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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*.*

SUMMARY:

a. **The work capacity decision of the Insurer dated 26 August 2013 is set aside.**

b. **The applicant is to be reinstated to her weekly payments at the rate applicable immediately prior to 3 December 2014.**

c. **The payments are to be back-dated to 3 December 2013.**

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 made by the Insurer on 26 August 2013. The decision stated that payments were to cease on 3 December 2013. The applicant sought internal review. The Internal Review Decision (IRD) was issued on 14 October 2013. The applicant sought Merit Review by the Authority on 30 October 2013. The Merit Review recommendation was issued on 4 June 2014, a cool 217 days later.

2. The applicant was injured on 5 July 2006. The injury was psychological. She 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 (the Regulation) required the transitioning process to be completed *"within 18 months"* of 1 October 2012.

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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 went to the merits of the case, that is, the judgement or discretion of the Insurer. As such, the submissions are not relevant.

Submissions by the insurer

7. The Insurer advised that it would make no submissions.

The Decision

8. The decision does not appear to state that a work capacity assessment was undertaken. The decision has a heading *"Work Capacity assessment – Capacity Decision (Section 43(1))".* There seems to be confusion in the mind of the Insurer as to the difference between an assessment and a decision. The decision does not state that an 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.

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;*

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- *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.

10. The decision states that notice is given pursuant to section 54 of the 1987 Act. The correct reference is to section 54(2)(a) of the 1987 Act. An appropriate time for 3 months notice is then given to 3 December 2013. It should be explained that the 3 months notice takes into account the time for delivery of the notice by post which is governed by section 76(1)(a) of the *Interpretation Act* 1987 which allows for service by post to be effected on the 4th working day after the day of posting. The decision states that the time limit is 3 months and 1 week. A week may at times be insufficient to allow 4 working days such as when public holidays intervene. The 4th working day after 24 December will usually be 2 January, much more than a week. A decision may only be served in person or by post. In this time it is peculiar that a document cannot be served, when appropriate, electronically.

11. Section 43 of the 1987 Act is then set out as to decisions which may be made, including *"a decision about the amount of an injured worker's pre-injury average weekly earnings or current weekly earnings"* (section 43(1)(d) of the 1987 Act). For a claim which is being transitioned to the new legislation, as this claim is, the Insurer cannot make a decision about "*pre-injury average weekly earnings"* (PIAWE). The PIAWE is the transitional rate as set out in Clause 2, Part 19H, Schedule 6 to the 1987 Act. An informed applicant would be rightly concerned that there are two methods to determine PIAWE and would be under the impression that the Insurer has chosen one method in preference to the other. This is misleading, to say the least.

12. The decision states that *"All existing claims (those notified before 1 October 2012) are required to transition to the new entitlement periods*

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based on how many weeks of compensation already received". That is wrong. The Insurer should have referred to clause 1 (the definition of "*existing recipient of weekly payments*"), clause 2 (the transitional amount as indexed which is why the figure used is $938.30), and clause 9(3) (the deeming provision) of Part 19H of Schedule 6 of the 1987 Act. Further, while having notified a claim before 1 October 2012 is essential, the test for being an "*existing recipient of weekly payments*" is having been in receipt of weekly payment immediately before 1 October 2012.

13. The applicant has received 382.40 weeks of weekly payments as at the date of the decision. The relevance of the number of weeks is not explained. The applicant should have been referred to section 32A of the 1987 Act and the definitions of *"first entitlement period"* and *"second entitlement period."* The decision states that the PIAWE will be 80% of the transitional rate. Why this should be so is not explained. Reference is made to section 38(7) of the *Workers Compensation Legislation Amendment Act* 2012. If the applicant looked at that Act she would not find a section 38(7) which has become part of the 1987 Act. An applicant should not need to have grounding in the workings of legislative amendments to understand what she has been misleadingly referred to.

14. The reference to 382.40 weeks is also odd. The decimal seems to be a reference to point 4 of a week. That would be 2 days, 19 hours and 12 minutes. It is unlikely that compensation would be calculated to such a precise measure and would leave the applicant concerned as to the effort that has gone in to this decision. A reference to weeks and days, or merely weeks, would be much more helpful.

15. The decision then states that the applicant's *"entitlement will be calculated as 80% your pre-injury average weekly earnings minus your current actual earnings"* and that the PIAWE is the transitional amount. Again, where this amount is to be found in the legislation is not revealed. By this stage of the decision the applicant may correctly consider that the Insurer is simply making up numbers and figures to suit its own purposes.

16. *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 states that the notice *"does not affect*

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any ongoing entitlements to related medical, hospital, rehabilitation, and travel expenses that are reasonably necessary due to the injury". The decision does not refer to Section 59A(2) of the 1987 Act that provides that treatment expenses and related expenses are no longer payable 12 months after weekly payments cease. The legislation has not been properly referenced.

17. The Insurer failed to point out that 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 clearly because the Insurer was unaware of section 59A.

18. Guideline 5.3.2 requires the Insurer to *"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".* The decision does not state that the applicant has been sent copies of any documents referred to in the decision. She is not told that she may request copies of other documents. This is not assisted by the decision stating that there is a *"WorkCover NSW Certificate of Capacity dated 15.07.2013 states you have capacity for some type of employment from 18.07.2013 to 17.10.2013 for 7.6 hours per day, 3 days per week".* What this work may be is left unsaid. This is a demonstrable error.

19. The applicant is advised that she may seek an Internal Review within 30 days of receiving the decision. That is not correct. Section 44(1)(a) of the 1987 Act does not set any time limit in which the application for internal review is to be made. *Guideline* 7.1.2 refers to *"timely lodgement"* and that the application should be lodged *"as soon as practicable after receiving the work capacity decision."* A time-frame of 30 days may well be appropriate, but no assistance is given as to what may constitute *"timely lodgement."*

FINDING

20. I find that the Insurer has failed to follow the procedures as set out in the WorkCover *Guidelines* which is required by Section 44A of the 1987 Act.

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The Insurer has also failed to follow the 1987 Act and the *Workers Compensation Regulation* 2010.

RECOMMENDATION

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

22. I recommend that the Insurer pay the applicant the weekly benefit to which she was entitled prior to 3 December 2013 until such time as she is properly transitioned. Those payments should continue from 3 December 2013 being the date on which they ceased.

23. 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 3 December 2013 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
19 August 2014