WiRO
WorkCover independent review office

Level 4, 1 Oxford Street, Darlinghurst NSW 2010
T: 13 9476
contact@wiro.nsw.gov.au
www.wiro.nsw.gov.au

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*.*

SUMMARY:

a. The work capacity decision of the Insurer dated 31 October 2013 is set aside.

b. The applicant is to be reinstated to his weekly payments at the rate applicable at 31 October 2013.

c. The payments are to be back-dated to 7 February 2014.

d. The payments are to continue until such time as a further work capacity decision is made and comes into effect.

Background

1. The applicant seeks procedural review of a work capacity decision (decision) made by the Insurer on 31 October 2013. The decision stated that payments were to cease on 7 February 2014. The applicant sought internal review. The Internal Review Decision (IRD) was issued on 23 December 2013. The applicant sought Merit Review by the Authority on 13 January 2014. The Merit Review was issued on 29 May 2014.

2. The applicant was injured on 6 October 2004. The injury was to his neck, left shoulder and low back. He underwent operations to his shoulder in October 2005 and February 2007. He underwent low back surgery in February 2008. He returned to suitable employment with another employer. The Insurer made weekly payments as required under the provisions of the *Workers Compensation Act* 1987 (1987 Act).

3. The applicant was in receipt of compensation by way of weekly payments immediately before 1 October 2012. Accordingly Clause 8 of Part 19H of Schedule 6 to the 1987 Act required the Insurer to conduct a work capacity assessment for the purpose of facilitating the application of the amended weekly benefits provisions to the applicant's claim. Clause 17 of Schedule 8 to the Workers Compensation Regulation 2010

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(the Regulation) required the transitioning process to be completed *"within 18 months"* of 1 October 2012.

4. The relevant version of the WorkCover Work Capacity Guidelines *(Guidelines)* is the one dated 4 October 2013, published on 8 October 2013, and which came into effect on 11 October 2013. The *Guidelines* provide instructions and guidance to Insurers regarding the appropriate and consistent application of work capacity assessments and decisions.

5. Once the Insurer has conducted an assessment then the Insurer is required to make a work capacity decision. Where that decision involves a reduction in or cessation of the weekly benefits payable to the injured worker then the Insurer is required to give proper notice to the worker (see section 54(2)(a) of the 1987 Act).

Submissions by the applicant

6. Section 44(1)(c) of the 1987 Act states that this review is "*only of the insurer's procedures in making the work capacity decision and not of any judgment or discretion exercised by the insurer."* The applicant's submissions largely went to the merits of the case, that is, the very object of judgement or discretion of the Insurer excluded by section 44(1)(c) and therefore could not be relevant to this review. One submission is that the Insurer told the applicant that he would not be affected by the 2012 amendments to the 1987 Act. Such a statement was careless, but has no bearing on the decision.

Submissions by the insurer

7. The Insurer was invited to make submissions but did not do so.

The Decision

8. The decision states that a work capacity assessment was undertaken. The decision does not state that the assessment is required pursuant to Clause 8 of Part 19H of Schedule 6 to the 1987 Act. As such the legislation has not been properly referenced as *Guideline* 5.3.2 requires. No date is given as to when the assessment took place. The fair notice telephone call as required by *Guideline* 5.2 occurred on 3 October 2013. The applicant can assume that the assessment took place during

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October. This is important as the decision is required to be made *"as soon as practicable after"* the assessment: Clause 23 of Schedule 8 of the Regulation.

9. There does not appear to be any legislative requirement to notify the applicant of the outcome of the assessment. However, *Guideline* 5.3.2 stated that the decision must:

    - *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.*

    My finding is that the *Guidelines* result in the insurer being compelled to reveal the outcome of the assessment which would also reveal the date of the assessment.

10. The heading to the decision states that it is a *"notice of reduction or cessation of wages under section 54 of the Workers Compensation Act, 1987".* The Insurer should have just said that the decision is a notice of cessation. *Guideline* 5.3.2 requires the Insurer to refer to the legislation. The correct reference is to section 54(2)(a) of the 1987 Act.

