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 procedural review of a work capacity decision made by the Insurer.

2. The applicant suffered injury in the course of his employment as a shearer on or about 17 June 2008. He was dragging a very heavy sheep which kicked at him. Consequently he flexed awkwardly, which resulted in injury to the lower back. There is no dispute about the injury having occurred in the course of employment. The applicant also had low back symptoms prior to 17 June 2008, as many shearers typically do,[1] but had been able to work without restriction until that date.

3. The applicant no longer works as a shearer and until recently worked 15 hours per week doing the books for his father's business. He also does a course three days per week with a view to finding alternative employment using a computer. The insurer made weekly payments of compensation from 2008 until 2013. Accordingly the applicant was an "existing recipient of weekly payments" as at 1 October 2012.

4. On 28 March 2013 the Insurer, having ostensibly completed an assessment of the work capacity of the applicant, purported to issue a notice[2] of a work capacity decision pursuant to Section 43 of the *Workers Compensation Act* 1987 ("1987 Act"). 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 cessation of weekly payments was said to be effective from 28 June 2013. The applicant was also told that "under section 59" his "entitlement to medical treatment only extends for a 12 month period after weekly benefit payment ceases (*sic*)." The applicant was told that his "entitlement to medical treatment will therefore cease from 28/06/2014."

5. On 21 May 2013 the Insurer wrote to the applicant advising of the outcome of an internal review of the decision dated 28 March 2013. The

[1] In which case sections 15-16 of the 1987 Act would likely apply to the same employer.
[2] See *WorkCover Work Capacity Guidelines* 5.4.2

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internal review upheld the original decision. It purported to vary the notice previously given under section 54 to change the operative date of the decision to cease payments from 28 June 2013 to 28 August 2013. It is noted that 28 August 2013 is three months and seven days from the date of the letter. The following sentence also appeared: "We can confirm that the work capacity decision only related to your entitlements to weekly benefits and does not affect other entitlements that you may be entitled to under the Act."

6. A WorkCover Merit Review was completed and a Statement of Reasons issued on 18 July 2013. The Reviewer upheld the determination of the Insurer.

7. On 15 August 2013, application was made to 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 30 day time-limit imposed by section 44(3)(a), and the *WorkCover Work Capacity Guidelines* and on the relevant form.

Applicant's Stated Grounds of Review

8. The applicant raises issues which would normally be thought to form part of merit review only; however he does so in circumstances which are unusual and may warrant consideration on procedural review:

(a) Following receipt of the Insurer's work capacity decision and notice of outcome of internal review, and after he had already applied to WorkCover for Merit Review the applicant was perhaps understandably surprised to find himself being referred by the same insurer to an Independent Medical Examiner. An appointment with Dr P was arranged for 19 July 2013, which the applicant attended.[3]

(b) The applicant was not shown a copy of Dr P's report until he specifically asked for it. That report came with a supplementary report from the same doctor, since the Insurer had sought clarification of the original report

[3] Coincidentally, the WorkCover Merit Review decision is dated 18 July 2013.

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(c) As the applicant himself notes, the two reports of Dr P contradict the Insurer's work capacity assessment and decision, in that the doctor accepts the applicant's position that he could not work 40 hours per week in the type of "suitable employment" referred to by the Insurer. The doctor reinforced his first assessment [in the report dated 22 July 2013] by the supplementary report dated 1 August 2013 where he said that in his view "the main barrier to returning to work are in my opinion his very genuine symptoms." Perhaps irrelevantly but interestingly Dr P also said this of the applicant: "He feels that the insurance company has been putting a lot of pressure on him, particularly since January of this year and have told him that he should be fit for 40 hours per week of restricted duties. He feels he is simply unable to do this."

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. There are no less than four steps in the transition process, all of them mandatory. There is also a clause in the *Workers Compensation Regulation* 2010[4] which purports to amend the Act[5] in a way which is both confusing and most probably invalid.

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. A work capacity decision may be made at any time according to *Guideline* 5 and a work capacity decision is any decision as described within section 43 of the 1987 Act. Guideline 4 of the *WorkCover Work Capacity Guidelines* sets out the matters which should be considered by an Insurer when making a work capacity assessment:

- reports from the treating doctor, treating specialist or other allied health professionals
- *WorkCover Certificates of Capacity*
- independent medical reports

[4] See schedule 8, clause 22(1) of the *Regulation*.
[5] See sched 6, Pt 19H Div 1 clause 9 of the 1987 Act.

