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 licensed self insurer (Insurer) under the New South Wales workers compensation scheme. The Insurer was also the employer of the applicant.

2. The applicant suffered injury on or about 20 August 2007 in the course of his employment with the Insurer as a Storeperson. There is no dispute about the injury having occurred in the course of employment. The applicant is currently self-employed.

3. The Insurer accepted liability and made continuing weekly payments for all periods of total or partial 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 1 May 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 6 August 2013.

   Relevantly, the applicant was advised in the following terms:

   > ... your weekly compensation benefits will be reduced to $zero per week commencing from 6 August 2013.[1]

[1] It might be noted for future reference at this point that the applicant was not told that his entitlement to weekly benefits would *cease*.

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5. On 11 June 2013 the Insurer wrote to the applicant's legal representatives advising of the outcome of an internal review of the decision dated 1 May 2013. The internal review upheld the original decision.

Oddly, the letter dated 11 June 2013 was given the following heading:

> **REVIEW NOTICE UNDER SECTION 74 OF THE WORKPLACE INJURY MANAGEMENT AND WORKERS COMPENSATION ACT 1998**

Despite the anomalous, inappropriate and inaccurate heading, the body of the letter contained this sentence:

> We have disputed ongoing weekly compensation for your claim under section 43 of the *Workers Compensation Act* 1987...

Once again the applicant was informed as follows:

> ... your weekly compensation benefits will be reduced to $zero per week commencing from 6 August 2013.[2]

6. A WorkCover Merit Review was completed and a Statement of Reasons issued, dated 9 August 2013. The Merit Reviewer upheld the determination of the Insurer. In the course of the decision, the Merit Reviewer was kind enough to make the following finding:

> 4. [The applicant] has *an ongoing entitlement to weekly payments of compensation* in the amount of nil.[3]

7. On 9 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 relevant form.

Applicant's Stated Grounds of Review

[2] See footnotes 1 and 3
[3] Emphasis added - see footnotes 1 and 2 *supra*.

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8. The applicant takes issue with the decision of the Insurer on the following grounds:

(a) Not a single medical report was referred to in the course of the Insurer's correspondence;

(b) Such medical reports as were in the possession of the Insurer were so old (October 2010 and before) as to be of no relevance to the applicant's *current* work capacity in 2013;

(c) Both the Insurer and the Merit Review service had no regard to the opinion of the applicant's current treating doctor who provided a report dated June 2013 on the basis that the doctor had not provided any previous reports; and then the Insurer had submitted at merit review (and it was accepted) that there was "no medical evidence" from the applicant of his current level of work capacity.[4]

(d) The final submission is quoted verbatim:

> It is submitted that capacity for employment cannot be determined in a vacuum. Regard must be had for the real world. The fact that the insurer have (*sic*) financially supported the Applicant by setting up his own business is evidence that they do not really believe he was capable of undertaking the work for somebody else.
>
> We maintain the submission that the amendment to section 38 was to in effect reward workers such as the Applicant who had received payments for more than 130 weeks, had returned to work for more than 15 hours per week and earning more than $155 per week. It is submitted that it is disingenuous to expect the Applicant to now effectively cease self-employment to look for employment with someone else when the Applicant shares

[4] In the course of procedural review I can have no regard to the deliberations of the merit review service; however in this case the submissions by the applicant do require an incidental recitation of the submissions made by the Insurer to the merit review service.

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> the view expressed by [his treating doctor] that he would be unable to do so.[5]

Submissions in Reply from Insurer

9. In response to the application, the Insurer submitted the following chronology:

> To assist with your review we provide the following:
>
> 1) Fair Notice phone call made to [applicant] 27 March 2013
> 2) Fair Notice letter sent 27 March 2013 advising Work Capacity Decision will be made 10 April 2013
> 3) Further Fair Notice phone call made to [applicant] 4 April 2013
> 4) Further Fair Notice letter sent 4 April 2013 advising Work Capacity Decision will be made 29 April 2013 advising [applicant] of potential decision
> 5) Work Capacity Assessment completed 30 April 2013
> 6) Work Capacity Decision letter under Section 54 sent 1 May 2013 with 3 month and 5 days notice period expiring 6 August 2013 reducing weekly benefits to Nil.
> 7) Internal Review request received 31 May 2013
> 8) Internal Review response from Insurer sent 11 June 2013
> 9) Merit Review lodged by [applicant] 12 July 2013

