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*.*

1. The injured worker is the applicant for a review of the decision made by the Insurer.

2. The applicant worked as an Aged Care Nurse and sustained injury to her neck and right shoulder in the course of her employment in1998.

3. Having ceased work in 2000, the applicant had a subsequent injury in 2001. This resulted in injury to the right wrist and arose in interesting circumstances: the applicant was returning home from a "work assessment" arranged by the Insurer when she was involved in a car accident. She had been subject to an assessment for suitability to perform lighter duties with her former employer. Any permanent impairment would clearly be compensable.

4. The applicant did not resume paid employment until 2 July 2010, when she commenced work at a nursing home as a Registered Nurse, where she continues to work for 22 hours per week. Liability was in dispute but as a result of a settlement in the Workers Compensation Commission and an ensuing Certificate of Determination dated 30 April 2012 weekly benefits were paid at a weekly rate of $447.70 continuously beyond 1 October 2012. Therefore the applicant was an "existing recipient of weekly payments" as defined in Schedule 6, Part 19H, Division 1 of the *Workers Compensation Act* 1987 (1987 Act) as at 1 October 2012.

5. The Insurer issued a notice of a work capacity decision pursuant to Section 43 of the 1987 Act on 26 March 2013. They had given the applicant notice of the impending decision by telephone on 6 March 2013 and solicited any further information from the applicant which she might wish to submit in support of her claim to ongoing weekly payments. No further information was provided. In the letter of 26 March 2013 the applicant was advised that her weekly payments would be reduced to $22.72 per week and that the decision would come into effect 3 months after the date of the letter, on 26 June 2013. There was no reference in that letter to section 54 of the 1987 Act.

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6. On 24 May 2013 the Insurer wrote to the applicant advising of the outcome of an internal review of the decision dated 26 March 2013. The internal review resulted in a slight change to the earlier decision, in that the transitional rate was changed from the former $920.90 to the indexed rate of $938.30 per week. An oblique reference to section 43(1)(f) was also added to the decision. As a result of the internal review the applicant was advised that her entitlements would be reduced to "nil." The Insurer used this wording in the letter dated 24 May 2013:

> "Because I have issued *a new work capacity decision* and some/all elements of the original decision have changed, the notice period before these changes take effect will start again.
>
> "WorkCover has instructed that an extra 7 days be added to the notice period. The changes will now be effective on 31 August 2013."

The above sentences are notable for two reasons:

(a) The internal review is said to result in *a new work capacity decision*; and

(b) While on this occasion the notice given to the applicant was correctly expressed to be 3 months and 7 days, no reference was made to section 54 of the 1987 Act.

7. A WorkCover Merit Review was completed and a Statement of Reasons issued on 16 July 2013. The Reviewer upheld the determination of the Insurer. To be clear, the decision upheld was the second decision, being the one notified by letter dated 24 May 2013.

8. On 7 August 2013 the applicant requested the Independent Review Officer to undertake a review of the decision of the Insurer pursuant to Section 44(1)(c) of the 1987 Act. I am satisfied that the applicant has made that application within the time provided by that section.

Applicant's Grounds for seeking Procedural Review

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9. The applicant made the following lengthy submissions:

a. She alleges that she is a "seriously injured worker" since she has "whole person impairment equal to or greater than 31%". The wrist injury she sustained in 2001was as a result of a car accident which occurred when she was travelling home from a "work assessment" for a possible return to lighter duties with her former employer, and is thus compensable and should be aggregated with the injuries sustained in 1998 to her neck and shoulder. Since she alleges that she meets the "seriously injured worker threshold," the applicant asserts that she is exempt from the amendments limiting her rights to weekly benefits to either a maximum of 130 or 260 weeks and medical expenses to 12 months following the cessation of weekly payments.

b. The medical reports regarding the level of "whole person impairment" are said to be "inherently biased" as they represent the interests of the Insurer. "The original internal reviews also ignore and omit significant pieces of evidence such as the documents dated 27th July 2000 by Dr G and 12th of February 2002 by Dr F. Specifically the document dated 12 February 2002 by Dr F contradicts the agreed percentage loss of the right arm below the elbow (21% v 15% respectively). This evidence, combined with the total "whole person impairment" of 30% (as calculated based on the reports and complying agreements) is enough to show that the applicant's permanent impairment of her left arm should be greater than 30% and likely to deteriorate further either due to the repetitive and strenuous tasks she encounters as a registered nurse at her current employment or with the passage of time. She is currently seeking treatment for chronic pain in her right hand.

