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 16 December 2013 is set aside.

b. The applicant is to be reinstated to his weekly payments at the rate applicable at 16 December 2013.

c. The payments are to be back-dated to 10 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 16 December 2013. The decision was made to cease weekly payments with the last date for payment to be 10 March 2014. The applicant sought internal review. The internal review decision (IRD) was sent to him on 13 February 2014 and was received on 19 February 2014. That decision confirmed the original work capacity decision. The applicant sought merit review by way of an application received by the Authority on 12 March 2014. A recommendation was issued on 6 May 2014. Again, the applicant was unsuccessful. 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 22 January 1999 in the course of his employment as an Engineering Operator. His employment was ultimately terminated during 2002 and since that time he has operated a business involving a varying number of vending machines. He was paid weekly benefits as a partially incapacitated worker for all relevant periods, including immediately prior to 1 October 2012, which means that the applicant was an "existing recipient of

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weekly payments" for the purposes of the *Workers Compensation Act* 1987 (1987 Act).

3. The work-related injury is a knee injury. In more recent times, the applicant has had the misfortune to be diagnosed with oesophageal cancer in addition to suffering deterioration of a hip joint to the extent that it requires replacement. Consequently the applicant has been less active in the operation of the vending machine business, which he has scaled down.

Submissions by the applicant

4. The applicant made submissions which ranged from the broad to the particular, thus:

- The Insurer failed to follow the *WorkCover Guidelines* and *Best Practice Decision Making Guide* in making its decision.

- The Insurer provided inaccurate and incorrect information as to when the work capacity decision would take effect. The Insurer gave notice that payments would cease on 17 May 2014 but implement[ed] its decision on 10 March 2014. The notice was defective an invalid.

- The Insurer failed to make an evidence-based decision about whether the worker is a "seriously injured worker" within the meaning of section 32A.

- The Insurer improperly rejected the expert medical opinion of Dr H who assessed 36% whole person impairment.

- The Insurer ought to have been satisfied that the degree of permanent impairment is likely to be more than 30% (Section 32A(c)). The failure to make that evidence-based decision is in breach of Section 32A(c) and in breach of the Guidelines which impose a mandatory obligation to make decisions on the basis of the evidence.

- The only evidence about the degree of permanent impairment was from Dr H who assessed 36% whole person impairment.

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- The opinion of a Dr A. S. who examined the applicant on 26 February 2013 at the request of the Insurer is inconsistent with factual findings made by the (former) Compensation Court of NSW (the doctor reported that the applicant has an "inherited disease of osteoarthritis").[1]

- The WorkCover Guidelines state that a work capacity decision must not be made in the case of a "seriously injured worker," unless the worker requests it. Consequently the purported work capacity decision is a nullity.

- In the alternative, the applicant has been working in self-employment and earning at least $168 per week. The worker satisfies the pre-requisites for section 38. The value of his labour to his business needs to be calculated and the section 38 formula needs to be applied.

5. The applicant raised these 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) *or discretion exercised by the insurer."* In some respects 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 to the extent that the merits were raised those submissions could not be relevant to this review.

Submissions by the Insurer

6. The Insurer made no new submissions to this office, but did forward the submissions they had made to the merit review service of the Authority.

Understanding the submissions

7. The applicant makes submissions which perhaps in part confuse the 1987 Act as it was in 1999 with the way it is now, i.e. post 19 June 2012. The submissions made concerning the applicant being a "seriously injured worker" are misconceived, since there is no medical opinion in evidence giving an assessment of greater than 30% "whole person impairment" (as that term is used in the *WorkCover Guides for*

[1] See paragraph 9, *infra*.

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the Evaluation of Permanent Impairment). It is true that Commissioner Hunt, latterly of the former Compensation Court of NSW, decided in 2002 that the applicant had sustained a 15% permanent loss of efficient use of each leg at or above the knee, but those assessments are of no relevance, being referable to the former table of disabilities in the now repealed section 73. The definition of "seriously injured worker" is not strictly objective in any event – section 32A relevantly sets out the definition as follows:

> **"seriously injured worker"** means a worker whose injury has resulted in permanent impairment and:
>
> (a) the degree of permanent impairment has been assessed for the purposes of Division 4 to be more than 30%, or
>
> (b) the degree of permanent impairment has not been assessed because an approved medical specialist has declined to make an assessment until satisfied that the impairment is permanent and the degree of permanent impairment is fully ascertainable, or
>
> (c) the insurer is satisfied that the degree of permanent impairment is likely to be more than 30%.

