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Work Capacity decisions and the work capacity review service

A system of work capacity assessments and work capacity decisions was introduced as a result of the 2012 legislative amendments to the workers compensation system. This system did not exist in NSW prior to the amendments. Previously South Australia was the only state or territory to utilise a work capacity system in determining an injured workers level of capacity. The rationale for the introduction of this system was the idea that there needed to be an increase in the return to work rate among injured workers. However, like the South Australia system, work capacity assessments and work capacity decisions are used as a mechanism for pushing people off the workers compensation system or pressuring injured workers to remove themselves from the system voluntarily rather than being constantly subject to the whim of the work capacity process.

The process is not being implemented rationally, efficiently or effectively. The CFMEU proposes that the system be abandoned in its entirety. Should that proposal be deemed unreasonable, the CFMEU proposes a complete overhaul of both the work capacity system and the review system as it currently stands.

Legislative framework

The basis for the work capacity system can be found in Part 3 Division 2 Subdivision 3 of the *Workers Compensation Act 1987* (**the Act**). The subdivision is broken into the following sections:

1. Section 43: Work capacity decisions by insurers
2. Section 44: Review of work capacity decision
3. Section 44A: Work capacity assessments
4. Section 44B: Evidence as to work capacity

These sections are to be read in conjunction with Guidelines issued and updated by WorkCover. The Guidelines are treated as de facto delegated legislation.

In order for the work capacity system to function rationally, efficiently and effectively the entire system needs to be overhauled. The CFMEU proposes a series of amendments to ensure that the system functions fairly and continues to adequately support injured workers.

Removal of the work capacity system

As mentioned, the system fails to function in a rational, efficient or effective manner. The system is flawed in many respects and is a burden for both insurers and injured workers alike. The system works on a theoretical basis with little recognition of the reality of the labour market or the demands on workers within the labour market.

Life altering decisions are being made by unqualified case managers with no legal training and who have a vested interest in finding that an individual worker has capacity to work.

The system cannot achieve the aims for which it was created. Rather the system works to increase poverty among the disadvantage in our society further widening the gap between the different classes in our population. The system creates a new class where people who have ongoing injuries are unable to earn an income, pay for adequate medical expenses, receive social security benefits and are forced to use their superannuation to cover mortgage payments.

The system must be abandoned to protect those who need protecting and provide adequate support to those disadvantaged members of society.

Work Capacity Assessments should be a mandatory requirement prior to the making of a work capacity decision.

Section 44A of the Act provides the basis for work capacity assessments (**WCA**). While the section places on obligation on the insurer to conduct a WCA, currently there is no requirement to conduct a WCA prior to making a work capacity decision (**WCD**) as outlined in s 44A (3):

> *"A work capacity assessment is not necessary for the making of a work capacity decision by an insurer."*

Arguably, by not requiring a WCA prior to the making of a WCD, the system is absolving the insurer of any obligation to ensure that the most up to date information is available when assessing an injured worker's current work capacity. It allows the insurer to make a decision based solely on the documentation within an injured workers file, information that is potentially out dated.

The only way to ensure that the insurer has all the necessary evidence to make a sound and defensible work capacity decision is to require an up to date assessment of an injured worker's capacity. The best way to achieve that is by requiring a WCA for all WCDs.

In reality, this requires that s 44A (3) of the Act to be removed entirely.

An insurer should not be allowed to dismiss the opinion of a Nominated Treating Doctor without solid evidence to support a contrary opinion.

An injured worker is required to visit their nominated treating doctor (**NTD**) regularly so that the NTD can assess the injured workers capacity for work. Ideally it is the NTD that has the greatest understanding of the injury that is the subject of the claim and the effect that the injury has on the injured worker on a day to day basis.

A rehabilitation report is compiled by a person (often without medical training) who is contracted by the insurer to assess the injured worker's ongoing capacity. These reports or functional assessments take approximately 20 minutes to complete. The assessment may potentially be an accurate depiction of an injured workers capacity in that particular 20 minute period, but it is not an accurate depiction of an injured worker's ongoing capacity. There is no provision for assessing how an injured worker feels in the hours or days following the assessment. A worker may have some capacity at the time of the assessment but the following day may have no capacity as a result of the assessment.

Currently, if an injured worker's certificate of capacity is inconsistent with the insurer's opinion or that expressed in a functional assessment, the insurer may place greater emphasis on the findings of the rehabilitation report, thereby ignoring the sound medical advice of the NTD.