c. Payslips indicate she was working 22 hours per week at a suitable working environment, however she has used much recreational and sick leave due to issues relating to the chronic pain in her right hand. As a registered nurse in her current employment, the applicant finds that repetitive, strenuous physical tasks "such as medication preparation and administration, document writing etc." are present and unavoidable. She is unable to reduce her working hours because her shift times were set and made permanent by her employer,

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however in light of recent medical certificate, said to be dated 27 July 2013, she was able to come to an agreement with the employer to drop one day of shift work. The work changes have caused great concern for her job security.

d. The Insurer relied on a report from Dr B of January 2012 which assessed 15% permanent loss of efficient use of the right arm below the elbow, contrary to the agreed percentage of 20% which was the subject of a settlement entered into by the parties on 30 April 2012.[1] There was allegedly a settlement agreed to in 2004 between the same parties for 10% loss of efficient use of the right arm at or above the elbow.

The Legislative Framework

10. The legislative framework which governs the entitlement to and the transition from the previous benefits is complex and must be difficult for an injured worker without legal assistance to navigate through and to understand its impact. Set out shortly, there may be thought to be no less than four steps involved, all of them mandatory.

i. An insurer may make a work capacity assessment at any time (see section 44A(1)). Section 44A(3) also provides that an assessment is not necessary for the making of a work capacity decision.

ii. Section 43 provides that a work capacity decision may be made by an insurer and is binding on the parties, subject to review only under section 44 or by judicial review in the Supreme Court of NSW. Under *WorkCover Work Capacity Guidelines* published on 28 September 2012 (the version relevant for the purposes of the applicant's claim), *Guideline 5* states in part:

> "A work capacity decision is a discrete decision that may be made at any point in time and can be about any one of the factors described in section 43(1), such as the worker's capacity to earn in suitable employment. This is different to a

[1] cf sub-para (b) above where it is asserted that an earlier settlement had been reached for 15% below the elbow. The seeming anomaly is resolved by the explanation that the 2012 settlement was an additional 5% to the former settlement of 15%, giving a total of 20% below the elbow.

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> work capacity assessment which is a review process that may or may not lead to the making of a work capacity decision or another type of decision regarding a claim."

iii. In *Guideline 5.2* a "fair notice provision" sets out the information which must be communicated to a worker "at least two weeks prior to" the work capacity decision.[2] So far the Insurer would have had to make an *assessment*, or be in the process of making an *assessment*, and prior to the finalisation of that *assessment* and the subsequent making of a *decision*, "at least two weeks" notice must be given to the worker of the following matters:

- inform the worker that a review of their current work capacity is being undertaken and that a work capacity decision is going to be made;
- an explanation that this review may include further discussions with other parties such as their employer, nominated treating doctor or other treatment providers;
- advise the potential outcome of this review and detail the information that has led the insurer to their current position;
- provide an opportunity for the worker to supply any further information to the insurer for further consideration and the date that this information is to be provided by; and
- tell the worker wheh this decision is expected to be made.

This pentalogue of bullet points is prefaced with the following words (emphasis added):

> "...the insurer must ... communicate this to the worker in a way that is appropriate in the circumstances of the case, and *preferably by telephone* or in person."

In a workers compensation system where the overwhelming majority of claimants are manual workers with limited education, and a high percentage do not have English as a first language, it is surprising that it would be thought appropriate to try to communicate important and complex information concerning a workers livelihood over the

[2] This of course means that a decision cannot be made "at any point in time," (*contra Guideline 5)* since it cannot be made until the fair notice period has elapsed.

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telephone rather than in writing. Further, in the process of determining whether or not a worker has been afforded procedural fairness, it is impossible for a reviewer to know the adequacy or even the accuracy of any information communicated verbally to a worker by an insurer over the telephone.

iv. In the event of a decision resulting in a variation of the weekly benefits payable to a worker, section 54 requires that the worker be given at least 3 months notice of that proposed variation, which must be notice delivered either in person or by post. I should emphasize here that there is no statutory requirement for a "notice" to be given to a worker of a *decision* under section 43. The notice requirement in section 54 arises from a proposed variation in payments and therefore the issue of "notice" may not arise in circumstances where no variation in payments results from a work capacity decision.

