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RECOMMENDATION FOLLOWING AN APPLICATION FOR REVIEW OF THE INSURER'S WORK CAPACITY DECISION PURSUANT TO SECTION 44BB(1)(c) OF THE *WORKERS COMPENSATION ACT* 1987*.*

SUMMARY:

a. The work capacity decision dated 1 August 2016 is set aside.
b. The insurer should make another work capacity decision in accordance with the legislation and Guidelines.
c. Payments to the applicant should continue until a new decision issues and any notice period therein has expired.

Introduction and background

1. On 16 July 1999 in the course of his employment as a Manager the applicant tripped over electrical appliances which were scattered on the floor near his desk. He fell heavily and later reported injury to his lower back and neck. The insurer accepted liability and commenced weekly payments.

2. The applicant was unfit for work for three months and returned on suitable duties, until being made redundant in July 2002. Between 2003 and 2010 the applicant ran an importing business in his own right. Currently he works from home as an Online Retailer. He has a Certificate of Capacity saying he can work for 15 hours per week. He asserts that he earns $185 per week, but this is currently disputed by the Insurer. On this issue much turns, because he needs to earn at least $183 per week to satisfy the requirements of section 38(3)(b).

3. The applicant seeks procedural review of a Work Capacity Decision made by the Insurer on 1 August 2016. The Decision informed the applicant [1] that his weekly payments would be ceasing from 09 November 2016, due to failure to satisfy section 38(3)(b).

4. The insurer has also issued a section 74 notice in relation to the neck injury. The work capacity decision is said to only refer to the applicant's

[1] On page 8 of 15.

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work capacity resulting from any restrictions caused by the back injury, for which liability remains accepted.

5. An internal review by the insurer confirmed the original work capacity decision. In the course of internal review it was noted that even if the applicant were earning the amount he claims to be earning it would be substantially below the minimum award rate and he would therefore be in breach of section 38(3)(c) because the Insurer believes he could earn much more than he currently is by doing the same work elsewhere. He claimed to be paying himself around $13.33 per hour whereas the rate he could earn for the same work with a different employer is $24.50 per hour.

6. The applicant sought Merit Review from the Authority by way of application received 25 October 2016. The Authority delivered its Findings and Recommendations dated 30 November 2016. The Authority made findings that the applicant:

   (i) has a present inability arising from an injury such that he is able to work for 4 hours per day, 5 days per week with: lifting/carrying up to 10kg, siting tolerance of 15-30 minutes with a break, standing tolerance of 15 minutes, pushing/pulling ability of 10 kg, avoid bending, twisting or squatting, and a driving ability of 15-30 minutes with a break;
   (ii) has a present inability arising from an injury such that he is not able to return to his pre-injury employment but is able to return to work in suitable employment and therefore has "current work capacity" as defined in section 32A; and
   (iii) does not meet the special requirements of section 38(3) of the 1987 Act to be entitled to receive payments after the expiration of the second entitlement period (130 weeks).

7. An application was subsequently made to this Office for procedural review, received on 23 December 2016. I am satisfied that the application has been made within time and in the proper form.

Submissions by the applicant

8. Section 44BB(1)(c) of the *Workers Compensation Act* 1987 (1987 Act) states that this review is *"only of the insurer's procedures in making the*

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work capacity decision and not of any judgment or discretion exercised by the insurer."

9. The submissions made by the applicant are as follows:

- He believes the process has been unfair and he has no means by which his claim might be determined fairly;
- The insurer is aware that the neck injury was caused at the same time as the back injury and the Insurer has previously paid for medical treatment for the neck injury;
- A doctor has recently advised not to proceed with surgery on the neck "at this stage";
- It is unfair to consider his work capacity only in relation to his back, as though he had no neck injury;
- This is in accordance with some authority for the proposition that a return to work plan should accommodate restrictions caused by injuries for which liability is disputed[2];
- He objects to the Insurer purporting to determine Whole Person Impairment (WPI) by using a "quality assessor of WPI" rather than going through the correct process of engaging an Approved Medical Specialist who can issue a binding Medical Assessment Certificate (MAC);
- He notes that even the merit reviewer described this as "misleading," having said at paragraph 67: "[it is] misleading for an insurer to give the impression to an injured worker that it is able to assess the degree of permanent impairment and should not be done.";
- He says that the insurer has:
  (a) Misled him;
  (b) Purported to provide a concluded opinion on assessment impairment not in accordance with section 32A; and
  (c) Adopted an approach which does not provide a solid foundation for an insurer to conclude or to have an opinion as to whether the degree of permanent impairment is likely to be more than 20% as required by section 32A(c);
- He has approached a lawyer for assistance with the assessment of WPI and he attended an appointment with an AMS in November

[2] The reference given is said to be *Divertie v Track Express Pty Ltd* (2009) NSWWCC PD45.

