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 his lower back on or about 13 April 2009. There is no dispute about the injury having occurred in the course of his employment, although radiological investigations reveal pre-existing pathology.

3. The applicant resumed work in a self-employed role in around 2010 and worked as many as 56 hours per week on occasions, but eventually he ceased work altogether in late May 2012. He was paid weekly benefits for all relevant periods and therefore he was a continuing recipient of weekly payments of compensation immediately prior to 1 October 2012.

4. While the applicant was in receipt of weekly payments of workers compensation the Insurer contacted him in June 2013 giving "fair notice" that they proposed to assess his work capacity and to make a work capacity decision in the near future. The applicant was given the opportunity to provide any further information or documents he wished to have considered by the Insurer, and he forwarded to the Insurer at least four documents on this basis.

5. On 9 July 2013 the Insurer advised the applicant in writing of a work capacity decision which had been made on that date. He was advised that his entitlement to ongoing weekly payments of workers compensation would be terminated since he was found to have no entitlement under section 38 of the *Workers Compensation Act* 1987 (1987 Act). He was told the following things:

    - As a result of your work capacity assessment,[1] a decision has been made that you are no longer entitled to weekly payments under the new section 38 of [the 1987 Act].

[1] No date (or range of dates) was given for the assessment.

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- This decision is effective from 16 October 2013.[2]

- Any entitlement you may have to payment of pre-approved reasonable and necessary medical and other expenses, until 16 October 2014, will not be affected.[3]

- Your entitlement to weekly payments at your current rate must cease within 3 months of this decision – please refer to: section 54(2)(a) of [the 1987 Act].[4]

- We acknowledge receipt of the following documents forwarded to [the Insurer] by yourself during the Fair Notice period:

    - Email correspondence dated 13 June 2013
    - Job Search diaries
    - Medical report of Dr B
    - Claim reimbursement request

  and advise our decision is not altered by service of these documents.[5]

- The documents that were considered in making this decision were provided to you with the Fair Notice Letter dated 13 June 2013.[6]

6. On 5 September 2013 the Insurer wrote to the applicant advising that an Internal Review had upheld the original decision. In this letter the Insurer was at pains to elucidate the medical evidence relied upon, together with giving a cogent explanation of the relevant sections of the Act in relation to weekly payments, and made a closely nuanced analysis of the applicant's post-injury work experience and his medical conditions and work capacity as disclosed in various reports.

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[2] Thus the Insurer has complied with the notice requirement in section 54(2)(a) and with the postal service notice requirement of section 76(1)(b) of the *Interpretation Act* 1987.
[3] Perhaps a failed litotes - this is an attempt to convey the thought that medical expenses will not be covered by the Insurer after 16 October 2014 without actually having to say so. See paragraph 15 *infra*.
[4] The section says the exact opposite (see extract below).
[5] Query whether this discloses any attempt to give due or any consideration to those documents.
[6] Quite an admission, in light of the previous bullet-point.

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Despite this, there was no reference of any kind to the effect this decision would have on the applicant's entitlement to reasonably incurred medical and related treatment expenses.[7] This omission is significant because it means that no attempt was made to remedy the error in the previous letter dated 9 July 2013.[8]

7. On 4 October 2013 the applicant applied to the WorkCover Authority for a Merit Review of the Insurer's decision. A WorkCover Merit Review was completed and a Statement of Reasons issued on 14 November 2013. The Merit Reviewer upheld the original decision of the insurer. The Merit Reviewer found that the applicant has no entitlement to weekly benefits in accordance with section 38(3)(b) of the 1987 Act.

8. On 20 November 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 that section and on the correct form.

The Applicant's Stated Grounds for Procedural Review

9. The applicant's grounds for pursuing procedural review might be summarised thus:

(i) It is impossible for the applicant to work, since the prescription medication he is currently taking precludes the type of work he might otherwise be able to perform.

(ii) The applicant questions the qualifications of the Insurer and the merit reviewer to assess the varying medical opinions in his case.

(iii) The applicant has acquired both physiotherapy equipment and medication for which he has not be reimbursed by the Insurer.

(iv) To suggest that the applicant is unhappy with the Insurer's management of his claim might be to indulge in understatement, there being such an

[7] This is a breach of *Work Capacity Guideline* 5.4.2.
[8] See footnote 3 *supra*.

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abundance of uncomplimentary commentary in the application as to leave room for little else. Such a wide and varied selection of allegations, assertions, insults and invective probably reflect no more than the frustrations and exasperations of a person who has lost their livelihood or the greater part of it and not had any assistance with coping with this dramatic change.

