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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 a work capacity decision made by a licensed scheme agent of the Workers Compensation Nominal Insurer ("Insurer").

2. The applicant was most recently injured in the course of his employment on 21 October 2009 when he suffered injury to his upper torso, lower rib area of right side of torso and "slipping rib syndrome," accompanied by ongoing "pain syndrome" which is exacerbated by movement of the right arm and breathing in. This was caused by traumatic impact to the right side of the head, neck and shoulder, in addition to the right side of the chest. Despite the applicant having sustained previous thoracic spinal injury in 1992 and having been involved in a car accident in 1994, there is no dispute about the most recent injury having occurred in the course of employment. Liability was accepted and the insurer made continuing payments of compensation until 2013. The applicant was therefore an "existing recipient of weekly payments" immediately prior to 1 October 2012.[1]

3. The Insurer completed an assessment of the work capacity of the applicant and purported to issue a notice of a work capacity decision on 17 April 2013 pursuant to Section 43 of the *Workers Compensation Act* 1987 (1987 Act). Any such notice should comply with *WorkCover Work Capacity Guidelines* 5.4.2[2].

4. The Insurer also purported to give the applicant notice pursuant to Section 54 of the 1987 Act of the reduction of his weekly payments to "nil." The applicant was advised that the payments would reduce to "nil" as from 17 July 2013, that is, exactly three months from the date of the letter. He was also told that his entitlement to payment of pre-approved reasonable and necessary medical and other expenses until 17 July

[1] See Schedule 6, Part 19H, Division 1 *Workers Compensation Act* 1987.
[2] As gazetted on 28 September 2012. The equivalent in the current version (gazetted on 9 August 2013) is 5.3.2.

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2014 would "not be affected." This latter information[3] might be superseded at least in part by a letter dated 20 May 2013 purporting to be a section 74 Notice terminating liability for specific medical or related treatment – identified as "cryotherapy and swimming pass."

5. On 12 June 2013 the Insurer wrote to the applicant advising of the outcome of an internal review of the decision dated 17 April 2013. The internal review upheld the original decision.

6. A WorkCover Merit Review was completed and a Statement of Reasons issued on 23 August 2013. The Reviewer upheld the determination of the Insurer.

7. On 27 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 section 44(3)(a) and *WorkCover Work Capacity Guidelines* 6.4.[4]

Applicant's grounds of review

8. The applicant makes the following points:

   (a) When the Insurer purported to make a "fair notice" telephone call[5] on or about 26 March 2013, the line was so bad that the caller was unintelligible. The applicant was able to work out from odd words that the call concerned an imminent decision of some type or other concerning his ongoing weekly payments of compensation, but no more than that. He sought written confirmation of the conversation. Even the Insurer, in subsequent emailed correspondence with the applicant, has conceded that the line was bad and that they were aware that the applicant found it hard to hear what the caller was saying.

   (b) The applicant goes on to note that the emailed follow-up from the Insurer was not received when sent, due to some international

[3] To use the term "information" loosely.
[4] Numbered 7.4 in the current version (see footnote 2).
[5] See *WorkCover Work Capacity Guideline* 5.2.

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computer hacking problems which interrupted email services world-wide. This apparently delayed his receipt of an email from 26 March 2013 until 1 April 2013, which was Easter Monday. He asserts that he did not receive "notice" until 2 April 2013.

(c) The applicant suggests that the IME to whom he was referred was inappropriate, not being a pain specialist. This unusual submission arises from the applicant's reading of these words in the IME report:

"In terms of the ***non-compensable injury of 1994***, it is clear that [the applicant] has a long history of chronic pain. He is a complex patient and the specifics in relation to pain syndrome may be better considered by a consultant pain physician." [Emphasis added.]

Despite the obvious reference to a former episode of injury, the Insurer did ultimately obtain two reports from the applicant's treating pain specialist which are referred to in the letter of 12 June 2013 advising the applicant of the outcome of internal review.

(d) The applicant seeks to have his cryo-treatment reinstated, since it is "100% effective in stopping the pain" in his affected areas. He also seeks reinstatement of his swimming pass, since he is "pain free" when swimming.

The Legislative Framework

9. 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. It involves a consideration of the 1987 Act, the *Workplace Injury Management and Workers Compensation Act* 1998 (1998 Act), the *Interpretation Act* 1987, the *Workers Compensation Regulation* 2010 (the Regulation) and various *Guidelines* issued by WorkCover which are themselves so inferential, allusive and opaque as to render a complete understanding all but impossible.

Process of the Insurer

10. The decision reached by the Insurer appears to be appropriate in the circumstances of the case. The decision maker had regard to:

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- a vocational assessment report of IPAR 18/12/2012
- a functional capacity report of IPAR 17/12/2012
- a workplace preparation and job-seeking skills training report from IPAR 07/03/2013
- various medical certificates from Dr M (x 3)
- a report of Independent Medical Examiner Professor M K dated 15/03/2013
- two medical reports from Dr M R, 09/05/2013 and 23/05/2013
- applicant's job-seeking diaries for May 2013.

While it is normally an irregularity for an Insurer to seek medical reports after the date of the original decision, the two reports from Dr R were clearly obtained in response to the representations of the applicant that a report from a pain specialist ought to be obtained. On that basis the applicant cannot sustain a realistic objection to the reports, albeit they were not obtained prior to the original decision being made.

Both the original decision and the Internal Review decision were upheld by the Merit Reviewer.