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[6] (the Regulation) which purports to

[5] While the applicant's current working hours at 15 or more per week were not disputed by the Insurer, and the applicant's legal representatives noted that this was "not in dispute," the merit reviewer stated in the course of reasons that " .. there is certainly no information before me to indicate how many hours per week [the applicant] is currently working." It is hard to see on what basis it is that an applicant bears an onus to prove an undisputed fact.
[6] See schedule 8, clause 22(1) of the *Regulation*.

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amend the 1987Act[7] 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*[8] issued by WorkCover.

The *WorkCover Work Capacity Guidelines* which were gazetted on 28 September 2012[9] 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
>
> • 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

[7] See sched 6, Pt 19H Div 1 clause 9 of the 1987 Act.
[8] *Work Capacity Guidelines* and *Review Guidelines*.
[9] 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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• 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 temper induced by 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. This position is fortified by the status of the *Guidelines* as delegated legislation.

Process of the Insurer

11. The 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 work capacity decision:

- Functional Assessment provided by IT 2 January 2013
- Vocational Assessment provided by IT 21 December 2012
- Final Maximum Medical Improvement Certificate 14 October 2010.[10]

Those are the only documents referred to in the letter dated 1 May 2013 advising the applicant of the work capacity decision. In the letter dated 11 June 2013 advising of the outcome of internal review the Insurer enumerated the following documents in addition to those above:

- Initial WorkCover Medical Certificate issued by Dr M 22 August 2007[11]
- Written statement and quarterly earning statements submitted by [the applicant]

[10] No provider name is given in relation to this document. In subsequent correspondence the author of the document is described as the applicant's Nominated Treating Doctor.
[11] That is, the insurer purported to rely on a document prepared six [6] years ago, some two [2] days after the date of injury.

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It is of interest that the Insurer nowhere refers to the report of Dr P, dated 11 September 2008. While the merit reviewer describes this report as "well dated" (by which it can only be concluded that the report was thought to be of little relevance due to age), the Insurer does not refer to it at all. This is unusual in a case where a document dated August 2007 is thought be important enough to warrant a reference in the letter advising the outcome of internal review. It is also a breach of the *Guidelines*, which require an Insurer to evaluate "all available and relevant evidence" in the course of making a work capacity decision.[12]

"Evaluation" in this context would go beyond mere reference and would require something greater than an enumeration of the documents by title, date and author. The Guidelines do not authorise an insurer to simply say "we have carefully considered your claim" then list a series of documents with no commentary on their contents. In the words of Gummow and Hayne, JJ it is

> not enough for the [decision maker] to say in its final determination that it had considered those matters in the sense of having looked at but discarded them.[13]

In the current context the Insurer has not even purported to evaluate the report of Dr P. The references to the three documents enumerated in the letter dated 1 May 2013 are so fleeting and cryptic as to afford no comprehensible rationale for the decision made by the Insurer. The later correspondence advising of the outcome of internal review gives slightly more commentary, but no greater insight.

My Reasons:

[12] See the 11th bullet-point in Guideline 5.1 of *WorkCover Work Capacity Guidelines* gazetted 28 September 2012.
[13] *East Australian Pipeline Pty Ltd v Australian Competition and Consumer Commission* (2007) 233 CLR 229 at 256. For this reference I am indebted to Stephen Free who provided me with a copy his paper, co-authored with Richard Lancaster, SC - *The relevancy grounds in environmental and administrative law* (presented to the NSW Bar Association on 30 October 2013).

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

(a) There is no specific provision in either the *Guidelines* or the legislation requiring an Insurer to have regard to medical reports. While an Insurer must comply with the requirement to evaluate all available evidence, the *Guidelines* do not specify what that evidence must be or how much weight ought be given to that evidence. Further, the Insurer has a wide discretion when making a work capacity decision and no one piece of evidence is determinative. Having said that, the purpose and subject matter of the legislation make it obvious that a work capacity decision made in the absence of medical reports can have no validity.