Submissions by the Insurer

10. The Insurer made no submissions in response to the application.

Legislation

11. Section 44(1)(c) of the 1987 Act limits the scope of procedural review to a review only of:

> the insurer's procedures in making the work capacity decision and not of any judg[e]ment or discretion exercised by the insurer in making the decision.[9]

Therefore while it remains the case that no discretion is unreviewable,[10] the Insurer's discretion when making a work capacity decision appears only to be reviewable in the course of merit review or Judicial review.

The procedures to be followed by the Insurer are set out in *WorkCover Work Capacity Guidelines* and *WorkCover Review Guidelines*.[11] Both sets of *Guidelines* are said to be delegated legislation and therefore must be complied with in order for a work capacity decision to be validly made. Given the overall beneficial nature of the 1987 Act and the serious consequences to workers if decisions are made incorrectly, strict compliance with the Guidelines is required.

Process of the Insurer

[9] Judgement is misspelt in the Act as "judgment."
[10] See *Padfield v Minister of Agriculture, Fisheries and Food.* [1968] AC 997
[11] A short-hand name for *Guidelines for Work Capacity Decision Internal Reviews by Insurers and Merit Reviews by the Authority.*

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12. The decision reached by the Insurer was certainly within the range of available decisions, and was upheld by the merit review service. The applicant has been paid for more than 130 weeks, and does not currently work. Being an existing recipient of weekly payments immediately prior to 1 October 2012, the applicant is subject to the transitional rate in Schedule 6, Part 19H, clause 2 of the 1987 Act. However, such considerations are of no interest on procedural review where the main relevant consideration is not *why* a decision is made, but *how* it is made.[12]

My Reasons:

13. The applicant's stated grounds for seeking procedural review can be dealt with using the numbering in paragraph 9 (i)-(iv) above:

(i) My only power is to review the procedures of the insurer in making the work capacity decision. This does not permit an examination of the merits of the case. The applicant's ability to work is a matter going to the merits of the case, and accordingly cannot be considered.

(ii) The entitlement of the Insurer to make a work capacity decision is statutory[13] as is the entitlement of the merit review service to review those decisions.[14] The capacity of individuals tasked with making those decisions or conducting those reviews is not a matter for procedural review.

(iii) The non-payment of medical or related treatment expenses is not a matter for procedural review.

(iv) The applicant's allegations against the Insurer concerning the conduct of his claim do not assist me with an evaluation of the Insurer's compliance with procedural requirements. The failure of the Insurer or the Authority to provide counselling or similar pastoral support to workers who are unable to cope with the consequences of work capacity decisions, while inconsistent with the original intention

[12] For a related discussion of the distinction see *Minister for Immigration and Citizenship v Li* (2013) 297 ALR 225 per Gageler, J at 253.
[13] Section 43(1) of the 1987 Act
[14] Section 44(1)(b) of the 1987 Act

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of the transition process, does not provide grounds for procedural review.

None of the grounds specified by the applicant would suffice to overturn the Insurer's work capacity decision.

14. The Insurer made no submissions about compliance with the relevant statutory provisions and *Guidelines*.

Since procedural review requires a scrutiny of the decision-making processes of the Insurer, including an examination of compliance with legislation and *Guidelines*, rather than a consideration of submissions made by either party, the review process may proceed despite the absence of relevant submissions.

15. There are in my view several breaches of the *Guidelines* which either individually or taken together are sufficient to invalidate the work capacity decision made by the Insurer.

- *Guideline* 5.4.2 of the *Work Capacity Guidelines*[15] requires the Insurer to "reference the relevant legislation." While the Insurer has gone to considerable lengths to cite and even quote the legislation, they have done so in a way which is at some times misleading and at other times completely erroneous. Illustrative examples are as follows:

    - The insurer only told the applicant that his entitlements to reasonably incurred medical and related expenses "until 16 October 2014 will not be affected." He was never told that by virtue of the operation of section 59A(2) any such entitlement would immediately cease 12 months after the last payment of weekly compensation. Similarly, he was never told of the existence or effect of section 59A(3). Saying that rights will be unaffected until a certain date in the future is a very long way from the same thing as saying that rights will be affected after a date in the future and clearly makes no reference to the way

[15] A gazetted 28 September 2012.

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in which those rights will later be affected by operation of the statute.

- This was compounded by the complete failure of the Insurer to even refer to medical expenses in the letter advising the outcome of Internal review.

- In the letter advising of the work capacity decision the applicant was told that his weekly payments at the current rate "must cease within 3 months of this decision – please refer to: Section 54(2)(a) of the [1987 Act]." Had the applicant consulted the section to which he was referred he might have been surprised to find that it says precisely the opposite of what he had been told. The section is relevantly in these terms:

54(2) The required period of notice for the purpose 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 compensation resulting from a work capacity decision of the insurer – 3 months

Which is to say that the three months is a minimum notice period, not a maximum payment period.

