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 This latter information[3] might be superseded at least in part by a letter dated 20 May 2013 purporting to be a section 74 Notice terminating liability for specific medical or related treatment, identified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 treatment 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 cryotherapy 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, contradictory, internally inconsistent and opaque as to render a complete understanding all but impossible.[6]

[6] New *Guidelines* were gazetted on 8 October 2013 [to take effect on 11 October 2013] which appear to be an improved version.

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Process of the Insurer

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

- a vocational assessment report of Ip 18/12/2012
- a functional capacity report of Ip 17/12/2012
- a workplace preparation and job-seeking skills training report from Ip 07/03/2013
- various medical certificates from Dr M (x 3)
- a report of Independent Medical Examiner Professor K dated 15/03/2013
- two medical reports from Dr 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. Of the grounds relied upon by the applicant and enumerated at paragraph 8 (a)-(d), the first three appear to be procedural and the last is an objection he raises to the effect of the section 74 Notice, which is beyond the jurisdiction of the Independent Review Officer. The applicant may have other remedies in another place in relation to the section 74 Notice. The procedural grounds can be dealt with shortly:

(a)-(b) The Insurer admits that the "fair notice" telephone call on or about 25 March 2013 was unintelligible for the applicant. This is a clear admission that one of the mandatory requirements as set out in the *Work Capacity Guidelines* was not satisfactorily complied with. There was no explanation from the Insurer as to why they did not simply ring the

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applicant back hoping for a better connection on the next occasion. It would seem to be an obvious step. The relevant *Guideline* requires the fair notice call to be made "at least two weeks prior to the work capacity decision"[7] although it is not mandatory that a telephone call be made. The *Guideline* uses this wording:

> "Before making a work capacity decision that may result in a reduction or discontinuance of the worker's weekly payments the insurer must, at least two weeks prior to the work capacity decision, communicate this to the worker in a way that is appropriate in the circumstances of the case and preferably by telephone or in person."[8]

Since the applicant concedes that he received written notice by 2 April 2013, a date which precedes the date of the letter enclosing written notification of the work capacity decision by more than two weeks, it may be that this *Guideline* has not been breached. If a decision had been made before 16 April 2013, that position would be different.

(c) The Insurer made a work capacity decision about this applicant prior to receipt of reports from his pain specialist (or any pain specialist), despite comment from the Independent Medical Examiner that such a report or reports may be necessary in light of the complexities of the case, which involved pre-existing injuries.

This situation is not remedied by the late reports obtained by the Insurer some weeks following the original work capacity decision at the behest of the applicant. At the least it means that the assessment process was not completed at the time of the original decision, and since the reports certainly did form part of the documentary evidence on which the internal review decision was made, that internal review decision must be treated as a new decision. It follows that the notice provisions and the review procedures would commence again from the date of that later decision. It is hard to see how clause 23 of Schedule 8 to the *Workers Compensation Regulation* 2010 (the Regulation) can be complied with in these circumstances. Clause 23 is in these terms:

[7] See *Work Capacity Guideline* 5.2.
[8] In the August 2013 version, the words "*that may result in a reduction or discontinuance of the worker's weekly payments*" had been removed, for reasons which are not obvious. They now reappear in the October 2013 version.

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> **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.

For present purposes, either the assessment process was not completed by 17 April 2013 and was only completed once the Insurer read the reports of Dr R in May 2013 (which must result in procedural unfairness to the applicant), or the assessment process might be thought to be ongoing. But the "ongoing process" argument does not sit at all well with the requirement that a decision be made "as soon as practicable after the first work capacity assessment ... conducted by the insurer" as those words appear in clause 23, Schedule 8 of the Regulation.

12. In addition to what appears above, 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 (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

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set an earliest possible date of 24 July 2013.[9] The situation was exacerbated somewhat by the following words having appeared in the letter of 17 April 2013:

> "Your entitlement to weekly payments at your current rate must cease within 3 months of this decision: Section 54(2)(a) of the *Workers Compensation Act* 1987."

As opposed to this misrepresentation, the wording of the relevant section is this:

> **54 Notice required before termination or reduction of payment of weekly compensation**
>
> (1) If a worker has received weekly payments of compensation for a continuous period of at least 12 weeks, the person paying the compensation must not discontinue payment, or reduce the amount, of the compensation without first giving the worker not less than the required period of notice of intention to discontinue payment of the compensation or to reduce the amount of the compensation.
> Maximum penalty: 50 penalty units.
>
> (2) The **"required period of notice"** for the purposes of this section is:
>
> > (a) 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 section clearly does not require the cessation of payments "within 3 months" of a work capacity decision: it requires the Insurer to give a worker a ***minimum*** of 3 months notice prior to the cessation of payments. The difference is considerable.

[9] Since 9 August 2013 insurers would be bound by *WorkCover Work Capacity Guideline* 6 which requires seven days to be allowed for postal service. (But see footnote 10 *infra*.)

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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 for service) given to the worker.

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

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• 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).

18. The 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(2) of the 1987 Act. Further, there is no reference to section 59A(3) which allows for the reinstatement of medical and

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related treatment expenses upon the resumption of weekly payments at any time in the future.

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 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 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.

22. 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. Such notice should include four clear working days for service by post and comply with *Guideline* 6 which was gazetted on 8 October 2013.[10]

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

[10] Note that while the *Guideline* 6 in force between 12 August and 10 October 2013 required 7 days for postal service, the latest iteration says that delivery will be "taken to have been received" on a day "4 days after the document is posted." This is in conflict with s 76(1)(b)of the *Interpretation Act* 1987 which refers to "working days" and excludes weekends and holidays.

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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
10 October 2013