11. I note that in both the first edition of the *WorkCover Work Capacity Guidelines* published on 28 September 2012 and those more recently published on 8 August 2013, reference is made to the *Best Practice Decision-Making Guide. Guideline 5* concludes with this sentence:

"Work capacity decisions should be made in line with the *Best Practice Decision-Making Guide.*"

Guideline 5.1 says in part:

"When making a work capacity decision the insurer should follow the *Best Practice Decision-Making Guide* .. "

and then goes on to list certain characteristics of what is apparently thought to be "best practice." I advisedly used the word "apparently" in the previous sentence, since it is impossible to check whether or not the items listed in *Guideline 5.1* are "best practice" due to there being in existence no such document as the *Best Practice Decision-Making Guide.*

The *Guidelines* are made pursuant to section 376(1) of the 1998 Act and section 44A of the 1987 Act. They purport to give guidance and

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instruction to insurers as to how to conduct work capacity reviews and how to make work capacity decisions. In paragraph 2.3 they say this:

> "All decisions made in relation to a worker's recovery and work capacity should be timely, informed and evidence based. Decisions should be made and communicated in a transparent and robust manner free from preference and prejudice ensuring that effective outcomes are achieved and due process is followed. Decisions should be made in line with the *Best Practice Decision-Making Guide*."

Due to the non-existence of the *Best Practice Decision-Making Guide*, I am unable to confirm that the insurer has complied with the relevant *Guidelines* when making its decision. My enquiry is therefore limited to an examination of the compliance with the rules of natural justice, procedural fairness, and the timeframes which appear to be set out in relevant sections of the legislation together with such *Guidelines* as are published, accessible, within power and comprehensible in the absence of the *Best Practice Decision-Making Guide*.

. **Process of the Insurer**

12. The second decision reached by the Insurer as a result of internal review of the first decision appears to be appropriate in the circumstances of the case. As far as the process undertaken by the Insurer in reaching the work capacity decision is concerned, I am satisfied that there was no breach of procedural fairness and that the rules of natural justice were fully complied with. The Insurer had regard to (i) a statutory declaration of the applicant; (ii) five payslips and a PAYG summary produced by the applicant; and (iii) a medical certificate from Dr K. The Insurer asked the applicant to provide any further material she sought to rely on twenty days prior to the decision being sent out. Nothing further was produced. There is no suggestion that the assessment of permanent loss of efficient use of the right arm at/above or below the elbow made by either Dr B or any other doctor was considered by the Insurer, as asserted by the applicant.

My Reasons:

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13. The grounds upon which the applicant seeks to rely can be dealt with using the numbering by letter (a-d) appearing in paragraph 9 above:

(a) The term *seriously injured worker* is defined in clear terms in section 32A:

> **"seriously injured worker"** means a worker whose injury has resulted in permanent impairment and:
>
> (a) the degree of permanent impairment has been assessed for the purposes of Division 4 to be more than 30%, or
>
> (b) the degree of permanent impairment has not been assessed because an approved medical specialist has declined to make an assessment until satisfied that the impairment is permanent and the degree of permanent impairment is fully ascertainable, or
>
> (c) the insurer is satisfied that the degree of permanent impairment is likely to be more than 30%.

It is interesting to note that the term *permanent impairment* is used, rather than *whole person impairment*. Prior to 1 January 2002 there was no such concept as *whole person impairment* and there was a clear distinction between those body parts which could sustain *permanent impairment* (back, neck and pelvis) and those which could suffer *permanent loss of efficient use* (limbs, senses) or *scarring and disfigurement* (face, torso). Prior to 2002 the term used in section 66 was “loss of a thing” (the various “things” being set out in a Table in section 73) and the section itself was in the following terms:

> "(1) A worker who has suffered the loss of a thing mentioned in the Table to this Division as the result of an injury is entitled to receive from the worker's employer by way of compensation for the loss, in addition to any other compensation under this Act, the amount equal to the percentage of $80,000 set out opposite to that loss in that Table.