- The same *Guideline* 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.

It is clear that the impact on the applicant's ongoing entitlement to medical and related treatment expenses was never explained by the Insurer. The confusing reference made in the letter advising of the work capacity decision was caused by the Insurer engaging (however unconsciously) in the practice of antenantiosis, a process by which something is said by denial of its opposite. Rather than saying straightforwardly that medical benefits would cease on and from 16 October 2014, the Insurer found it more convenient to say that any

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entitlement the applicant "may have" to medical benefits would be unaffected until that date. This does not meet the requirement in the *Guidelines* to "state the impact of the decision."

- *Guideline* 5.4.2 also requires the Insurer to outline all evidence considered in the making of a work capacity decision. In the current instance the Insurer listed many documents in both the work capacity decision letter and the Internal Review letter. Some doubt may arise in relation to the "consideration" given to some of the documents, particularly in light of the comment that the documents provided by the applicant in response to the Fair Notice letter did not alter the decision made by the Insurer.[16] This impression is given greater weight by the very next sentence in the same letter which says that the documents "that were considered in making this decision were provided to [the applicant] with the fair Notice Letter dated 13 June 2013." This is a clear admission by the Insurer that no consideration was given to any document received after 13 June 2013, a category which would include the four documents sent by the applicant and set out above at paragraph 5. At least one of those documents was a medical report and another was a claim for reimbursement. A third document was the Job Search Diary of the applicant.

- *Guideline* 5.1 requires the Insurer to "evaluate all available and relevant evidence."

  Evaluation as a concept must require more than merely reciting the documents received from the applicant and then saying that they did not influence the outcome. This conduct by the Insurer infringes the principle set out by the High Court[17] which says that where there are mandatory considerations in a statute the decision-maker is not authorised to "jettison or ignore" some of those factors, nor may they give them "cursory consideration only in order to put them to one side."[18] In a separate judgment two other Justices of the Court held that is was "not enough for [the decision-maker] to say in its final determination that it had considered those matters in the sense of

[16] See at paragraph 5 *supra*.
[17] See *East Australian Pipeline Pty Ltd v Australian Competition and Consumer Commission* (2007) 233 CLR 229
[18] Per Gleeson CJ, Heydon and Crennan, JJ at 244 [52].

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having looked at but discarded them."[19] It is clear that the *Guidelines*, being delegated legislation, must be followed and applied in the scrupulous way described by the High Court. It is equally clear that in this case they have not been so followed and applied.

- In the work capacity letter the Insurer advised the applicant that the work capacity decision resulted from "your work capacity assessment." No date was specified for this assessment. This may be a breach of clause 23 of schedule 8 to the *Workers Compensation Regulation* 2010 (the Regulation) which is in these 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.

The failure to specify a date for the assessment gives the applicant no idea of how soon after the assessment the decision was made. In the current case it is notable that all the documents on which the work capacity decision was based were said to be attached to a letter dated 13 June 2013, which might indicate that an assessment had occurred approximately one month prior to a decision being made.

16. 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 more than one breach of the *Guidelines* which are to be treated as delegated legislation. Accordingly the work capacity decision must be found to be invalid.

[19] Per Gummow and Hayne, JJ at 256 [102].

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My Recommendation:

17. For the reasons set out above I recommend that the Insurer undertake another work capacity assessment and, if it arises, make another work capacity decision, according to the *Guidelines* as gazetted by the Authority and according to the relevant legislation.

18. 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. Accordingly he remains entitled to his former weekly payments until he is validly transitioned and a section 54 notice issues and the relevant period of notice therein has expired.

19. Because the review process does not operate as a stay of the original decision, the applicant has not received weekly payments since 16 October 2013. Therefore it cannot be said that he "is receiving" compensation. This means that clause 21 of schedule 8 to the *Workers Compensation Regulation* 2010 cannot apply. It follows that he may be restored to the correct pre-transition amount forthwith, since there is no need for the effluxion of any notice period.[20]

20. Noting the binding nature of these recommendations[21] I recommend that the Insurer takes my views into account, and I recommend that the Insurer immediately gives effect to them.

Wayne Cooper
Delegate of the WorkCover Independent Review Officer
3 December 2013

[20] To the extent that clause 21 of schedule 8 of the *Regulation* conflicts with both section 9 ("A worker ... shall receive compensation") and section 38(2) ("A worker ... is entitled to compensation"), it is *ultra vires*.
[21] See section 44(3)(h) of the 1987 Act – recommendations made by the Independent Review Officer are binding on the insurer and the Authority.