WIRO
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 suffered injury to her left shoulder and neck in August 2004 while employed by LAC. She continued with that employment until 2007, but was terminated in March of that year. In February 2010 she started with BS as a level 1 kitchen hand, and remains with that employer at present, working approximately 25 hours per week.

3. There is no dispute about the injury having occurred in the course of employment. Liability was accepted and the insurer made 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 20 May 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 gave the applicant notice pursuant to Section 54 of the 1987 Act of the reduction of her weekly payments to "nil." The applicant was advised that the payments would reduce to "nil" as from 27 August 2013, that is, three months and seven days from the date of the letter. She was also told that her entitlement to "medical treatment" would "therefore expire" on 27 August 2014 by operation of "section 59."

5. On 26 June 2013 the Insurer wrote to the applicant advising of the outcome of an internal review of the decision dated 20 May 2013. The internal review upheld the original decision, but made some odd observations, including this:

[1] As defined in Schedule 6,Part 19H, Division 1 of the *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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"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 6 August 2013. The Reviewer varied the determination of the Insurer, finding that the applicant was entitled to ongoing payments at a rate of $217.89 per week.

7. On 12 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.[3]

Applicant's grounds of review

8. The applicant makes the following points:

   (a) The applicant says that the work capacity decision is based on incorrect criteria, since both the Insurer and the merit reviewer accepted the report of W dated 19 December 2012, which recognised no distinction between her current occupational grading (kitchen hand, level 1) and the much higher level of kitchen hand (kitchen hand level 5) which includes skilled trades people, such as cooks. The applicant has no trade qualifications and could not possibly be employed as a level 5 kitchen hand. She has certainly never been given or offered any training as a cook or any other trade training by the Insurer.

   (b) The applicant alleges that the WorkCover Merit Review service made their decision based on further inappropriate criteria, since they say at paragraph 37 of the decision dated 6 August 2013 that the hourly rate for a kitchen hand is $21.31. The applicant notes that this is the causal rate and that if she were employed as a casual there is no guarantee that she would get 25 hours work per week, which she does at present.

[3] Numbered 7.4 in the current version (see footnote 2).

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(c) The applicant alleges that the report by W was based on insufficient information, since no physical review was conducted at the time, due to her having an elevated pulse, the circumstances being described thus:

"A physical review was unable to be done because during the lunch break I found out that my brother-in-law had passed away and my pulse was over 100. I was informed that the physical part of the review could not take place because of this. W contacted [the] case manager from [the Insurer] and were told not to worry about it. In a further conversation with [the case manager] she said that she will use the vocational assessment."

The applicant also observes that the final rehabilitation report from CRSA, dated 5 October 2010, is "not current" and therefore does not reflect her present condition and situation.

Insurer's Reply

9. In response to the applicant's submissions the Insurer submitted a brief summary and timeline, which accords with the history as set out in the Merit Review decision and the applicant's documents and submissions. The Insurer also forwarded a number of supporting documents.

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. 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

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11. The decision reached by the Insurer appears to be within the range of possible outcomes for a worker in the position of the applicant. To the extent that the decision was either incorrect or inadequate, this was remedied, at least in part, as a result of the merit review process. The work capacity decision maker had regard to the following list of documents:

- WorkCover Medical Certificates dated 07/08/2012, 15/11/2012, 21/02/2013 and a Certificate of Capacity dated 29/04/2013 completed by Dr MB (the applicant's nominated treating doctor [NTD])
- Medical Report by the NTD dated 02/05/2013
- Independent Medical Examination Report of Dr AM (Occupational Medicine) dated 18/03/2013
- Final Rehabilitation Report dated 5/10/2010 from CRSA.
- 'Capacity to Work' report from W dated 19/12/2012
- Payslips from BS dated variously and continuously between 22/10/2012 and 06/05/2013
- Various emails from the applicant

The applicant objects to the report from W on the basis that it was completed in the absence of any physical testing or examination due to the high pulse rate of the applicant at the time. The applicant also objects to the Final Rehabilitation Report of CRSA on the basis that it was more than two years old at the time of the work capacity decision, thereby lacking currency.

My Reasons:

12. I can have no regard to the processes of Merit Review undertaken by the Authority. Nor can I look to the merits of the case when undertaking procedural review. The applicant raises grounds (set out at paragraph 8 (a)-(b) *supra*) which go to the merits of the case, including the decision of the Merit Review Service, which cannot assist her for current purposes.