(b) The certificates and other reports in the possession of the Insurer which were created by medical providers were no more recent than October 2010, with a decision being made on 1 May 2013. The failure to obtain reports created no more recently than 30 months previously is scarcely a sign of good faith by the Insurer. This situation is not assisted by the insurer having completely ignored such medical reports as it had in its possession.[14]

(c) The report of the applicant's treating doctor dated June 2013 could clearly form no part of the work capacity assessment process which took place in April 2013. Therefore the Insurer could have had no regard to it; however it might be asked more than rhetorically why it was that the report was not solicited from the applicant's treating doctor prior to the work capacity decision being made. That the Insurer went on to make submissions in the process of merit review to the effect that since this doctor had never provided a previous report they should therefore be disregarded and opinions on file for more than three years should be preferred goes only to illustrate the attitude with which this insurer approached the review process.

(d) It can hardly be in dispute that the applicant has returned to work and has done so for more than 15 hours per week. It was certainly not disputed by the Insurer. Nonetheless, this ground, such as it is a ground, goes to the merits of the case and is irrelevant to procedural review.

[14] See paragraph 12 (a) *supra*.

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13. To the extent outlined above the Insurer, in making the original work capacity decision, partially complied with the relevant legislation and the *Regulation* and the *Guidelines.* The legislation was relevantly referenced and explained, including the entitlement periods for weekly payments; the applicant was given fair notice; he was advised of the date of the work capacity assessment; and the Insurer even complied with the notice period for variation of payments under section 54 of the 1987 Act and the *Interpretation Act* 1987. But with regard to the decalogue in *Guideline* 5.4.2 and the *Guidelines* generally, there are several breaches which cannot be overlooked:

    - *Guideline* 5.4.2 requires the Insurer to explain 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." At no time did the Insurer tell the applicant that his entitlement to medical expenses would be affected by operation of section 59A(2) or (3).[15]

    - *Guideline* 5.1 requires an evaluation of "all available and relevant evidence." The report of Dr P was certainly available, but the Insurer might argue that relevance was questionable due to the age of the report. Such an argument can have little force in circumstances where the same insurer purported to rely on a medical certificate which was a year older than Dr P's report.

14. I am aware of an approach commonly taken by scheme agents to the calculation of weekly entitlements which has arisen in this case, however indirectly. It is the practice of some to say that in a week in which a worker is not entitled to be paid compensation only by operation and application of a mathematical algorithm, even though they have a continuing physical incapacity, such a week is counted towards the numbered weeks as set out in sections 36-38. This means that in a week where a worker is in receipt of no weekly payments, it is still counted as a week of entitlement which is then counted against the future eligibility of the worker to continue to receive such payments. It would conceivably be

[15] But see further on this *infra*.

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therefore possible for a worker to receive $0.00 per week for 260 weeks and so exhaust their entitlements.

This argument is very convenient for Insurers until the current situation arises: here a merit reviewer has determined that an applicant has:

> *an ongoing entitlement to weekly payments of compensation* in the amount of nil

Similarly the Insurer has advised the applicant that his "weekly payments of compensation" will be reduced to $zero. The applicant has not been told [and the merit reviewer has not found] that his entitlement to weekly compensation ceases at any time. This has an interesting implication for the operation of section 59A(2). The section is in these terms:

> (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***.[16]

On any view of it, the section is not activated by mere cessation of payments – it is also necessary for the *entitlement* to weekly payments of compensation to have ceased. Therefore, using the same logic as used by the Insurers in counting unpaid weeks against a worker's future eligibility, it can confidently be stated that section 59A(2) would not be activated in a case such as the present where the applicant has been told that he has an ongoing weekly entitlement, albeit it is for nil.

15. 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.

[16] Emphasis added

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My Recommendation:

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 43 is issued and the relevant notice period has expired. The applicant should be reinstated to his pre-work capacity assessment/pre-work capacity decision rate of compensation.

17. I recommend that a further work capacity assessment be undertaken, this time taking into consideration all available evidence and in addition more recent medical evidence than is currently in the Insurer's possession. A further work capacity decision should then be made in accordance with the legislation, *Regulation* and *Guidelines*.

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
1 November 2013