11. The Insurer states that an assessment must be made for all claims where the Insurer *"was notified of the injury prior to 1/10/2012. Work capacity decisions for these claims must occur during the 2013 calendar year".* While it is imperative that a claim must be notified prior to 1 October 2012 the test is that the applicant is in receipt of weekly payments immediately before 1 October 2012. The Insurer should have referred to clause 1 (the definition of "*existing recipient of weekly payments*") of Part 19H of Schedule 6 of the 1987 Act. It is also clearly inaccurate to say (as this Insurer has said) that the "*decisions for these claims must occur during the 2013 calendar year".* What Clause 8(2) of Part 19H of Schedule 6 to the 1987 Act requires is for the Insurer to conduct a work capacity assessment, not complete the decision, for the

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purposes of transitioning a claim *"no later than 12 months (or such longer period as may be prescribed by the regulations) after the commencement of the weekly payments amendments."* While the amendments commenced on 1 October 2012, the *Workers Compensation Regulation* 2010 says at Clause 17, Schedule 8 that *"a period of 18 months is prescribed for the purposes of Clause 8(2) of Part 19H of schedule 6 to the 1987 Act."* It follows that there was no requirement for the Insurer to conduct a work capacity assessment and for a decision to be made during the 2013 calendar year.

12. Later in the decision it is stated that the legislative changes in 2012 *"are coming into effect for claims that existed prior to 1/10/2012".* This statement seems to suggest that the claim need not have been notified prior to 1 October 2012, and that the applicant need only to have suffered a work injury prior to that date. On two occasions the Insurer has failed to explain the legislation adequately, accurately or at all.

13. The decision states that *"as your claim is transitioning to the new weekly payment arrangements in accordance with Schedule 12, Part 19H, Division 1, Part 2 of the Workers Compensation Legislation Amendment Act 2012 the deemed amount of your pre-injury earnings is $948.50".* Were the applicant to study the Act to which he is referred he would find that Schedule 12 has been repealed. An applicant should not need to have a fine understanding of the legislative process in order to discover that he is being referred to Schedule 6 of the 1987 Act. If he could find his way to the correct Schedule he would see that the Transitional rate is said to be $906.25. The Insurer should explain that the rate is indexed.

14. The Insurer then makes the following statement: *"Under subsection 43(1)(f), any other decision of an insurer that affects a worker's entitlement to weekly payments of compensation, including a decision to suspend, discontinue or reduce the amount of the weekly payments of compensation payable to a worker on the basis of any decision referred to in paragraphs (a)(b)((d)(f)".* The actual paragraph in the 1987 Act refers to *"paragraphs (a)-(e)".* Were the applicant to check the legislation he might be justifiably concerned that the Insurer has misrepresented the legislation.

15. The applicant is advised that he has received more than 130 weeks of weekly payments. The Insurer should explain the *"second entitlement*

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period" and refer to the definition of that phrase in section 32A of the 1987 Act. Section 38 of the 1987 Act is then set out and it is stated that the applicant is pursuant to *"subsection 38(3)(b), assessed by the insurer as having current work capacity and has returned to work for more than 15 hours per week and earning at least $168 per week".* The Insurer has failed to explain "*current work capacity"* and refer to its definition in section 32A of the 1987 Act. That term refers to an inability to return to pre-injury employment but being able to work in *"suitable employment".* That term is also defined in section 32A. The definition of suitable employment is an important concept in the 2012 amendments to the 1987 Act. It involves, *inter alia*, having regard to *"the worker's age, education, skills and work experience"* while having no regard to *"the nature of the worker's pre-injury employment".* Few people relying on a normal understanding of English would realise that such a concept would be included in a simple phrase like suitable employment.