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(2) A worker who has suffered more than one of the losses mentioned in the Table to this Division as a result of the same injury is not entitled to receive as compensation under this section more than $80,000 in respect of those losses.

(3) Where by the operation of Division 6 the amount of $80,000 is adjusted, the compensation payable under this section shall be calculated by reference to the requisite percentage of the amount in force at the date of injury."

In section 4 of the 1998 Act the following definition appears:

> **"permanent impairment compensation"** means compensation for permanent impairment under section 66 of the 1987 Act.

For the sake of completeness, the relevant parts of the current version of section 66 are in the following terms:

> **66 Entitlement to compensation for permanent impairment**
>
> (1) A worker who receives an injury that results in a degree of permanent impairment greater than 10% is entitled to receive from the worker's employer compensation for that permanent impairment as provided by this section. Permanent impairment compensation is in addition to any other compensation under this Act.
>
> > **Note:** No permanent impairment compensation is payable for a degree of permanent impairment of 10% or less.
>
> (1A) Only one claim can be made under this Act for permanent impairment compensation in respect of the permanent impairment that results from an injury.
>
> .....
>
> (3) The amount of permanent impairment compensation is to be calculated under this

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> section as it was in force at the date the injury was received.

It is therefore the case that there is no legislative requirement for a worker to be assessed as having more than 30% ***whole person impairment*** in order to be assessed as a seriously injured worker. This would be impossible in any event for a worker injured prior to 1 January 2002, in light of section 66(3).

The seeming neologism "permanent impairment" may be seen as a portmanteau term, including within it all the modes of assessment of lump sum compensation payable to workers under the various iterations of section 66 and the Table in the former section 73 of the 1987 Act. It might therefore include the terms "loss of a thing," "permanent scarring," "permanent disfigurement," "permanent loss of efficient use of," and "whole person impairment."

In my view an applicant would be eligible to be assessed as a *seriously injured worker* if the aggregate of their section 66 assessments exceeded 30% because they were injured prior to 1 January 2002.

In the instant case, while there is an argument to suggest that the applicant has 30% permanent impairment, for the purposes of section 66, she does not reach, let alone exceed, 30% on any view of her case. Therefore the applicant certainly does not currently comply with s 32A(a) or (b) and it is clear that the insurer does not regard her as suffering more than 30% permanent impairment, which therefore also means that she does not currently qualify under s 32A(c).

Further, the applicant's submission proceeds on the basis that it is possible to add together assessment for two parts of the same limb. It is complicated by the argument that the second injury sustained in 2001 is consequential upon the first injury in 1998 and thereby compensable. But this is not possible because the Table in the former section 73 was amended in light of a High Court decision in 1995[3] and the following words were inserted:

> Section 73 (d1)
>
> > Loss of an arm at or above the elbow includes the loss of the arm below the elbow and loss of the hand and is to be compensated as a loss, or a proportionate loss, of a single item only (namely, the loss of the arm at or above the elbow).

[3] *K B Hutcherson Pty Ltd v Jose Correia* [1995] (1995) 183 CLR 50.

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This produces the anomaly that the applicant's lower percentage loss (10% at or above the elbow) is statutorily deemed to include the higher percentage loss (20% below the elbow). Despite this statutory provision, it seems the applicant was compensated for both losses separately in 2004 and 2012. In that circumstance it may be that the insurer agreed to regard the injuries as completely unrelated and separate incidents, a circumstance which would distinguish this applicant from the plaintiff in *K B Hutcherson Pty Ltd v Jose Correia.*[4]

In the event of deterioration of her symptoms the applicant might well be able to bring a further claim (or claims) under section 66, in light of the Court of Appeal decision in *Goudappel v ADCO Construction P/L* [2013] NSWCA 94 which held that the 2012 amendments to the lump sum compensation provisions do not apply to injuries sustained prior to 19 June 2012.[5] This would also exclude the operation of the newly inserted section 322A of the *Workplace Injury Management and Workers Compensation Act* 1998 (1998 Act) which limits claimants to only one assessment of "degree of permanent impairment."[6] Since any such future section 66 claim might well be based on a deterioration of existing pathology, with liability already conceded by the insurer, the WCC or the Registrar would be able to refer the applicant for assessment by an approved medical specialist by warrant of sections 319 and 321 of the 1998 Act.[7]

