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 31 July 2013 is set aside.

b. The applicant is to be reinstated to her weekly payments at the rate applicable at 31 July 2013.

c. The payments are to be back-dated to 8 November 2014.

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 (decision) made by the Insurer on 31 July 2013. The decision stated that payments were to cease on 8 November 2014. The applicant sought internal review. The Internal Review Decision (IRD) was issued on 27 September 2013. The applicant sought Merit Review by the Authority. That application was received by the Authority on 25 October 2013. The Merit Review recommendation was issued on 24 April 2014, some 181 days later.[1] Application was subsequently made to this office on 23 May 2014. I am satisfied that the applicant has applied within time and on the correct form.

2. The applicant was injured on 12 September 2001. She returned to suitable employment with the employer until May 2004. Since that time the applicant has been employed in suitable duties with another employer. 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

[1] Cf: *Review Guideline* 10.14 (as amended). The 181 days might be added to the 86 days between the date of the work capacity decision and the application to the Merit Review Service and 53 days between the date of the Merit Review Service recommendation and this recommendation. The review process has taken just six weeks short of one year. In that time the *WorkCover Work Capacity Guidelines* have been twice amended, with a third amendment apparently imminent.

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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 assessment 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 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.[2]

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 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

6. 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."* Many 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.

7. The applicant raised a number of procedural issues, such as the calculation done purportedly under section 38(7) of the 1987 Act (which calculation, it has to be said, is a nonsense), the requirement for 15 hours of work having no legislative basis cited, and that the Insurer had prejudged the matter before the assessment was completed and therefore before the "decision" was made. The first 2 points are made out; the last point is the applicant's opinion which is not supported by evidence, compelling or otherwise.

[2] See footnote 1 *supra*. While new *Guidelines* were gazetted on 9 August 2013 and 8 October 2013 (the latter replacing the former in short order) the relevant *Guidelines* are those in force as at 31 July 2013, when the work capacity decision was made.

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Submissions by the insurer

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

The Decision

9. The decision states that a work capacity assessment is required to be undertaken. 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 requires. The decision does not state that the assessment was ever done. One is required to assume that it occurred.

10. There does not appear to be any legislative requirement to notify the applicant of the outcome of the assessment, if it was ever done. However, *Guideline* 5.3.2 stated 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 which would involve showing the date of the assessment.

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 weekly payments cease. The decision states that: *"Your entitlement to reasonable and necessary medical and related treatment will also continue."* A reader familiar with section 59A(2) might reasonably reply:

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"No, it won't." Even if it is by omission only, this must constitute demonstrable error on the part of the Insurer.[3]

12. In addition, 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 and for such time as those weekly payments continue. This was not disclosed by the Insurer, possibly because the Insurer was unaware of the effect of section 59A(2)

13. The decision states that *"you alleged* (sic) *to have sustained an injury to your neck due to nature and conditions of your employment."* As the Insurer has been paying compensation for over 12 years it seems peculiar that at this stage the injury is described as being merely *"alleged."* An objective observer might reasonably regard it as a bit late to bring injury and causation into dispute after more than a decade of payments.

14. The decision states that the applicant has an inability to return to her pre-injury employment but is able to work in suitable employment. There is no attempt to explain that an inability to return to pre-injury employment is what the 1987 Act defines as *"current work capacity"* in section 32A. In the same way *"suitable employment"* is not referred to as also being defined in section 32A. The definition is very important as it bears little relationship to the ordinary meaning of that phrase. The concept that suitable employment includes work that may not be readily available would be alien to an untutored reader hoping to get by using no more than common sense and the ordinary meaning of words.

15. The applicant is then told that she has a capacity to work 18 hours per week. It is unclear where this information comes from but it may be from one of the two documents referred to in the decision being a *"Certificate of Capacity"* from a doctor dated 19 June 2013. The applicant is then told that she is not working *"more then* (sic) *15 hours per week."* The

[3] For a recent discussion of "demonstrable error," see *NSW Police Force v Registrar of WCC of NSW* [2013] NSWSC 1792 at paragraphs 39-56. Demonstrable error in the context of medical appeals was earlier discussed by Hoeben, J in *Merza v Registrar of WCC of NSW* [2006] NSWSC 939 (at 39) and the Court of Appeal in *Pitsonis v Registrar of WCC of NSW* [2008] NSWCA 88.

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relevance and considerable significance of "15 hours per week" is not disclosed. Section 38(3)(b) and (c) of the 1987 Act should be referred to as should the definition of *"second entitlement period"* in section 32A of the 1987 Act.

16. The applicant is advised that her deemed Pre-Injury Average weekly Earnings (PIAWE) is $938.30. The reference given is *"Schedule 6 Part 19H(2) 0f the Workers Compensation Act 1987."* There is no Part 19H(2). The correct reference is to clause 1 (the definition of *"existing recipient of weekly payments")*, clause 2 (the transitional amount as indexed), and clause 9(3) (the deeming provision) of Part 19H of Schedule 6 of the 1987 Act.

17. The applicant is advised that she was in receipt of weekly payments immediately before 1 October 2012 and as a result she must be transitioned. Again, no reference is made to Part 19H of the 1987 Act.

18. The applicant has received *"699.80"* weeks of weekly payments. The .8 must refer to a decimal place which means 699 weeks, 5 days, and 14 hours and 24 minutes. Such precision seems unlikely given the rest of the decision. The calculation under section 38(7) is then set out as follows: *"$938.64 x 80% = $750.64 = Nil Entitlement."* There are no ostensible means set out in the decision by which the applicant could understand this "calculation" of an "entitlement" to "nil" even if it could be categorised as a calculation.[4]

19. The decision states that the Insurer has considered "all available and relevant evidence," including 2 listed documents. The IRD lists 16 documents. The original decision-maker has clearly not reviewed all documents whether or not the documents support the decision, as required by *Guideline* 5.4.2. This is a further clear breach of the Guidelines.

20. The applicant is advised that she may request an internal review. The Insurer has not referred to section 44(1)(a) of the 1987 Act. This is a breach of *Guideline* 5.4.2 and the need to *"reference the relevant legislation."*

[4] A cruel misdescription, which is the keener for its being repeated at paragraphs 57-58 of the Merit Review recommendation.

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21. The application for internal review is said to be required to be lodged within 30 days of receipt of the decision. That is not correct. Section 44(1)(a) of the 1987 Act does not set any time limit in which the application for internal review is to be made. *Guideline* 6.2.2 states that there is a 30 day time limit. *Guideline* 7.2.2 that came into force on 12 August 2013 corrected this error and refers to *"timely lodgement."*[5]

FINDING

22. I find that the Insurer has failed to follow the procedures as set out in the WorkCover *Guidelines* which is a requirement of 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 in accordance with the WorkCover *Guidelines* and make a new work capacity decision. The relevant guidelines will be those gazetted on 8 October 2014, or such newer iteration of the Guidelines as may be gazetted between the date of this recommendation and the new assessment being completed.

24. I recommend that the Insurer pay the applicant the weekly benefit to which she was entitled prior to 31 July 2013 until such time as she is properly transitioned. Those payments should continue from 8 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 8 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.

[5] A nice touch, scarcely informative.

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