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 2 December 2013 is set aside.**

**b. The applicant is to be reinstated to her weekly payments at the rate applicable at 2 December 2013.**

**c. The payments are to be back-dated to 6 March 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 made by the Insurer on 2 December 2013. The decision stated that payments were to cease on 6 March 2014. The applicant sought internal review. The Internal Review Decision (IRD) was issued on 5 February 2014.

2. The applicant sought Merit Review by the Authority. The Authority purported to refuse in writing to undertake a Merit Review. By email the Authority on 7 May 2014 stated that, as the Insurer had made a decision to decline liability, the "*Authority is unable to go behind the decision of* [the Insurer] *in relation to the issue of liability, where the Insurer has declined liability of* [the applicant's] *claim."* The basis of this conclusion is unstated, but may well turn on the interpretation of section 43(2)(a). No section 74 Notice was involved, as far as I am aware. Both the Insurer and the injured worker regarded the decisions made by the insurer as work capacity decisions. The only way to categorise the email of 7 May 2014 is as a decision by the merit review service in relation to its own jurisdiction. That decision is not reviewable by this office. The applicant may have a remedy in another place. Nonetheless, the applicant has applied for Procedural Review on 27 May 2014, within time, and on the correct form. Since the merit review service has, however perfunctorily, reviewed the Insurer's decision in order to come to the conclusion that it is not a work capacity decision, it may well follow that this office has the

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power to conduct a procedural review of the work capacity decision. I will proceed on that basis.

3. The applicant injured her lower back on 18 December 2010. She underwent surgery to implant a stimulator which enabled her to return to suitable employment with the employer. The Insurer made weekly payments as required under the provisions of the *Workers Compensation Act* 1987 (1987 Act).

4. 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 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.

5. The relevant version of the *WorkCover Work Capacity Guidelines (Guidelines)* is the one dated 4 October 2013, which came into effect on 11 October 2013. The *Guidelines* provide instructions and guidance to Insurers regarding the appropriate and consistent application of work capacity assessments and decisions.

6. Where the work capacity 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**

7. 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 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**

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8. The Insurer's submissions also went to the merits of the matter and as such are not relevant.

**The Decision**

9. The assessment was completed on 2 December 2013.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 which would involve showing the date of the assessment.

10. *Guideline* 5.3.2 requires the Insurer to reference the legislation. The applicant is advised that she is an *"existing recipient"* of weekly payments. Reference should be made to clause 1 of Part 19H of Schedule 6 to the 1987 Act and the definition of *"existing recipient of weekly payments"*.

11. The decision correctly states that an assessment must be made within 18 months of the commencement of the 2012 amendments pursuant to Clause 17 of Schedule 8 of the Regulation. What is not stated is the date the amendments commenced, being 1 October 2012.

12. The decision states that 3 months notice is required to be given pursuant to section 54 of the 1987 Act. The correct reference is to section 54(2)(a) of the 1987 Act. Proper advice is important as failing to provide the proper notice is an offence pursuant to section 54(1) of the 1987 Act punishable by 50 penalty units (currently $5,500).

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13. The decision is dated 2 December 2013, but it states that due to the postal rule (section 76(1)(b) of the *Interpretation Act* 1987) 4 working days is allowed for service *"from 06/12/13",* and therefore weekly payments will cease *"from 06/03/14".* The applicant must have been confused by this change of dates which rendered the postal rule ineffective.

14. Reference is made to sections 36, 37, and 38 of the 1987 Act and the entitlement periods. Reference should also be made to section 32A of the 1987 Act and the definitions of *"first entitlement period'* and *"second entitlement period".* The decision fails to clearly state that the entitlement periods are defined terms.

15. The decision states that the *"definition of "current work capacity" requires that I consider whether you are able to return to work in suitable employment".* That is only part of the test. The Insurer also has to find that the applicant is unable to return to her pre-injury employment. That has not been done by the Insurer. The usual meaning of the phrase would not encompass these 2 tests. The Insurer has also not referred to the definition of *"current work capacity"* in section 32A of the 1987 Act.

16. After setting out the definition of *"suitable employment"* the decision states that the Nominated Treating Doctor, an IME, and a functional assessment report have found that the applicant is fit for full hours in suitable employment. Another IME found that she could work full hours in her pre-injury employment. It is the stated that after *"consideration of all the evidence, it is my view that you have a current work capacity".* Nothing further is explained as to how that conclusion was reached. *Guideline* 5.3.2 requires the Insurer to give brief reasons, outline the evidence and explain the line of reasoning.[1]The Insurer has failed to clearly explain why it has concluded that the applicant has a current work capacity when the medical evidence is not in agreement.

17. There are 3 suitable employment options listed and the wage for each is given. The decision states that average earnings of the 3 is $XX, and therefore *"given the definition of "E"* [in section 35 of the 19897 Act]*, I*

[1] See paragraph 8 *supra.*

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*must take the higher of these figures, which is $XX",* that is, the average. The average cannot be the higher of these 3 figures.

18. *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 is silent as to any support which may be available.

**FINDING**

19. 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**

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

21. I recommend that the Insurer pay the applicant the weekly benefit to which she was entitled prior to 2 December 2013 until such time as she is properly transitioned. Those payments should continue from 6 March 2014 being the date on which they ceased.

22. 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 6 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
26 June 2014

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