If the applicant were to successfully bring a further section 66 claim (or claims) and the losses aggregated to a figure of more than 30%, an interesting conundrum might thereby arise as to whether or not she can have her status as a seriously injured worker re-examined and, if so, whether that can result in the transitioning process being rendered a nullity. If so, her entitlements to weekly benefits might be continued beyond the otherwise maximum period of 260 weeks and her medical expenses might continue to be met as well. Hypothetical though this question might be today, there is a prospect (albeit remote) of it arising for serious consideration in the future should the applicant suffer any

[4] See note 3.
[5] While *Goudappel* is currently on appeal to the High Court, subsequent decisions by the WCC including *Di Matteo v RDM Ceramics Pty Limited* [2013] NSWWCCPD 27 have applied the reasoning of the Court of Appeal.
[6] *Di Matteo* (*supra*) is authority for the proposition that the 2012 amendments do not prevent a worker who had made a claim prior to 19 June 2012 from making a further claim.
[7] See *Abou-Haidar v Consolidated Wire Pty Ltd* [2010] NSWWCC PD128 at [57].

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further deterioration in light of her current aggregated total of 10%[8] or even possibly 20%.[9]

(b) The second ground raised by the applicant goes to the merits of the case and cannot be considered. I would say only that having agreed to settle a case for 15% loss of efficient use of the right arm below the elbow at the same time as having a report from a doctor assessing 21% the applicant has forfeited any prospect of relying on that report for lump sum compensation purposes. The settlement extinguishes the currency of the report.

(c) The third ground also goes to the merits of the decision and cannot be reviewed by me.

(d) The fourth ground fails for the same reason as the second.

14. Although the applicant has not established any basis on which the work capacity decision of the insurer might be successfully challenged on procedural grounds, there are some shortcomings which might be addressed:

(i) In the letter to the applicant dated 26 March 2013 advising of the original work capacity decision, reference is made to "the post 260 week period which is for workers that (*sic*) have been in receipt of payments in excess of 260 weeks." Later it says: "As a result of your claim transitioning into the post 260 week period.." with no further comment as to where this "260 week period" comes from. This is in clear breach of the first two bullet points set out at 5.4.2 in *WorkCover Work Capacity Guidelines* gazetted on 28 September 2012.

Just to remind the Insurer, those first two points which appear at the very beginning of a decalogue of "Requirements of a Work Capacity Assessment Decision Notice" are in these terms:

- reference the relevant legislation; and
- explain the relevant entitlement periods.

[8] Which would require significant deterioration from the current level of 10%, in light of s 73(d1)..
[9] Depending on the applicability of the former s 73(d1) and *K B Hutcherson Pty Ltd v Jose Correia.*

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Nothing in the letter of 26 March 2013 explained the reference to 260 weeks beyond the bald statement that it is a period "for workers that (*sic*) have been in receipt of payments in excess of 260 weeks." A slightly better effort was made in the letter advising of the second decision, which noted the following: "You have been in receipt of weekly benefits for more than 130 weeks since the date of injury. Under the amended legislation this means you are paid under the third entitlement period, being section 38 of the Workers Compensation Act 1987." While slightly better, this is still well short of explaining the relevant entitlement periods or giving a proper reference to the legislation. The worker would be left guessing at the significance or extent of the first or second entitlement periods, and could have no idea how many such periods there are.

(ii) As noted in paragraph 5 above, the applicant was advised in a letter dated 26 March 2013 that her benefits would be reduced, effective from 26 June 2013. No reference was made to section 54 of the 1987 Act, in breach of point one of the decalogue in *Guideline* 5.4.2. Further in breach of section 54 the notice given was inadequate, since it should include time for postal service (ideally, 3 months plus 7 days).

(iii) Once again, a better effort from the Insurer was displayed in the letter advising of the second decision, dated 24 May 2013. In that letter the Insurer went so far as to say the following: "WorkCover has instructed that an extra 7 days be added to the notice period.[10] The changes will now be effective on 31 August 2013." While better than the first letter, this one still makes no reference to either section 54 of the 1987 Act or the postal service rule in section 76(1)(b) the *Interpretation Act* 1987, in clear breach of bullet point number one of the decalogue in *Guideline* 5.4.2.

