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

2. The applicant suffered injury to his right wrist in the course of his employment as a shearer. On or about 16 September 1987 he reported symptoms which had in all likelihood developed over a period of time. Since he ceased working as a shearer the applicant has engaged in casual farm work and received weekly payments of compensation. There is no dispute about the injury having occurred in the course of employment.

3. The insurer accepted liability and made continuing weekly payments for all periods of incapacity until 2013. Accordingly the applicant was an "existing recipient of weekly payments" of compensation (as that term is defined in Schedule 6, Part 19H Division 1 of the *Workers Compensation Act* 1987 [1987 Act]) immediately prior to 1 October 2012.

4. On 4 April 2013 the Insurer, having completed an assessment of the work capacity of the applicant, issued a notice of a work capacity decision pursuant to Section 43 of the 1987 Act. The Insurer also gave 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 "4/07/2013."

   Relevantly, the applicant was advised in the following terms:

   > We have carefully considered your claim and have made a work capacity decision that will take effect from 4/07/2013.
   >
   > Up until recently you have been paid weekly benefit compensation under section 40 at the rate of $878.20. This decision will mean that you no longer have any weekly benefit entitlement. In line with the notice period [the Insurer] is required to give under Section 54, your weekly benefits will

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continue at the current rate for three months to 1/07/2013.[1] The change in your benefit rate will become effective following this notice period.[2]

The decision is only related to weekly benefit compensation payments on your claim. However, under Section 59 entitlement to medical treatment only extends for a 12 month period after weekly benefit payment ceases. Your entitlement to medical treatment will therefore cease from 2/07/2014.[3]

5. On 6 June 2013 the Insurer wrote to the applicant advising of the outcome of an internal review of the decision dated 4 April 2013. The internal review upheld the original decision.

Relevantly, the applicant was further advised in the following terms:

> In line with Section 54 of the *Workers Compensation Act* 1987, the initial notice period continues to aply resulting in discontinuation of your entitlement to weekly benefits from $878.20 per week to $0 effective from **11/07/2013**.
>
> Please be advised that the date has been amended from the original date of 04/07/2013 in accordance with Section 54(3)(b) of the *Workers Compensation Act* 1987 and the WorkCover *Guidelines*.[4]
>
> 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.**

[1] Despite the letter being dated 4 April 2013 and notice in the previous paragraph being expressed (equally incorrectly) to expire on 4 July 2013.
[2] See footnote 1.
[3] A date inconsistent with notice being given to 4 July 2013, but consistent with the presumptive (while still incorrect) date of 1 July 2013.
[4] Neither section 54 of the Act nor the *Guidelines* authorise the amendment of a period of notice in this way.

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

7. On 6 September 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 correct form.

Applicant's Stated Grounds of Review

8. The applicant protests the decision of the insurer on the following grounds:

(a) The Insurer has not taken into account or given proper weight to the reports of the applicant's treating doctors and has instead given undue weight to the reports of doctors retained by the Insurer.

Submissions in Reply from Insurer

9. In response to the application, the Insurer submitted the following timeline and list of documents:

Below is a brief summary/timeline of work capacity events on this claim to date:

- A fair notice call was delivered to [the applicant] on 05/03/2013. [The applicant] was advised that the reason for the telephone call was to discuss changes in the legislation and how this would impact his claim. He was then advised he would be contacted in 2 weeks in regards to a decision on his claim.
- A WCD was made on this claim on 04/04/2013. [The applicant] was contacted on the same day and advised that a WCD had now been made on his claim and when his weekly benefits would cease. The decision was based on various medical and rehabilitation reports. [The applicant] was advised that we will be forwarding a copy of all reports relied upon in making our decision and explained

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the review process. [The applicant] was advised that medical treatment will continue for 12 months after the date his weekly benefits cease.

- [The applicant] completed an Application to Insurer for Internal Review on 07/05/2013. An acknowledgement letter was also sent to [the applicant] on 13/05/2013 advising that a decision would be made by 06/06/2013.
- Phone call to [the applicant] on 03/06/2013 to clarify conflicting information regarding statements made in the Application for Internal review and information on our file. The Application states that he is currently involved in "self employment in relation to the activities upon the farmlet owned by his wife and of which exceed 15 hours per week and produce earnings of at least $155.00 per week." Information on [the Insurer's] file indicates [the applicant] is currently not working or earning any income. [Applicant] confirmed he is currently not working or earning any income. [The applicant] was advised that the conversation would be file noted to confirm that he is not involved in any employment.
- On 05/06/13 new information was received from [the applicant]. He submitted his 2012 Taxation Return for returns on a family partnership. It stated [the applicant's] occupation as a farmer or farm overseer and the main business activity is Horse Breeding. The business income is $21,755.00 for the year.
- Phone call to [the applicant] on 06/06/2013 advising the outcome of the internal review. He was advised he has no entitlement to ongoing weekly benefits as medical evidence on file supports that he has a current work capacity for full hours and also based on the Earning Capacity Assessment supporting his earnings in suitable employment. A letter was sent to [the applicant] on 06/06/2013 explaining the reasons for the decision and also provided information on how to request a review of this internal decision.
- A Work Capacity – Application for Merit Review by the Authority form was completed by [the applicant] on 03/07/2013 and received by [the Insurer] on 08/07/2013. Attached previous information supplied from Internal Review. Page 1 of the application was not received therefore e-mail was sent to [the applicant] requesting he forward which was received on 09/07/13.
- [Insurer] completed a Work Capacity – Reply to an Application for Merit Review on 11/07/13 with a copy being sent to merit review and also [the applicant] on this day.