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2016, but the report was not as yet received as at the date of the merit review recommendation;

- He is therefore prejudiced because his WPI has not been appropriately considered by an insurer or conclusively determined or agreed as provided by section 32A;
- While there is no MAC certifying WPI, it is procedurally unfair for an insurer to rely on a lack of evidence (or inadequate information) to reach a binding decision – the Insurer should have arranged or invited the applicant to arrange for an appropriate assessment to be made prior to making the work capacity decision and concluding that the applicant did not have high needs or highest needs, as those terms are defined; and
- He believes that the failure of the insurer to take those steps has prejudiced his position.

10. The applicant appears to have no objection to the Insurer's calculation of his weekly earnings in his present occupation. Given that it was the low level of earnings which caused the Insurer to conclude that the applicant was in breach of both sections 38(3)(b) and 38(3)(c), that being a conclusion with which the merit reviewer agreed, it is quite an omission and might be thought to be an admission.

Submissions by the Insurer

11. The Insurer made submissions in reply, thus:

> 1) Irrespective of the submissions made by [the applicant] with regards to the inclusion of his cervical spine injury in the assessment of his work capacity, the exclusion of non-compensable/declined injuries has been well-established via several earlier decisions by both MRS and WIRO.
>
> 2) [The applicant] has not yet challenged the decision to decline liability for his cervical spine and, as a result, this injury is not an accepted part of his workers compensation claim.
>
> 3) As outlined by Merit Review in their decision, even <u>if</u> [the applicant's] cervical spine was to be included in the assessment of his work capacity, the available medical evidence indicates that this would not significantly alter his capacity to undertake suitable

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employment.

4) The insurer acknowledge that the inclusion of a decision under Section 43(1)(f) of the Act that [the applicant] is not a worker with high needs, in the WCD dated 1/8/2016, was incorrect. This is on the basis that this issue is not a work capacity decision.

5) As outlined by Merit Review at paragraph 67 of their decision dated 30/11/2016, the insurer acknowledges that it does not have ability to determine WPI and this can only be performed by an appropriately qualified medical professional. Therefore, any such statement to this effect which was contained in the WCD and Statement of Reasons was incorrect.

6) Irrespective of this, as outlined by Merit Review at paragraph's 71 & 72 of their decision dated 30/11/2016, there is currently *"no persuasive information or reasoning"* which supports that [the applicant's] WPI is likely to be sufficient to satisfy the relevant threshold.

7) In any case, the issue of [the applicant's] WPI is not a work capacity decision, as outlined by WIRO in their recent Procedural Review of another QBE matter, dated 5/10/2016.

8) The insurer submit that, notwithstanding the issue of [the applicant's] WPI, the inclusion of this in the WCD dated 1/8/2016 and the issues in the communication of this matter, these issues do not materially change the basis of the work capacity decision, nor has it disadvantaged [the applicant].

12. The Insurer may have a point in relation to splitting the case between the back and the neck, issuing a work capacity decision in relation to one and a section 74 notice in relation to the other, but they are obviously on much thinner ice when attention is turned to the issue of 'high needs' and the purported assessment/determination of WPI.

13. It cannot be thought that providing misleading and erroneous information to a worker in the course of a work capacity decision is excusable on the basis that it is extraneous to the process and therefore cannot prejudice the worker's rights. If that argument were to be accepted, then there would be nothing to stop an Insurer purporting to include a section 74 Notice in a work capacity decision and claiming

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that, even if it is misleading, it can have no effect on the work capacity decision because it is not one when considered on its own. The work capacity process is separate from the section 74 process (by which liability is disputed) and the medical dispute process (by which WPI is determined) and they cannot impinge on one another. That is the reason for the existence of section 43(2).