Capacity is fundamentally a medical decision and should be made based on sound medical evidence.

The original work capacity decision should be stayed while undergoing the review process

Section 44 (4) of the Act states:

> *"A review of a work capacity decision does not operate to stay the decision or otherwise prevent the taking of action based on a decision."*

Based on the CFMEU's experience a merit review decision takes approximately 154 days to complete from the day the application is lodged. During this time there are injured workers whose weekly benefits cease prior to the conclusion of the review process as a direct result of this provision.

While we note that in their appearance before the Committee, WorkCover representatives indicated that they were working with insurers to ensure workers were not disadvantage, the CFMEU's recent experience shows otherwise. In the last month, two of our members have ceased to receive weekly benefits whilst awaiting the outcome of the merit review.

Furthermore, emails received from the WorkCover Merit Review Service continue to contain the following warning:

> *"Please note that a review of a Work Capacity Decision does not operate to stay the decision of the insurer or otherwise prevent the taking of action based on the decision."*

Injured workers are being severely disadvantaged as a result of this provision which is amplified by the fact that the WorkCover Merit Review Service is taking in excess of 5 months to make a decision.

To restore some sense of fairness to the system, this provision needs to be removed. All work capacity decisions should be stayed until the review process has been exhausted. Alternatively a slightly less adequate response would require the insurer to stay a decision once an application for a review is lodged until the Merit Review Service has made its decision either way.

Of course the preferable approach would be to stay the decision until the review avenues have been exhausted.

Breach of s 54 of the Act should result in an automatic penalty

Section 54 of the Act requires an insurer to provide 3 months notice prior to discontinuing an injured worker's weekly compensation. Experience has shown that this requirement has not always been met. In its written submission to the Committee, WIRO indicated that there had been a widespread failure to provide the appropriate notice and that WorkCover had not prosecuted these breaches despite section 54 being a civil penalty provision.

Civil penalty provisions and the imposition of penalties can be used to deter an insurer from acting in contravention of the Act. However, if the Authority chooses not to follow up on the breaches these tools lose their deterrent failure.

To ensure compliance with the notice requirements, an automatic penalty system should be introduced. There is very little investigation required to prove whether s 54 has been breached, since the notice itself will indicate when weekly benefits are scheduled to cease. It is a relatively inexpensive exercise which can potentially deter insurers from acting in contravention of the legislation. The Authority needs to use the power given to it by virtue of s 23 of the Act and enforce the penalties under the legislation.

Internal Review and Merit Review should investigate both merit and procedural grounds

Currently the internal review and merit reviews services only consider arguments that go to the merit of the decision and actively ignore any procedural arguments. A WCD may be riddled with procedurally abnormalities which can render the decision invalid but an injured worker will be required to wait until the procedural review stage where ultimately WIRO will find that the WCD is invalid and will recommend that the insurer make a new decision. Given the time delay with

the merit review service this can severely disadvantage an injured worker.

Allowing procedural arguments to be considered in the internal review and merit review stages can reduce the adverse impact on injured workers as well as the bureaucratic burden on insurers. The current system requires insurers to respond to applications made by the injured worker and to provide either the Authority or WIRO with additional information as requested. If a WCD is able to be declared invalid earlier in the process it will reduce the paperwork burden on the insurer. Additionally, allowing a WCD to be declared invalid early in the process will reduce the stress and uncertainty faced by injured workers and their families. It will streamline and quicken the process for all the parties involved.

There should be the option to appeal to the Workers Compensation Commission where the decision is disputed

Section 43 (3) of the Act prohibits the Workers Compensation Commission (**WCC**) from being involved in the work capacity process. Section 43(3) states:

> *"The Commissioner does not have jurisdiction to determine any dispute about a work capacity decision of an insurer and is not to make a decision in respect of a dispute before the Commission that is inconsistent with a work capacity decision of an insurer."*

The first two tiers of the review process allow the insurer and then the Authority to review a WCD upon application by the injured worker. Both these parties have a conflict of interest and therefore neutrality is not confirmed. The system would benefit greatly by having an independent party review the merits of a WCD.

The WCC has a panel of arbitrators who have experience and knowledge of the workers compensation system and who would ensure that any decision is impartial and based on sound medical advice.