16. The Insurer has also misrepresented subsection 38(3)(b). That subsection states that the test is having returned to work *"for a period of not less than 15 hours per week",* not "*more than 15 hours per week"* as the decision states. The subsection has a figure of $155 and the reference to earning $168 requires the Insurer to explain that this figure is indexed.

17. The decision states that the applicant has received 353 weeks of weekly payments. Sections 36, 37, 38, and 39 are then briefly explained. No reference is made to the definition of *"first entitlement period"* and *"second entitlement period"* in section 32A of the 1987 Act. Section 39 is described as cessation of weekly payments after 5 years. The applicant would be concerned that as he has already received more than 5 years of weekly payments that his entitlement is at an end no matter what he does. The Insurer should have pointed out that Clause 4 of Schedule 8 to the Regulation states that in reckoning the 5 years *"in respect of a claim made before 1 October 2012, no regard is to be had to any weekly payment of compensation paid or payable to the worker before 1 January 2013".*

18. The decision states that 3 months notice is required and that the Insurer has *"extended that period by a further week to allow for the delivery of this notice by post in accordance with section 76(1)(b) of the Interpretation Act 1987, and Clause 6 of the WorkCover Work Capacity*

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Guidelines". Section 76(1)(b) says that service will be deemed to have been effected on the fourth working day after the letter is posted. *Guideline* 6 states that for delivery of documents service is taken to have been effected on a day 7 days after the document is posted. The fourth working day after the Thursday before Good Friday is the following Friday, more than a week later. The *Guideline* is wrong and the best solution is for Insurers to follow the *Interpretation Act* 1987.

19. *Guideline* 5.3.2 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 decision correctly states that treatment and related expenses are no longer payable 12 months after weekly payments cease. The decision does not refer to section 59A(2) of the 1987 Act. The legislation has not been properly referenced as required by *Guideline* 5.3.2.

20. In addition, section 59A(3) of the 1987 Act states that the applicant may, after the entitlement to compensation for medical expenses ends, become eligible for further payments for medical expenses if the applicant becomes entitled to compensation for weekly benefits at some stage in the future and for such time as those weekly payments continue. This was not disclosed by the Insurer.

21. Guideline 5.3.2 requires the Insurer to *"detail any support, such as job seeking support, which will continue to be provided during the notice period".* The decision states that the Insurer during the notice period *"will continue to manage your claim and process your weekly payments".* That does not comply with the *Guideline*.

22. The decision states that it has been made by reviewing *"all relevant information available to me at the time of the decision".* It then states that the *"documents relied upon to make the decision are"* and only 1 document is listed. That document is a *"Certificate of Capacity".* There is no reference to either the author or the date of the document. The applicant cannot know what document has been considered. The IRD lists 7 documents. *Guideline* 5.3.2 requires the Insurer to "*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".* The decision

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maker has clearly not considered all the evidence. The applicant cannot know if there is any evidence that does not support the decision. This is a demonstrable error.

FINDING

23. I find that the Insurer has failed to follow the procedures as set out in the WorkCover *Guidelines* which is a requirement of Section 44A of the 1987 Act. The Insurer has also failed to follow the 1987 Act and the *Workers Compensation Regulation* 2010*.*

RECOMMENDATION

24. I recommend that the Insurer conduct a new work capacity assessment in accordance with the WorkCover *Guidelines* and make a new work capacity decision.

25. I recommend that the Insurer pay the applicant the weekly benefit to which he was entitled prior to 31 October 2013 until such time as he is properly transitioned. Those payments should continue from 7 February 2014 being the date on which they ceased.

26. Since the applicant is not currently in receipt of weekly payments, clause 21 of schedule 8 of the *Regulation* cannot apply and payments may resume immediately. The applicant is not required to produce work capacity certificates for the period from 7 February 2014 to date by virtue of the operation of section 44B(2) of the 1987 Act. These recommendations are binding on the insurer: see section 44(3)(h) of the 1987 Act.

Wayne Cooper
Delegate of the WorkCover Independent Review Officer
15 July 2014