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 December 2013 is set aside.

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

c. The payments are to be back-dated to 7 April 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 31 December 2013. The decision stated that payments were to cease on 7 April 2014. The applicant sought internal review. The Internal Review Decision (IRD) was issued on 10 February 2014. The applicant sought Merit Review by the Authority. The Merit Review was issued on 9 May 2014.

2. The applicant was injured on 20 August 2007. The injury was to his right hip. He returned to suitable employment in self-employment. 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 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 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 4 October 2013, published on 8 October

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2013, and 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.

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 largely 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 also dealt with the merits and as such are not relevant.

The Decision

8. The decision states that a work capacity assessment was undertaken on 31 December 2013. 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* 5.3.2 requires.

9. There does not appear to be any legislative requirement to notify the applicant of the outcome of the assessment. However, *Guideline* 5.3.2 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*

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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.

10. The decision states that notice is given pursuant to section 54 of the 1987 Act. The correct reference is to section 54(2)(a) of the 1987 Act. That section is then misquoted in the decision. The section says *"when the discontinuation or reduction is on the basis of any reassessment by the insurer of the entitlement to weekly payments of compensation resulting from a work capacity decision of the insurer—3 months".* The decision states that the section says *"when the discontinuation or reduction is on the basis of any reassessment by the insurer of the entitlement to weekly payments of compensation resulting from a work capacity decision of the insurer—3 months and 5 business days".* A better way to explain the 3 month period is to explain that the *Interpretation Act* 1987 section 76(1)(b) states that service by mail is taken to be on the fourth working day after the letter 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. Allowing 5 days will often cause problems. The fourth working day after a Friday would normally be the following Thursday; Wednesday would be 5 days after the Friday.

11. Section 43 of the 1987 Act is then set out as to decisions which may be made, including *"a decision about the amount of an injured worker's pre-injury average weekly earnings or current weekly earnings"* (section 43(1)(d)). For a claim which is being transitioned to the new legislation, as this matter is, the Insurer cannot make a decision about "*pre-injury average weekly earnings"* (PIAWE). The PIAWE is the transitional rate as set out in Clause 2, Part 19H, Schedule 6 to the 1987 Act. The decision states that on the following page. An applicant would be concerned that there are 2 methods to determine PIAWE and the Insurer has chosen 1 method over the other.

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12. The reason given for choosing the transition rate is that it applies to the applicant as he was in receipt of weekly payments *"as at 1 October 2012".* Whether or not the applicant was in receipt of weekly payments on 1 October 2012 is irrelevant. The test is being in receipt of payments immediately before 1 October 2012. The Insurer should have referred to clause 1 (the definition of "*existing recipient of weekly payments*"), clause 2 (the transitional amount as indexed which is why the figure used is $948.50), and clause 9(3) (the deeming provision) of Part 19H of Schedule 6 of the 1987 Act.

13. The decision states that weekly payments are divided into 3 entitlement periods. The 4th period is the period after 5 years pursuant to section 39 of the 1987 Act although there is little need to point that out to the applicant in this matter. The applicant has *"received more than 130 weeks of weekly compensation".* The applicant should have been referred to section 32A of the 1987 Act and the definitions of *"first entitlement period"* and *"second entitlement period".*

14. It is then stated that section 38 of the 1987 Act applies and that section is set out in full. Section 38(3)(b) provides the test of working for not less than 15 hours and earning $155. The decision states the money figure as $168. That is the indexed figure. It is correct, but if the applicant was to read the section he would be perplexed as to why the Insurer has seemingly raised the bar for him. It is imperative that indexation of figures be explained. This will become more important as inflation draws a greater gap between the figures used in the 1987 Act and the actual figure used.

15. Section 38 refers to *"current work capacity"* which is a term defined in section 32A of the 1987 Act. That definition refers to being unable to return to pre-injury employment, but being able to work in *"suitable employment",* itself defined in section 32A. The applicant is advised that certain jobs have been identified as *"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. The decision uses both of these terms without explaining their technical, rather than, common-sense meanings.

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16. *Guideline* 5.3.2 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."* The decision correctly states that Section 59A(2) of the 1987 Act provides that treatment expenses and related expenses are no longer payable 12 months after weekly payments cease although the reference is only to *"the Act".* The legislation has not been properly referenced.

17. The Insurer failed to point out that 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.

18. The applicant is advised that he 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* 5.3.2 and the need to *"reference the relevant legislation."* He is advised that he may seek assistance from a solicitor *"at your own expense".* Section 44(6) of the 1987 Act states that a *"legal practitioner acting for a worker is not entitled to be paid or recover any amount for costs incurred in connection with a review under this section of a work capacity decision of an insurer".* In this case this issue is of little note as the applicant has had a solicitor acting in the review of the decision and he must know that he cannot be charged for that work.

19. Guideline 5.3.2 requires the Insurer to *"advise that any documents or information that have not already been provided to the worker can be provided to the worker on request to the insurer".* The decision only states that the applicant may request copies of the 10 documents listed in the decision. The decision also states that the documents have been provided pursuant to section 74 of the Workplace Injury Management and Workers Compensation Act 1998 and clause 37 of the Workers Compensation Regulations 2003. Section 74 deals with claims in dispute and is not relevant. In any event, the 2003 *Regulation* was repealed on 1 February 2011. The relevant provision would be clause 46 of the *Workers Compensation Regulation* 2010.

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FINDING

20. 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

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

22. I recommend that the Insurer pay the applicant the weekly benefit to which he was entitled prior to 31 December 2013 until such time as he is properly transitioned. Those payments should continue from 7 April 2014 being the date on which they ceased.

23. 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 7 April 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.

Tracey Emanuel
Delegate of the WorkCover Independent Review Officer
14 July 2014