8. Clearly clause (a) has not been satisfied. Further, the suspension or postponement referred to in clause (b) has not occurred. It is clear from their own submissions that the Insurer does not accept and is not satisfied that the applicant is a seriously injured worker, as otherwise required by clause (c). it follows that the applicant must fail on all grounds where he relies on the "seriously injured worker" argument.

9. The applicant may be on firmer ground in other respects. At the hearing before Hunt, C in 2002 medical opinion was tendered in the respondent's case from a Dr A. S.[2] In the course of the judgment delivered by Hunt, C paragraphs 23 and 25 are of relevance:

[2] See paragraph 4, *supra*.

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> 23. The respondents tendered, firstly, a report of Doctor A.S. of 24 December 2000 which assessed 20 percent permanent loss of efficient use of each leg at or above the knee. Doctor S said that three quarters of the left leg condition could be attributed to the 1986 fracture and that the balance in respect of both legs is all degenerative disease.
>
> 25. Doing my best to weigh up all the medical opinions with the applicant's evidence I find that the applicant did suffer a 10 percent permanent loss of the left leg or the greater part thereof[3] due to the incident in 1986. I also find that he has suffered a further 15 percent permanent loss of efficient use of the left leg at or above the knee and 15 percent loss of efficient use of the right leg at or above the knee due to the nature and conditions of his employment […]. All of this has been in the form of aggravation of a disease.[4]

10. The ominous thing for the Insurer here is that the opinion of Dr A.S. was clearly not accepted by the Court. A doctor of the very same name as Dr A.S. was used by the Insurer in February 2013 to examine and report on the applicant in the guise of an "Independent Medical Examiner." If it is the same doctor, then how a doctor whose opinion of the aetiology of a worker's condition was rejected by the Court could possibly be considered "independent" when reporting on the very same worker following that judgment is unknown. The use of that doctor was unwise at best. Of itself that may have been sufficient to ground a successful challenge on the basis of procedural unfairness. If it is not the same doctor, then while an unfortunate coincidence of nomenclature, it cannot ground an objection on procedural grounds. The worker does have other grounds for complaint, to which I will now move.

11. The applicant states that the Insurer had represented the final date of monetary entitlement to be 17 May 2014 and then peremptorily ceased payments on 10 March 2014. This is not borne out by the correspondence, which clearly stated that the final date for payment would be 10 March 2014. Both the work capacity decision itself and the

[3] This is the correct test and is from section 16 of the 1926 Act which was still in force in 1986.
[4] "Aggravation" and "disease" are here used in the sense as repeated in the current section 16 of the 1987 Act.

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covering letter sent with it on 16 December 2013 nominated 10 March 2014 as the relevant date.

12. This is both good and bad for the applicant. It is bad because it contradicts his submission in a material respect; it is good because it shows that the Insurer gave insufficient notice under section 54(2)(a) for the termination of weekly payments. This is both a breach of the legislation and a breach of the *WorkCover Work Capacity Guidelines*. A minimum of three months notice is required and there is not three months between 16 December 2013 and 10 March 2014. It follows that the notice is invalid and must be reissued.

13. There are further breaches of the *Guidelines* which are sufficient to set aside the decision of the Insurer. Included in such grounds are the following:

- The applicant was told that his "entitlement to benefits for medical or related expenses will continue in accordance with the provisions of the Act" with no reference being made to sections 59A(2),(3). This is a breach of the requirement to reference the legislation and fully explain the effect of the decision on the worker's entitlements including medical expenses, both appearing in Guideline 5.3.2.

- The *Work Capacity Guidelines* require an Insurer to consider all the evidence available (even if it does not support the decision reached) and to set out all evidence considered. I note that there is no reference in the work capacity decision notice dated 16 December 2013 to any report by Dr H, despite there being multiple reports of that doctor in the possession of the insurer.

FINDING

14. 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

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

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

17. 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 10 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.

Wayne Cooper
Delegate of the WorkCover Independent Review Officer
6 June 2014