My Reasons:

11. All the grounds referred to by the applicant go to the merits of his case and were dealt with by the Authority on merit review. I can have no regard to any such considerations when examining the procedures of the Insurer. Accordingly I find that none of the grounds on which the applicant seeks to rely will assist him on procedural review.

12. Despite the observations in paragraphs 10 and 11, I remain unsatisfied on the question of notice given to the applicant under section 54.

13. In the letter to the applicant dated 17 April 2013 the Insurer advised that under section 54 of the 1987 Act the applicant's weekly payments of compensation would be reduced to "nil" as of 17 July 2013. Section 54 requires that workers in the position of the applicant should be accorded three months clear notice prior to having their payments changed. The Insurer was required by Section 54(4) of the 1987 Act to give the applicant notice personally or by post. By virtue of the postal service rule

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(Section 76(1)(b) of the *Interpretation Act* 1987), postal service is deemed to be effected on the fourth working day after a document is posted.

14. Therefore in order to comply with the requirements of Section 54 of the 1987 Act a notice posted on 17 April 2013 would not permit the reduction in payments until the expiry of three months following four working days (not including the day of posting) after the date of posting, which would set an earliest possible date of 24 July 2013.[6]

15. The question which arises is whether strict compliance with the provision of the proper notice is required such as to render a non compliant notice invalid. In my view strict compliance is required for three reasons:

    (a) The effect of a Work Capacity Decision to reduce weekly benefits payable to the injured worker has the potential to impact on that worker's ability to meet financial obligations and the time period was important to ensure that the worker could reorganise his or her affairs.

    (b) Failure to give the proper notice is regarded so seriously in the legislation that it is an offence.

    (c) There is no provision in the legislation which enables an insurer to amend the notice.

16. It might be argued that if an insurer pays a worker compensation for the extra time between the wrongly given earlier date and the correct date the worker will have suffered no loss and the problem will have been overcome. This is to misconstrue section 54(3), which is a penalty clause, not a remedial clause. Section 54(3) only applies following the commission of an offence (whether prosecuted or not) and does not overcome the slightly awkward fact that the 1987 Act has no provision enabling an insurer to issue an amended notice. If the notice is invalid due to the wrong date being given because no time was allowed for service in contravention of section 76(1)(b) of the *Interpretation Act* 1987, it must be re-issued, with a further three month period (plus time

[6] Since 9 August 2013 insurers would be bound by *WorkCover Work Capacity Guideline* 6 which requires seven days to be allowed for postal service.

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for service) given to the worker. Equally, it is not possible to "amend" a prior notice. In the current case, the Insurer purported to extend the time to 24 July 2013 in the course of advising the applicant of the outcome of his internal review in a letter dated 22 May 2013. The correct approach would have been to extend the time for notice under section 54 to 29 August 2013, in a letter dated 22 May 2013, which would have then been able to operate as a new notice under section 54.

17. This insurer has also breached the *WorkCover Work Capacity Guidelines* in the way notice was provided to the applicant. *Guideline* 5.4.2 says that an Insurer ***must*** adhere to the following decalogue of requirements:

> **5.4.2 Requirements of a work capacity decision notice**
>
> The work capacity decision notice must:
>
> • reference the relevant legislation
>
> • explain the relevant entitlement periods
>
> • 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
>
> • 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
>
> • advise the date when the decision will take effect
>
> • detail any support, such as job seeking support, which will continue to be provided during the notice period
>
> • 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

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• advise of the process available for requesting review of the decision and how to access the required form, *Work capacity - application for internal review by insurer* (catalogue no. WC03304).

18. In the current case, as referred to in paragraph 4 above, this applicant was advised that "any entitlement you may have to payment of pre-approved reasonable and necessary medical and other expenses, until 17 July 2014, will not be affected." In my view this is a clear breach of *Guideline* 5.4.2 which 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 applicant was not told that his medical and related treatment expenses would no longer be paid after 17 July 2014, nor was he referred to section 59A of the 1987 Act.

19. The Insurer in advising that the decision would take effect on 17 July 2013 has also breached *Guideline* 5.4.2 which requires the Insurer to:

- advise the date when the decision will take effect.

Given the flaw in the notice period described in paragraphs 13-16 above, the date of 17 July 2013 is erroneous and the guideline has *a fortiori* been breached.

20. These breaches of the *Guidelines* might seem trivial to the Insurer, but when a worker's livelihood is being affected, the Insurer has an obligation to strictly observe the legislation, *Regulation* and *Guidelines* in order to provide fairness.

My Recommendation:

21. I recommend that the Insurer issue a valid section 54 notice, which gives the applicant three clear months notice of variation of his weekly benefits.

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Such notice should include four clear working days for service by post and comply with *Guideline* 6 which was gazetted on 9 August 2013.

22. I recommend that the Insurer issue a proper notice in accordance with *Guideline* 5.4.2, setting out the full impact of the decision, including the termination of medical expenses 12 months following the cessation of weekly payments and references to the relevant sections of the legislation.

23. Since the applicant was an existing recipient as at 1 October 2012, he remains entitled to receive his pre-transition rate of weekly payments until such time as he is validly transitioned under the Act. This cannot happen until a valid notice under section 54 is issued and the relevant notice period has expired. Accordingly I recommend that the Insurer recommence weekly payments to this applicant at his pre-transition rate.

24. 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 WorkCover Independent Review Officer
16 September 2013