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(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 scheme agent of the NSW self- insurance corporation ("Insurer").

2. The applicant suffered injury to his lower back on or about 10 December 2007 during the course of his employment as a physical education teacher.

3. As a result of the injury the applicant has been unable to return to his pre-injury duties. At the time of the work capacity decision the applicant was not working. The applicant has been paid weekly payments for all relevant periods and was therefore an existing recipient of compensation immediately prior to 1 October 2012.

4. On 30 April 2013 the Insurer made a work capacity decision pursuant to Section 43 of the *Workers Compensation Act* 1987 ("1987 Act").

5. The applicant was advised of this decision by letter dated 30 April 2013. The applicant was informed that he had no entitlement to weekly payments under Section 38 of the 1987 Act and his weekly payments of compensation would cease within 3 months of the work capacity decision being 30 July 2013 (Section 54(2)(a)).

6. The Insurer advised the applicant that his entitlement to pre-approved reasonable and necessary medical and other expenses 'would not be affected' until 30 July 2014.

7. The applicant requested an internal review of the Insurer's decision. That review was responded to by the Insurer in writing on 10 July 2013. The review confirmed the original work capacity decision.

8. The applicant then requested a WorkCover Merit Review. The review was completed and a Statement of Reasons issued on 23 October 2013.

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The reviewer determined that the applicant was entitled to the amount of $nil per week in accordance with Section 38 of the 1987 Act.

9. On 28 November 2013, the applicant requested the Independent Review Officer to undertake a review of the decision of the Insurer pursuant to Section 44(c) of the *1987 Act*. I am satisfied that the applicant has made that application within the time provided by that section.

Applicant's Stated Grounds for seeking Procedural Review

10. The applicant's ground for seeking procedural review is that the Insurer did not fully explain the changes to legislation and procedure.

Submissions by the Insurer

11. The Insurer made no submissions in response to this application.

The Legislative Framework

12. 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.

Therefore while it remains the case that no discretion is unreviewable[1], the Insurer's discretion when making a work capacity decision appears only to be reviewable in the course of merit review or Judicial review.

13. The procedures to be followed by the Insurer are set out in the *WorkCover Work Capacity Guidelines* and *WorkCover Review Guidelines*. Both sets of *Guidelines* should be complied with in order for a work capacity decision to be validly made.

14. In this instance the relevant version of the *Guidelines* is the one dated 28 September 2012 and applied to all claims from 1 January 2013. That publication provides that the *Guidelines* provide instructions and guidance to Insurers regarding the appropriate and consistent application of work capacity assessment.

[1] *See Padfield v Minister of Agriculture, Fisheries and Food [1968] AC 997*

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Process of the Insurer

15. The decision reached by the Insurer was certainly within the range of available decisions. The decision was indeed upheld by the merit review service.

16. The important consideration on procedural review is not why a decision is made, but how it is made.

My Reasons:

17. The ground upon which the applicant seeks review is relevant as the Insurer has failed to adequately explain the line of reasoning and outline the evidence considered when making its decision.

18. The Insurer has made no submissions about compliance with the relevant statutory provisions and guidelines.

19. Since procedural review requires a scrutiny of the decision making processes of the Insurer, including 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 from either party. Any demonstrable error on the part of the Insurer may invalidate the decision.

20. There is in my view breaches of the *Guidelines* which are sufficient to invalidate the work capacity decision made by the Insurer.

21. The one major difficulty which faced the Insurer in making its work capacity decision is the requirement contained in Clauses 5 and 5.1 of the *Guidelines*. That was in the following terms:

"Clause 5

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Work capacity decisions should be made in line with the Best Practice Decision-Making Guide."

and then:

"Clause 5.1

When making a work capacity decision the insurer should follow the Best Practice Decision Making Guide."

22. That Guide did not exist and has never existed or been published by WorkCover.

23. I find the Insurer has failed to follow the procedure as set out in the *Guidelines* in making the work capacity decision of 30 April 2013 as it did not (and through no fault of its own) comply with the requirements of Clauses 5 and 5.1.

24. Further breaches of the *Guidelines* include failure by the insurer to give adequate notice of the cessation of the applicant's entitlements to weekly payments. Section 54 of the 1987 Act requires the applicant be accorded three months clear notice prior to having his payments changed. The Insurer was required (Section 54(4)) to give the applicant notice personally or by post. By virtue of the postal service rule (Section 76(1)(b) of the *Interpretation Act* 1987*)* , this would have required the Insurer to give the applicant 3 months plus 4 working days for postal service of the notice.

25. Therefore in order to comply with the requirements of Section 54 a notice posted on 30 April 2013 would not permit the reduction or cessation of weekly payments until the expiry of three months and four working days (not including the day of posting) which would set an earliest possible date of 5 August 2013. In my view strict compliance with this Section is required.

26. Additionally, the Insurer has erred in advising the applicant that any entitlement he may have to payment of pre-approved reasonable and necessary medical and other expenses will not be affected until 30 July 2014.

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27. *Guideline* 5.4.2 clearly states that the notice must state the impact of the decision on the worker in terms of their entitlement to medical and related treatment expenses.

28. The notice fails to advise the applicant that his entitlement to medical and treatment expenses will actually cease 12 months after the last date he receives weekly payments of compensation (Section 59A (2) of the 1987 Act).

29. *Guideline* 5.2 states that prior to making a work capacity decision that may result in the termination or reduction of the worker's weekly payments the insurer must contact the worker preferably by telephone or in person at least two weeks prior to the work capacity decision. The notice sent to the applicant in this case is dated 30 April 2013 and states in the first paragraph:

    "*We refer to our discussions with you on 30/4/13 and confirm you are certified fit for permanently modified duties for 12 hours per week."*

    Based upon the face of the letter I cannot for certain conclude that the applicant was given the required notice.

30. *Guideline 5.1* advises the insurer that when making a work capacity decision the insurer should evaluate all available and relevant evidence. *Guideline 5.4.2* further expands on this principle stating that the notice must outline the evidence considered in making the decision, noting the author, the date and key information. All evidence considered should be referred to regardless of whether or not it supports the decision.

31. The notice sent to the applicant refers to the applicant being certified fit for permanently modified duties for 12 hours per week. There is no reference made to any evidence, either medical report or work capacity certificate, supporting this statement. There is no reference to any primary medical evidence in relation to the applicant's capacity in the initial notice.

32. An ineffective attempt by the Insurer to rely upon documentary evidence is made in the Internal Review letter directed to the applicant dated 10

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July 2013. That letter refers to an Earning Capacity Assessment dated 14 February 2013 and an IMC report from Dr Keller dated 1 February 2013. Both of these reports, upon which the work capacity decision was based, pre date the original notice and in accordance with the *Guidelines* these reports should have been referred to in the original decision and copies provided to the applicant.

33. Further at *Guideline 5.4.2*, the notice must advise that any documents or information that have not already been provided to the worker can be provided upon request of the insurer. The insurer has failed to so advise the applicant.

34. I find that as a result of the above reasons the work capacity decision is not effective and the weekly payments amendments do not as yet apply to the applicant.

My Recommendation:

35. For the reasons set out above I recommend that the Insurer make another work capacity decision, according to the *Guidelines*.

36. Since the applicant was an existing recipient as at 1 October 2012, he remains entitled to receive his pre-transition rate of weekly payments 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. The applicant should have his weekly payments restored from 30 July 2013.

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

Tracey Emanuel
Delegate of WorkCover Independent Review Officer
9 January 2014