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- A merit review was completed on 09/08/2013 by Merit Review Service which found that [the applicant] has current work capacity and has received greater than 130 weeks of weekly payments. In accordance of the Workers Compensation Act 1987, [the applicant] has an entitlement to weekly payments of compensation in the amount of nil.
- WIRO Application for Review of Work Capacity Decision completed by [the applicant] on 06/09/13.

Please find attached copies of the following:

- Fair notice letter and file note dated 05/03/13
- WCD file note dated 04/04/13
- WCD Letter dated 04/04/2013
- Application to Insurer for Internal Review dated 07/05/13
- Acknowledgement of Application to Insurer for Internal Review dated 13/05/13
- File note dated 13/05/13
- File note dated 03/06/13
- File note dated 05/06/13
- Notification of [Insurer] Internal Review Decision letter dated 06/06/13
- File note dated 06/06/13
- Work Capacity – Application for Merit Review by the Authority form completed by [the applicant] dated 03/07/13 including attachments
- File note 08/07/13
- E-mail 09/07/13
- Work Capacity – Reply to an Application for Merit Review completed by [Insurer] dated 11/07/13
- WorkCover Merit Review dated 09/08/13
- Application for Review of Work Capacity Decision completed by [the applicant] dated 06/09/13.

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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. 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[5] (the Regulation) which purports to amend the 1987Act[6] in a way which is both confusing and most probably invalid. A person hoping to fully comprehend the process requires an understanding of the 1987 Act, the *Workplace Injury Management and Workers Compensation Act* 1998 (1998 Act), the Regulation and up to three iterations of two separate sets of *Guidelines*[7] issued by WorkCover.

The *WorkCover Work Capacity Guidelines* which were gazetted on 28 September 2012[8] set out the necessary requirements of a *Work Capacity Decision Notice* at 5.4.2 thus:

> **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

[5] See schedule 8, clause 22(1) of the *Regulation*.
[6] See sched 6, Pt 19H Div 1 clause 9 of the 1987 Act.
[7] *Work Capacity Guidelines* and *Review Guidelines*.
[8] Now replaced by the *WorkCover Work Capacity Guidelines* gazetted on 8 October 2013. In this case the relevant version remains those *Guidelines* gazetted 28 September 2012.

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• 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 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, *Application for review of a work capacity decision by insurer*.

There is a great deal of ground covered in those ten points, which may lead to difficulties with compliance. A particular difficulty is caused by the jussive efference from the word “must” immediately prior to the first bullet point. It would follow that a breach of even a single element of this decalogue similarly ‘must’ result in invalidity. While such invalidity would arise from no more than a close examination of what might be thought the trifling niceties or incidental quiddities inherent in the application of a set of inflexible rules to an individual factual matrix, it is the very existence and application of those rules which provide the only protection to a worker who might otherwise be seriously disadvantaged financially as a result of an error or errors made by an insurer.

Process of the Insurer

11. The work capacity decision reached by the Insurer appears to be within the range of available decisions and was upheld on merit review. The Insurer had regard to the following documentary evidence when making the original work capacity decision:

- Report from Dr P (IME) dated 29/06/12
- Vocational Assessment Report dated 30/06/09
- Copy of Terms of Settlement dated 05/05/92
- Report of Prof C dated 22/07/08

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- Statutory Declaration of dependants and employment dated 17/08/05 and 18/03/08
- Emails from RM of NS of 08/07/11, 11/07/11, 12/07/11 and 29/07/11
- WorkCover Medical Certificate dated 20/02/09 from Dr A
- Earning capacity Assessment Report from NS dated 13/09/11
- Dr A's approval of Vocational Options dated 08/11/11
- Closure report from NS dated 10/02/12
- Report of Dr O (IME) dated 11/05/11
- Report from FH of TW dated 10/08/10
- Report of Dr M, orthopaedic surgeon, dated 24/04/96.