Legal services should be permitted and paid by the system

A legal practitioner is prohibited from charging an injured worker for assistance with a WCD and WIRO is not permitted to grant an ILARS for assistance with a WCD. While an insurer is not permitted to pay for legal advice in relation to the making of a WCD decision in reality insurer are receiving comprehensive legal advice. Insurers either employ a legal team or have a lawyer on retainer, thereby avoiding the prohibition.

The prohibition on legal expenses puts many injured workers at a significant disadvantage when fighting a WCD. The system is cumbersome and difficult to navigate. An injured worker with low literacy skills or for who English is a second language will struggle with the process when faced with the prospect of applying for a review of a WCD.

To overcome the imbalance of the system, legal practitioners should be able to apply for a

standard ILARS grant to assist with a WCDs. Allowing for some payment will go far in ensuring that injured workers are given the appropriate support to manage a difficult process.

Training should be offered to case managers on a 6 monthly basis, or in the event that there is a change to the legislation or guidelines that will impact on injured workers

WorkCover offered training to insurers and their case managers after the 2012 amendments took effect. However, given that a great many WCD have been declared invalid by WIRO due to procedural irregularities, regular training for case managers should be considered. Some insurers continue to struggle to make sound WCD for an injured worker more than once. At least three of ours members have been subject to a second WCD that failed to meet the procedural requirements after the first WCD was declared invalid for failing to meet the procedural requirements. This is a clear disadvantage to injured workers as they face constant uncertainty about their ongoing weekly benefits.

In order to ensure that case managers have the most up to date knowledge, a regular training program is important. These are decisions that potentially have an adverse affect injured workers and their families. If it is intended that case managers are responsible for WCDs then it is fitting that they receive constant training.

Where WorkCover has failed to make a decision within the required time frame the injured worker has the right to appeal to the Workers Compensation Commission under the expedited system

The WorkCover Merit Review Service is given the authority to conduct a merit review of a WCD decision by virtue of s 44(1)(b) of the Act. Section 44(3) explains the circumstances in which WorkCover or WIRO may review a WCD. The WorkCover Merit Review Service is currently taking up to 5 months to make decisions. This is unacceptable given that the legislation prescribes a 30 day time frame. Currently, there is no avenue for an injured worker to enforce the 30 day period. An injured worker must wait for the WorkCover Merit Review Service to make a decision before continuing on to the next stage of the review process.

Injured workers need assistance in enforcing the 30 day period. The power of enforcement should be given to an independent body. The Workers Compensation Commission already employs a team of arbitrators to decide disputes of liability and return to work disputes. If the Workers Compensation Commission is given the power to enforce the time frames it will give injured workers the remedy they are currently lacking. Given that the amendments to the legislation have reduced the workload of the Workers Compensation Commission, vesting this power in the Commission is unlikely to be costly and will make good use of resources that the Commission already possesses.

The process should be simple and not overly legalistic. If a WCD dispute does end up in the Workers Compensation Commission an injured worker should be given access to legal advice

at the schemes cost since the reason for the application is the schemes failure to adhere to the legislative requirements.

Where WorkCover has failed to make a decision with the required time frame, the injured workers has the right to apply to WIRO for a procedural review

Alternatively, where the WorkCover Merit Review Service has failed to make a decision within the 30 day time period, the injured worker should be able to advance to the procedural review stage.

There is an element of ambiguity in how section 44(3) operates. Section 44(3) applies to both the Authority and to WIRO. Section 44(3)(b) allows an injured worker to apply for a merit review where an internal review is not made within the time frame, however there is no explicit right where the Authority has failed to make the decision with its time frame.

There is no logical argument for not allowing the procedural review to go ahead where the Authority has not made the decision within the 30 day period. WIRO resources have already been allocated to consider applications for procedural review. By allowing WIRO to conduct the review in this manner, there will be no extra cost to the system since the resources are already allocated.

WIRO should be able to review the entire review process in addition to the original decision

Currently, WIRO only has the authority to review the original WCD and while they can make observations as to the conduct of the insurer or the Authority in the review process, WIRO is not permitted to review the fairness of the review process.

There have been instances where the internal review process has overturned the initial WCD seemingly making a new WCD. The injured worker can continue to lodge applications up the review chain however, that internal review decision will not be reviewed. Further WIRO does not have the authority to review the procedural irregularities in the internal review or merit reviews stages. The failure to adhere to procedural requirements in the first two stages can have a devastating impact on the injured worker, for instance the Authority's failure to make a decision within the 30 day period.

WIRO should be authorised to review the entire process to at least give the impression of fairness rather than the injured worker having no recourse to dispute the conduct or finding of the internal and merit reviews.