13. The applicant is much closer to the mark in questioning the processes undertaken by W in the preparation of their report dated 19 December 2012. While I must reject any reliance upon hearsay evidence, such as the report of a person from the Insurer telling W "not to worry about" undertaking a review of the applicant's physical capabilities, it is

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concerning to learn from the applicant that a physical review was never undertaken, at least ostensibly because she had an elevated pulse rate on one particular day, having heard of a family bereavement. There appears to be no reason for the work capacity assessment to have been regarded as so urgent that a physical review of the applicant could not be postponed for a day or a few days or weeks. This appears to be a clear breach of the *WorkCover Work Capacity Guidelines*.[4] Relevantly, *Guideline* 2.4 is in the following terms:

> **2.4 A tailored approach**
>
> 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.

The failure of the Insurer to insist on a report from W which assessed the physical capacity of the applicant appears to have been the result of a conscious decision by either the Insurer or their agent or both of them to not reschedule the physical review for a time suitable to the applicant, when she was not likely to have an elevated pulse-rate. Therefore the Insurer and their agent have preferred their convenience to the needs of the applicant.

14. The objection by the applicant to the lack of currency of the Final Rehabilitation Report of CRSA (dated in 2010) might have had more force if the reports of CRSA were in any way binding on Insurers; but since such reports form only a part of the documentary record considered by the insurer, which had access to more recent reports from treating doctors, an IME and (for what it was worth) W, it is possible that the report was given only slight weight by the Insurer. I do not understand the applicant to be saying that she has deteriorated physically since 2010, so the objection might over-estimate the relevance of a rehabilitation report, whenever dated.

15. This insurer has breached the *WorkCover Work Capacity Guidelines* in the manner and form in which notice of the work capacity decision was

[4] See Guideline 2.4 of *WorkCover Work Capacity Guidelines* as gazetted on 28 September 2012.

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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

• 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).

16. This applicant was given different advice concerning ongoing entitlement

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to “medical benefits”[5] in the letter dated 26 June 2013 to the advice previously given in the letter dated 20 May 2013. 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.

In the letter advising of the original work capacity decision dated 20 May 2013 the applicant was given the following information:

> “[The Insurer] will continue to approve reasonable and necessary **treatment expenses** as defined by Section 60 of the *Workers Compensation Act* 1987. However, under Section 59 of the Act 1987, your entitlement to **medical benefits** is limited to a period of 12 months after weekly benefits cease. Your entitlement to **medical treatment** will therefore expire on 27/08/2014.”

The applicant was not referred to section 59A of the Act, nor was she told that her right to medical and related treatment expenses could be restored in the event that weekly payments of compensation resumed at any stage in the future.[6] She was simply told that her “entitlement to medical treatment” would “therefore expire.”

Leaving aside the slippery syntax involved in referring to section 59 instead of section 59A and referring to an “entitlement to medical treatment” instead of an entitlement to payment for medical and related treatment expenses, the Insurer did at least seek to convey the idea that the work capacity decision would have an adverse effect on the entitlement of the applicant to expenses in the way set out in section 59A(2).

The letter dated 26 June 2013 advising of the outcome of internal review provides the reader with a stark parataxis contrasting the three sentences quoted above with the following single sentence:

[5] A seeming lexical trimeme, described alternatively as “treatment expenses,” “medical benefits” and “medical treatment.”
[6] See section 59A(3).

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

In the event that the applicant had understood the first letter dated 20 May 2013 to be telling her that her entitlements to medical and related treatment expenses would cease one year following the cessation of her weekly payments, the second letter dated 26 June 2013 would have told her that this was not the case, since the work capacity decision was said to have no impact on her other entitlements. This is incorrect, misleading and in clear breach of the *Guidelines*.

17. 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. In the current matter the *Guidelines* have been breached at least three times.

My Recommendation:

18. I recommend that W or another provider be commissioned to provide an updated work capacity assessment to the Insurer, this time including a physical review of the applicant, in accordance with what was originally intended in December 2012.

19. I recommend that the Insurer allow the applicant to make further submissions in relation to the level of trade qualifications she has or would need in order to obtain and perform the duties of suitable employment, including a level 5 kitchen hand.

20. I recommend that the Insurer issue a proper notice in accordance with *Guideline* 5.4.2, setting out the full impact of the work capacity decision, including the termination of medical expenses 12 months following the cessation of weekly payments including references to the relevant sections of the legislation, including section 59A(2) and (3) of the 1987 Act.

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21. Since the applicant was an existing recipient of weekly payments as at 1 October 2012, she remains entitled to receive her pre-transition rate of weekly payments until such time as she is validly transitioned under the Act.

22. 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
1 October 2013