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- injury management consultant reports
- the worker's self report of their abilities and any other information from the worker
- the injury management plan
- reports from a workplace rehabilitation provider such as workplace assessment reports, return to work plans, functional capacity evaluation reports, vocational assessment report, work trial documents, job seeking logs, activities of daily living assessments, etc
- information from the employer such as documents relating to return to work planning
- information obtained and documented on the insurer's claim file.

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 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.[6] 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:

[6] 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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- 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 when 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 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.[7] The notice

[7] But cf: footnote 2 *supra*.

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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.

Process of the Insurer

10. The decision reached by the Insurer appears to be within the range of available decisions which could have been made, but this is despite the processes of the insurer, rather than because of them. The applicant was advised that the documents in "a." below were considered prior to the decision being made. It is not a full list, but is illustrative of the Insurer's approach. It is noted that some documents are more than four years old and others three years old. For reasons appearing in paragraph 8(a)-(c) above it is obvious that the documents listed in "b." below were not considered until well after the decision had been made

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a. Documents/evidence on which the Insurer relied in making the work capacity decision

- Worker Certificates of Capacity issued by nominated treating doctor dated 15 January 2013 and 16 March 2013.
- Email from the applicant dated 18 March 2013.
- NS Labour Market Analysis dated 19 February 2013.
- NS Assessment Report dated 18 August 2011.
- Vocational assessment report dated 5 June 2010.
- IME Report Dr S dated 30 October 2010.
- IME Report Dr L dated 22 January 2009.
- Vocational assessment report dated 22 January 2009.
- Section 53 Retraining submission dated 25 May 2009.
- Payslip (undated).

b. Documents acquired by the Insurer for unknown purposes following internal review

- IME report of Dr P dated 22 July 2013.
- Supplementary IME report of Dr P dated 1 August 2013.

11. It can be seen from the lists above that the Insurer had regard to

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various documents, including IME reports, which might not be thought current. This may go some way to explaining why it was that the applicant found himself being examined by Dr P the day *after* WorkCover had issued a Merit Review determination; but while it may be a partial explanation, it does not excuse the failure of the insurer to have a current IME report prior to conducting an assessment and making a decision.

My Reasons:

12. The reasons given by the applicant for seeking procedural review (as set out in paragraph 8(a)-(c) *supra*) are in every instance issues going to the merits of the decision reached. He is effectively arguing that the decision is against the weight of the evidence, and certainly against the most recent independent medical evidence. But in this case the underlying problem is that by arranging an IME appointment following completion of the entire review process, the Insurer has engaged in a procedural anomaly which undermines the assessment and decision-making process. A question arises as to why any further report would be sought at such a late stage, and a further question arises as to why, having obtained the report (and the supplementary report which reinforced it), the Insurer chose not to accept its findings and vary the original work capacity decision. Since the reports were obtained following the completion of the Merit Review by WorkCover, it can reasonably be argued that the applicant has been denied a proper opportunity to have the decision scrutinised on the merits.

(i) Nowhere in the *Review Guidelines* does it say that an insurer may obtain further medical reports in the course of internal review or at any stage following the making of a work capacity decision. An insurer may solicit new information or documents from a worker,[8] but there is no provision allowing for the collection of additional medical reports in the insurer’s interests.

(ii) This has wider implications, since the consideration of newly acquired medical evidence obtained by the Insurer takes the Insurer back to

[8] See Guidelines 7.1.3 and 7.4 of the *Review Guidelines.*

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the stage of assessment. It might reasonably be thought that the Insurer has made a decision prior to the completion of the assessment process. How this decision can then be said to "arise from the first work capacity assessment" as required by clause 22(1) of Schedule 8 of the *Workers Compensation Regulation* 2010 is unknown.

(iii) In order for the decision-making process to be comprehensible, the assessment process must have an end-point. But when an Insurer obtains reports post-dating the completion of the merit review process, it is clear that the assessment process has either (a) continued beyond the date of the original "decision" or (b) become confused and conflated in the mind of the Insurer with the decision-making process. As the *WorkCover Work Capacity Guidelines* say at *Guideline* 5:

> 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 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.

(iv) The *Guidelines* have been breached in more than one respect. In *Guideline 5.4.2* insurers are given a decalogue of bullet points to comply with when sending out a notice of a work capacity decision, including but not limited to:

- reference the relevant legislation
- advise when the decision will take effect
- 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

In the letter to the applicant dated 28 March 2013 reference was correctly made to sections 43 and 54 of the 1987 Act. The applicant was wrongly told that his weekly payments would be reduced to nil from 28 June 2013, since this did not allow for the postal service rule

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and the correct date of 8 June 2013 should have been given. Unusually, this was corrected in the letter dated 21 May 2013 advising of the outcome of internal review. In that letter the earlier error was noted and further notice was given, this time to 28 August 2013. Accordingly there is no live issue surrounding the giving of notice under section 54, since the letter of 21 May 2013 gives three months notice plus seven days for postal service in accordance with both the postal service rule and the more recently issued *WorkCover Work Capacity Guideline* 6 gazetted on 9 August 2013.

