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 7 August 2013 is set aside.**

**b. The applicant is to be reinstated to her weekly payments at the rate applicable at 7 August 2013.**

**c. The payments are to be back-dated to 16 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 7 August 2013. The decision stated that payments were to cease on 16 November 2013. The Insurer notes in its submissions that payments were to cease on 16 October 2013, but were *"last paid to"* the applicant on 1 November 2013. The applicant sought internal review. The Internal Review Decision (IRD) was issued on 4 October 2014. The applicant sought Merit Review by the Authority on 25 October 2013. The Merit Review was issued on 8 May 2014, some 195 days later. The application for Procedural Review was lodged on 8 June 2014.

2. The applicant was injured on 24 September 2009. The injury was to her left leg, heel, and lower back. She has suffered chronic pain and psychological sequelae. The applicant did not return to work. The applicant was made redundant in 2010. 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 Part 19H of Schedule 6 to the 1987 Act required the Insurer to conduct a work capacity assessment (assessment) for the purpose of facilitating the application of the amended weekly benefits provisions to the

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applicant's claim. Clause 17 of Schedule 8 to the Workers Compensation Regulation 2010 (the Regulation) required the transitioning 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.

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. 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**

7. The Insurer made submissions which were in the nature of a timeline which was helpful, together with many documents including notes of the fair notice telephone call.

**The Decision**

8. The decision does not state that an assessment was undertaken. The fair notice telephone call and letter do not mention that an assessment is to take place. The Insurers submissions state that the assessment was completed on 8 July 2013. The applicant cannot have known at the time she received the decision that an assessment was required to be made or that it had been made. The Insurer is required to make a decision "*as*

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*soon as practicable"* after the assessment is made: see Clause 23, Schedule 8, *Workers Compensation Regulation* 2010. The applicant cannot know whether that has occurred. Had the decision referred to an assessment it would have been required to 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.

9. There does not appear to be any legislative requirement to notify the applicant of the outcome of the assessment. However, *Guideline* 5.4.2 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.

10. The decision states that *"payments will cease from 16 November 2013".* It is then stated that *"weekly benefits will continue at the current rate for 3 months plus 1 week (to allow for the delivery of this notice) to 15 November 2013*". Having 2 dates for the cessation of payments would only serve to create confusion.

11. The reference to 3 months should refer to section 54(2) of the 1987 Act. Allowing 1 week for delivery may not always be appropriate. Section 76(1)(b) of the *Interpretation Act* 1987 allows for *"service"* by post to occur on the fourth working day after the day it is posted. A working day is a day other than *"a Saturday or Sunday, or a public holiday or a bank holiday in the place to which the letter was addressed"*: section 76(2)(a) and (b) of the *Interpretation Act* 1987. By way of example, the fourth

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working day after Thursday 2 April 2015 will be 10 April 2015, more than a week later due to Easter.

12. The applicant is advised that she has been receiving benefits pursuant to section 38. What legislation this section is in is not revealed. The next sentence is *"In accordance with Schedule 6, Part 19H, Clause 9 of the Workers Compensation Act 1987, Transitional Provisions".* Exactly what is *"in accordance"* with clause 9 is not said. It cannot be the rate at which the applicant is being paid as at the date of the decision as clause 9 relates to the transitional amount.

13. The applicant is then advised that the *"change in your benefit rate will become effective following this notice period".* A change in a rate must involve a continuation of payments, whether by way of an increase or decrease. A forthright author would have made the bold and honest statement that weekly payments are to cease.

14. Next follows a heading "[Insurer's] *decision".* The Insurer now states that the decision *"will result in a discontinuation of your weekly benefit".* It is then stated that the decision is based on the applicant having a *"current work capacity (Section 43(1)(a))",* and having *"suitable employment options (Section 43(1)(b))".* If the applicant was able to find the legislation in which these sections are to be found, she would not be greatly informed. The terms *"current work capacity"* and *"suitable employment"* are defined in section 32A of the 1987 Act. These definitions are important as they bear little relationship to the same words in everyday usage. *"Current work capacity"* refers to and is qualified by the definition of *"suitable employment"*. The definition of suitable employment is an important concept in the 2012 amendments to the 1987 Act. It involves, *inter alia*, having regard to *"the worker's age, education, skills and work experience"* while having no regard to *"the nature of the worker's pre-injury employment".* Few people would realise that such a concept would be included in a simple phrase like suitable employment.

15. The decision then states that that the applicant has been paid weekly payments for more than 130 week, is not working 15 hours or more and not earning more than $155 and refers to section 38(3)(b). Which legislation is being referred to is again not stated. The relevance of 130 weeks is not explained. That would also involve reference to the

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definition of *"second entitlement period"* in section 32A of the 1987 Act. The applicant should also be advised that the $155 amount is indexed, and be told what the current rate is.

16. The decision correctly states that medical and related expenses as defined by section 60 of the 1987 Act will cease 12 months after weekly benefits cease. It states that entitlement to such expenses will expire on 16 November 2014. This again raises the issue as to the correct date upon which weekly payments cease: 15 or 16 November 2013? If a claim for treatment obtained on 16 November 2014 can be claimed, that suggests that the last day for weekly payments is 16 November 2013. The confusion in the decision would be keenly felt by the applicant.

17. It is stated that the section 60 expenses are limited to 12 months pursuant to section 59 of the *"Act".* Which Act is not clear. The correct reference is to section 59A(2) of the 1987 Act.

18. 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.

19. The decision states that it relies upon certain documents. There are 4 documents listed. While the decision lists 4 documents, the IRD lists 10 documents. Guideline 5.4.2 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 maker has clearly not considered all the evidence. This is a demonstrable error.

20. The applicant is advised that she may request an internal review. 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 erroneously states that there is a 30 day time limit. The later iteration of the *Guideline* refers to *"timely lodgement"* and that the application should be lodged *"as soon*

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*as practicable after receiving the work capacity decision".* A time frame of 30 days may well be appropriate, but no assistance is given as to what may constitute *"timely lodgement."*

**FINDING**

21. 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**

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

23. I recommend that the Insurer pay the applicant the weekly benefit to which she was entitled prior to 7 August 2013 until such time as she is properly transitioned. Those payments should continue from 16 November 2013 being the date on which they ceased, according to the submissions of the Insurer.

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 16 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.

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Delegate of the WorkCover Independent Review Officer
10 July 2014

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