A thorough reading of the above list might cause a question to be asked as to why there are no medical reports post-dating 29 June 2012. It is no particular asperity to say that this question was probably anticipated by the Insurer, since three further reports were belatedly obtained following the letter dated 4 April 2013. They are enumerated in the letter advising the applicant of the outcome of internal review dated 6 June 2013. They are listed as follows:

- Medical report from Dr M (Hand, Plastic and Reconstructive Surgeon) dated 30/05/13
- Medical report from Dr H (Treating Hand and Wrist Surgeon) dated 11/04/13
- Medical report from Dr R (Treating Orthopaedic Surgeon) dated 08/04/213.

It is noted that two of these three reports are from the applicant's treating doctors.

My Reasons:

12. The reasons given by the applicant for seeking procedural review can be dealt with under the lettering used in paragraph 8:

(a) The Insurer has not taken into account or given proper weight to the reports of the applicant's treating doctors and has instead given undue weight to the reports of doctors retained by the Insurer.

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It is hard to see a flaw in the applicant's reasoning, particularly since relevant updated reports from his treating doctors were not obtained by the Insurer until a date following the assessment and the date of the letter advising the applicant of the work capacity decision. The reports were certainly obtained prior to notification of the outcome of the internal review, but by then the damage was both done and irreparable. Rather than wait for a week or two, the Insurer has for undisclosed reasons made a premature decision in the absence of reports which it clearly believes to be relevant, as is evident by the very fact that the Insurer ultimately obtained them. This must be a breach of the *Guidelines* requiring the Insurer to consider carefully all available evidence and a breach of the regulation requiring a work capacity decision to be made as soon as practicable *following* a work capacity assessment.[9] It is not possible for the Insurer to seriously argue that the assessment process had ended prior to a decision being made when no less than three further medical reports were obtained in the process of internal review.

The review *Guidelines* do allow for an Insurer to request further information from workers in the course of internal review,[10] but there is nothing in the *Guidelines* which allows the Insurer to breach the *Regulation* or to obtain further evidence to support its own position.

13. In addition to the ground relied upon by the applicant, there are other bases on which this decision might be determined to be invalid, including but perhaps not limited to the following:

a. In the letter dated 4 April 2013 the Insurer breached the notice provisions set out in the *Guidelines* and the *Interpretation Act* 1987 by purporting to give the applicant precisely three months notice under section 54 from the date of the letter rather than allowing additional time for postal service;

b. The Insurer unsuccessfully tried to remedy this breach in the second letter dated 6 June 2013 by purporting to extend the original notice period by a further seven days, rather than giving a new notice of three months plus time for postal service dated from 6 June 2013;

[9] See Schedule 8, clause 23 of the *Workers Compensation Regulation* 2010.
[10] See cll 7.1.3 and 7.4 of the *Review Guidelines*.

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c. The first letter contained incorrect and misleading information about section 59 in that it did not reference section 59A(2) or (3) and said that the provisions causing payments to cease 12 months after the cessation of weekly benefits could be found in section 59 itself. The failure to reference section 59A(3) meant that the applicant was never advised that his right to medical benefits could return if he were ever to be in further receipt of weekly benefits in the future;

d. The information sought to be conveyed in the first letter about the cessation of medical benefits was contradicted in the second letter by the Insurer saying that the work capacity decision only affected weekly payments and no "other entitlements"; in the event that the applicant had understood the insurer to be saying that medical benefits would cease 12 months after cessation of weekly benefits in the first letter, that understanding would not have survived a reading of the second.

e. The obtaining of new reports by the Insurer in the course of internal review must mean that the assessment process had not ended when a decision was made. It further creates an unfairness in that the applicant had no opportunity to address the contents of any of the reports prior to the original work capacity decision being made.

14. Under the legislation the Insurer can make an assessment of the applicant's work capacity and then a decision about that work capacity, but they must comply with the legislation, the Regulation and the *Guidelines* in order to produce a procedurally correct result. In the current instance there has been a breach the *Guidelines* which are to be treated as delegated legislation, the Regulation and even the rules of natural justice.

My Recommendation:

15. 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 43 is issued and the relevant notice period under section 54 has expired. The applicant should be reinstated

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to his pre-work capacity assessment/pre-work capacity decision rate of compensation.

16. I recommend that a further work capacity decision be made in light of the new evidence obtained by the Insurer in the course of the previous internal review. The applicant should be afforded the opportunity to address the Insurer on the content of the more recent reports, an opportunity previously unavailable to him.

17. In any future notice of an outcome of internal review the Insurer should delete the following sentence from their precedent form letter:

> "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."

18. 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
29 October 2013