(v) In the same letter of 28 March 2013 the applicant was told that his entitlement to “medical treatment” would cease twelve months after his weekly payments ceased, this being the effect of “section 59.” First, the relevant section is 59A. Secondly, section 59A does not prevent a worker seeking or having any medical treatment at any time. What it provides for is that *payment by the insurer for* medical and related treatment expenses ceases twelve after the cessation of weekly payments. Thirdly, the applicant was not told of the provision in section 59A(3) which allows for further payment of such expenses in the event that weekly payments are at any time resumed. All three errors are in breach of *Work Capacity Guideline* 5.4.2. Relevantly, section 59A is in these terms:

59A Limit on payment of compensation

(1) Compensation is not payable to an injured worker under this Division in respect of any treatment, service or assistance given or provided more than 12 months after a claim for compensation in respect of the injury was first made, unless weekly payments of compensation are or have been paid or payable to the worker.

(2) If weekly payments of compensation are or have been paid or payable to the worker, compensation is not payable under this Division in respect of any treatment, service or assistance given or provided more than 12 months after the worker ceased to be entitled to weekly payments of compensation.

(3) If a worker becomes entitled to weekly payments of compensation after ceasing to be entitled to compensation under this Division, the worker is once again entitled to

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compensation under this Division but only in respect of any treatment, service or assistance given or provided during a period in respect of which weekly payments are payable to the worker.

(vi) The breaches noted in (v) above were compounded by the Insurer in the letter dated 21 May 2013. In that letter the Insurer made two significant procedural errors: (a) having advised the applicant of the new date of cessation of weekly payments in accordance with the requirements of section 54, the Insurer did not also alter the date previously advised for the cessation of payments due to the operation of section 59A (the new date would have been 28 August 2014), and (b) the Insurer went so far as to make the following inaccurate, misleading and somewhat grammatically challenged remark:

"We can confirm that ***the work capacity decision*** only related to your entitlements to weekly benefits and ***does not affect other entitlements that you may be entitled to under the Act***."

13. The Insurer has therefore breached the *Work Capacity Guidelines* at 5.4.2 in relation to advising the applicant as to the effect the work capacity decision will have on his entitlements to payments under section 59 and 60 by virtue of section 59A, has exceeded what is allowed by the *Review Guidelines* in obtaining IME medical reports after the review process had already concluded, and has also thereby taken itself outside clause 22(1) of Schedule 8 to the *Workers Compensation Regulation* 2010 by continuing the assessment procedure long after the decision had been announced, which also creates a cart-before-the-horse problem in relation to clause 23 of Schedule 8 to the *Regulation* which is in the following terms:

23 Work capacity decision to be made as soon as practicable after assessment

An insurer must, for the purposes of Division 2 of Part 19H of Schedule 6 to the 1987 Act, make a work capacity decision in respect of an existing recipient of weekly payments as soon as practicable ***after the first work capacity assessment*** of the worker is conducted by the insurer as required by that Division.

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By obtaining the IME reports the insurer has prolonged the assessment process to such an extent that it cannot be accepted that the decision was made “after the first work capacity assessment” – rather I would incline to the view that the work capacity decision was made while the assessment process was still incomplete.

14. The *WorkCover Work Capacity Guidelines* at 2.4 states the following:

> Work capacity assessments should be tailored to the worker. An understanding of the worker’s circumstances and their injury ensures the right approach ***at the right time***.

This applicant had his work capacity assessed in the absence of recent IME reports precisely because the Insurer chose to ignore *Guideline* 2.4 and preferred their own convenience to his. The reports could and should have been obtained prior to completion of the assessment process in order to properly inform the decision-making process.

My Recommendation:

15. I recommend that the insurer conduct a new work capacity assessment of the applicant before making a new work capacity decision in accordance with the legislation, *Regulation* and *Guidelines.*

16. Since the applicant was an existing recipient as at 1 October 2012, he remains entitled to receive his pre-transition rate of weekly benefits 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 period has expired. The applicant should be reinstated to his pre-work capacity assessment/pre-work capacity decision rate of compensation.

17. In any notice issued pursuant to section 43 and *Guideline* 5.4.2 the applicant should be advised of the date or dates on which his first work capacity assessment is or was completed.

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18. If required, I recommend that the Insurer issue a further section 54 notice, which gives the applicant three clear months notice of variation of his weekly payments.

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19. 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
25 September 2013