should continue from 14 October 2013 being the date on which they ceased.

23. 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*." Clause 17 of Schedule 8 to the *Regulation* 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. Clause 17 ceased to have effect on and from 1 April 2014.

24. 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 14 October 2013 to date by virtue of the operation of section 44B(2) of the 1987 Act. These

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recommendations are binding on the Insurer: see section 44(3)(h) of the 1987 Act.

Tracey Emanuel
Delegate of the WorkCover Independent Review Officer
6 June 2014