WorkCover should provide up to date information to the injured worker where a decision is unable to be made in the required time frame, including the progress of the review and estimated completion date.

If the system is not changed to allow an injured worker to enforce the time periods, WorkCover should be required to provide constant updates on the progress of the merit review. On several occasions the CFMEU has made queries with the Merit Review Service on behalf of our members only to be told "It's in the queue." Meanwhile the injured worker in question has had their weekly benefits discontinued and they have no idea of when or if a decision will be made.

WorkCover needs to provide injured workers with more information, including an estimate time that it will take to make a decision. Telling an injured worker that it is likely to be another 2 months before a decision is made is better (albeit only slightly) than not giving the injured worker any information at all.

An injured worker's geographic location and labour market activity should be relevant considerations in determining whether an injured worker can engage in suitable employment

Suitable employment is a key concept when determining whether an injured worker has some work capacity. Suitable employment is defined by s 32A of the Act, which outlines what factors are to be taken into account when deciding whether suitable employment exists. The definition prohibits an insurer from taking into account the geographic location of the injured worker and the state of the labour market in that geographic. This essentially means that an insurer can decide that an injured worker has capacity to work because there are options for suitable employment 3 hours drive from the injured workers current residence.

People suffering, back, neck and leg injuries are less likely to be able to drive long distances for work thereby physically precluding them from taking jobs in other geographic areas. Additionally, the meager amount paid to an injured worker on workers compensation means that many do not have the financial resources to relocate. There is no justification for excluding an injured worker's geographic location from an assessment of suitable employment or work capacity.

The definition, and its application, must be realigned with society expectations of what is suitable employment.

Less emphasis on the theoretical aspects of employment and more emphasis on the reality of the workplace

Many vocational assessments rely on theoretical job assessments to determine whether a particular job is suitable employment. For instance, according to many vocational assessments a forklift operator is not required to do any lifting or engage in store person activities. According to the job assessments a forklift driver is able to sit in the forklift all day. This is not an accurate depiction of what occurs in the actual workplace. Forklift driving by itself is not a full time job. A forklift driver in a warehouse may be required to do some cleaning or move some materials. There is no option to just sit in the forklift all day. Rehabilitation providers have stated that the injured worker can merely refuse to lift a box

and therefore forklift driving is suitable employment. This fails to account for the reality of a workplace.

Before assigning a particular job to an individual, there should be an examination of what actually occurs in a workplace and that involves talking to foreman, or managers not just reading job advertisements.

Decisions as to capacity should be made by a medical practitioner not a case manager

Capacity to work is fundamentally a medical decision and should only be made by a medical practitioner. Such an important decision should not be left up to administrators who have never met the injured worker in person nor seen the extent of their injury.

The argument that a case manager has the ability to absorb all the medical reports and make a sound rational decision is fanciful at best. Most case managers do not have a medical background making it difficult for them to fully appreciate the opinion of a medical practitioner. Add the fact that case managers are making decisions contrary to the opinion of the NTD it is difficult to argue that WCD are based on medical evidence.

It is reasonable to expect that a medical practitioner be the person making a life changing decision since the decision is intended to reflect the medical evidence.

Failure to adhere to the procedural requirements should result in penalties.

A reading of WIRO procedural review decisions shows the extent of the procedural irregularities of WCDs. Twelve months on and there are still WCDs that breach the Guidelines and which WIRO has no choice but to declare invalid. Clearly merely overturning the decision is not enough of a deterrent to prevent further procedural breaches.

Penalties can be a good way of ensuring compliance and can be a very effective deterrent. Currently, there is no penalty for breach of the guidelines (beyond the penalty contained in s 54 of the Act). Meanwhile, an insurer's failure to comply with the guidelines can severely disadvantage an injured worker. It appears that the imposition of a penalty may be the only way to alter the approach of the insurers and deter them from making further procedural errors.

Conclusion

The work capacity process is inherently flawed and unfair. The only way to redress the imbalance inherent in the system is to make the changes outlined. Given the extent of the changes required to fix the system a better, more preferable and less expensive approach would be to remove the system entirely and return to the previous system of determining capacity for work.

Currently, the system operates to punish legitimate injured workers and to deter them from applying for a review of a WCD. A better approach is to punish the players within the system who are not acting in the best interests of the injured worker but who are only focused on removing these injured workers from the system entirely, either my force or persuasion.