(iv) The internal review resulted in a varied decision by the Insurer. That decision resulted in the applicant having her entitlement reduced to "nil" rather than $22.70 per week. On that basis, as the Insurer rightly advised the applicant, the notice period of three months plus postage time began again. But since it was described as a "new decision" rather than just a

[10] This is now enshrined in *Guideline 6* of *WorkCover Work Capacity Guidelines* gazetted on 9 August 2013.

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variation of the earlier decision of 26 March 2013, there may be room for the view that in such a case an applicant might have an expectation that more than the notice period begins to run again. It may be that the time for requesting an internal review of this "new" decision also begins to run again, in which case the applicant should be advised of their right to seek further internal review. Perhaps the better view is that this does not so arise, since if that happened there would be the potential for an ever extending series of decisions and internal reviews which would completely circumvent the review process. It may be preferable for insurers to avoid referring to variation of an original decision on internal review as a "new decision" for that reason.

15. In considering the facts and circumstances of this application I have had regard to the provisions of section 44(3)(a) of the 1987 Act which provides a timeframe of 30 days for the worker to seek a review by the merit reviewer of the decision, however the timeframe only commences from the receipt by the worker of the insurer's decision on internal review which must be contained in *the form approved by the authority.*

Section 44(3)(a) begins with the following words:

> (3) The following provisions apply to the review of a work capacity decision when the reviewer is the Authority or the Independent Review Officer:
>
> (a) an application for review must be made within 30 days after the worker receives ***notice in the form approved by the Authority of the insurer's decision on internal review***

To date there does not exist any such form. The Insurer's shortcomings in relation to their notice of decision might be solved by the production of such a form by the Authority.

An alternative reading of the clause in section 44(3)(a) is not possible, without rendering the language a nonsense. It has been suggested that the wording should be emphasized as follows:

> (3) The following provisions apply to the review of a work capacity decision when the reviewer is the Authority or the Independent Review Officer:

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(a) ***an application for review must be made within 30 days*** after the worker receives notice ***in the form approved by the Authority*** of the insurer's decision on internal review

The complete absence of punctuation in this sub-section renders such a reading impossible. The sentence can only be referring to the "*notice* in the form approved by the Authority *of the insurer's decision on internal review."*

Since there is no such form approved by the Authority the worker has yet to receive the proper notice of the decision of the internal reviewer and it appears that time has not started to run for him to seek a merit review.

A question of some nicety arises as to whether in that circumstance there was any jurisdiction for the WorkCover Authority to conduct a merit review and therefore whether there was any jurisdiction for me to consider a procedural review.

Given that my role is to make recommendations concerning outcomes in particular matters, this general issue may not arise, but it remains a matter of concern in relation to all applications to the Authority for merit review.

My Recommendation:

16. I recommend that the Insurer undertake a further Work Capacity Assessment.

17. I recommend that the applicant be given an opportunity to make further submissions prior to any further decision being made and issued.

18. In the issuing of the next decision I recommend that the Insurer advise the applicant of the relevant payment periods set out in sections 36-38 of the 1987 Act and the significance and relevance of those payment periods to her circumstances, in compliance with *Guideline 5.4.2.*

19. In the event that the next assessment and possible subsequent decision result in the Insurer determining that the applicant's payments should be reduced or ceased, I recommend that the Insurer advise the applicant in

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accordance with and with reference to both section 54 of the 1987 Act and section 76(1)(b) if the *Interpretation Act* 1987, in compliance with *Guideline 5.4.2*. Since the next decision will be made following the introduction of the *Guidelines* gazetted on 9 August 2013, I recommend that reference also be made to *Guideline 6.*

20. Since the applicant was an existing recipient as at 1 October 2012, she remains entitled to receive her pre-transition rate of weekly benefits until such time as she is validly transitioned under the Act. This cannot happen until a valid notice under section 54 is issued. Accordingly she remains entitled to $447.70 per week until such time as a section 54 notice issues and she is validly transitioned after the appropriate notice period has elapsed.

21. I recommend that the insurer take my views into account, and I recommend that the insurer immediately give effect to them.

Wayne Cooper
Delegate of the WorkCover Independent Review Officer
30 August 2013