14. If a decision "which can be the subject of a medical dispute" (such as the determination of WPI) is "not a work capacity decision" by virtue of section 43(2)(b), then a purported determination of such a dispute certainly cannot form part of a procedurally correct work capacity decision. That is what happened in the present case.

The relevant Guidelines

15. On 1 August 2016 a new set of *Guidelines for claiming workers compensation* came into effect, replacing the former *Work Capacity Guidelines* which had been in force from 11 October 2013. This means that for all of the fair notice period and most of the assessment period, the former Guidelines applied, but on the last day of the assessment, being the same day as the work capacity decision, the new Guidelines applied.

Decision

16. The Insurer contacted the applicant on 08 July 2016 giving notice that a work capacity decision might be made in around 21 days, following a work capacity assessment. This complies with the "fair notice" provision in the (now former) *Work Capacity Guideline* 5.2.

17. In the work capacity decision notice the Insurer advised the applicant that the work capacity assessment had commenced on 08 June 2016 and was completed on 1 August 2016.

18. The Insurer explained sections 43(1)(a),(b) & (f).

19. Under section 43(1)(a) the applicant was found to have current work capacity for 5 hours per day, 3 days per week with various restrictions of lifting and carrying, sitting, standing, pushing and pulling, bending/twisting/squatting and driving.

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20. The Insurer found the applicant to be capable of performing the "suitable employment" of "Online Retailer," in accordance with section 43(1)(b).

21. The applicant was assessed as currently earning less than $183 gross per week, which means that the applicant does not satisfy section 38(3)(b). This assessment was said to be made under section 43(1)(f).

22. The Insurer also purported to invoke section 43(1)(f) to say the following: "I have determined that you are not considered to be a worker with high needs in accordance with section 32A." The Court of Appeal has held that section 43(1)(f) does not confer on insurers powers to make decisions that they do not otherwise already have the power to make. The determination of a medical dispute is an example of such a decision[3].

23. The Insurer explained the entitlement periods and noted that the applicant had received no less than 402.3 weeks of payments, clearly placing him in that period following the second entitlement period which ends after 130 weeks. Section 38 was clearly set out and explained. While it was not until the internal review stage, when the Insurer found that the applicant could earn more in suitable employment than he is currently earning, that the Insurer informed him that he fails the test in section 38(3)(c), he was advised that his weekly earnings of less than $183 did not meet the requirements of section 38(3)(b).

24. The merit reviewer agreed with the internal reviewer about the merits of the decision.

25. Section 59A(2) and (3) were fully and clearly explained. The applicant was advised that his entitlement to payment for pre-approved ongoing medical expenses might continue for a further two years until 09 November 2018. This is the correct period for a worker with less than 10% WPI.[4]

26. The correct notice period was given in accordance with section 54(2)(a).

[3] See *Sabanayagam v St George Bank Ltd* [2016] NSWCA 145.
[4] However, see paragraphs 12-14, 22 *supra*.

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27. The new Guidelines, effective from 1 August 2016, introduced the concept of "substantial compliance" (see page 6). The Guidelines say this:

> If a worker, employer or insurer provides information or takes action that is substantially compliant with these guidelines (*sic*), but it is a technical breach of these guidelines (*sic*), then the information or action remains valid unless a party has, as a result of that breach:
>
> - been misled
> - been disadvantaged, or
> - suffered procedural unfairness.

28. There can be no dispute that the applicant was misled by the work capacity decision which purported to make a binding determination on the issue of "high needs." For the reasons set out at paragraphs 12-14 supra this constitutes a significant procedural breach and the decision must be found to have been invalidly made. This is despite the obvious merit of the insurer's decision, which was upheld by the merit review service and the relevant elements of which (including the assessment of current earnings) do not appear to have been challenged by the applicant.

Finding

29. The work capacity decision of the Insurer was not validly made and must be set aside.

RECOMMENDATION

30. The work capacity decision dated 1 August 2016 is set aside.

31. The insurer should make another work capacity decision in accordance with the legislation and Guidelines.

32. Payments to the applicant should continue until a new decision issues and any notice period therein has expired.

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25 January 2017