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*.*

SUMMARY:

a. The work capacity decision of the Insurer dated 2 October 2013 is set aside.

b. The applicant is to be reinstated to his weekly payments at the rate applicable immediately prior to 10 January 2014.

c. The payments are to be back-dated to 10 January 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 made by the Insurer on 2 October 2013. The decision stated that payments were to cease on 10 January 2014. The applicant sought internal review and that decision (IRD) issued on 5 November 2013. The applicant applied for Merit Review on 3 December 2013 and that decision was issued on 3 July 2014, 212 days later.

2. The applicant was injured on 25 September 2003. The injury was to his back. He returned to suitable employment with other employers. 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 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 assessment and subsequent 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 8 August 2013 which came into effect on 12 August 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 very object of judgement or discretion of the Insurer excluded by section 44(1)(c) and therefore could not be relevant to this review.

Submissions by the insurer

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

The Decision

8. The heading to the decision states that it is a notice *"in accordance with Section 54 of the Workers Compensation Act 1987". Guideline* 5.3.2 requires the Insurer to make reference to the legislation. The correct reference is to section 54(2)(a) of the 1987 Act.

9. The decision states that a work capacity assessment was completed on 19 August 2013. There does not appear to be any legislative requirement to notify the applicant of the outcome of the assessment. However, *Guideline* 5.3.2 states 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. *Guideline* 5.3.2 required the decision to *"reference the relevant legislation."* This would require any interpretation of the legislation (including delegated legislation) to be accurate. It is clearly inaccurate to say (as this Insurer has said) that the claim *"must transition to the new benefits system in 2013."* 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 (for the 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 the claim to be transitioned *"in 2013."*

11. *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 section 59A(2) of the 1987 Act provides that treatment expenses and related expenses are no longer payable 12 months after weekly payments cease. However, 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.

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12. The decision states that the applicant has a *"current capacity to work"* and reference is made to section 43(1)(a) of the 1987 Act. The correct reference is to the definition of *"current work capacity"* in section 32A of the 1987 Act. That definition means being unable to return to pre-injury employment, but being able to work in *"suitable employment."* That term is also defined in section 32A. It is central to the 2012 amendments. The definition includes, *inter alia*, that suitable employments includes work *"whether the work or the employment is of a type or nature that is generally available in the employment market".* An applicant is unlikely to know from the term suitable employment that it may include work which may not exist.

13. Further into the decision suitable employment is described in 2 paragraphs, but the reference to section 32A is only in the second paragraph. An applicant could believe that section 32A is only that 2nd paragraph and that the 1st paragraph is a policy of the Insurer.

14. The applicant is advised that section 38 of the 1987 Act applies to him as he has been in receipt of weekly payments for in excess of 130 weeks as that is the expiration of the second entitlement period. It should be explained that the *"second entitlement period"* is defined in section 32A of the 1987 Act. It is not merely a concept devised by the Insurer.

15. The decision then states that payments must cease within 3 months. The correct reference is made to section 54(2)(a) of the 1987 Act. Upon reading that legislation the applicant would see that the 3 month time limit is a minimum and not a maximum period. This is a demonstrable error.

16. The applicant is advised that the transition amount applies to him as his claim was notified prior to 1 October 2012. That is incorrect. While the claim must have been notified before that date, the test is being in receipt of weekly payments immediately before 1 October 2012. Reference is made to section 43(1)(d) of the 1987 Act. That reference would not assist the applicant. The Insurer should have referred to clause 1 (the definition of "*existing recipient of weekly payments*"), clause 2 (the transitional amount as indexed), and clause 9(3) (the deeming provision) of Part 19H of Schedule 6 of the 1987 Act.
17. The decision lists documents which the Insurer has *"reviewed and considered".* The Insurer also states that the *"information* ***which supports our decision*** *indicates …" Guideline* 5.3.2 states that all

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evidence considered should be referred to, whether or not it supports the decision. The Insurer by referring to *"information which supports our decision"* is making a statement[1] that the Insurer has *only* considered information which supports the decision. Any information which does not support the decision may well have been ignored. In the circumstances, this misleading (and probably inculpating) statement is a demonstrable error.

18. The decision states that it was made by a *"Technical Specialist."* The nature of this technical specialist's specialization is not stated and would not be apparent to the applicant.[2] It is then stated that the decision was reviewed and confirmed by the *"Work Capacity Team."* No names are given. The decision is signed by the "*Work Capacity Team*", not the Technical Specialist who is said to have made the decision. The applicant cannot know who made the decision. This is important as the IRD must be made by someone who was not involved in the decision: see *Guideline* 6.2.6.[3] When the decision-maker cannot be identified by the applicant, he cannot know whether the IRD was undertaken by someone not involved in the decision. This is a breach of the requirement that the assessment, decision-making and review processes be conducted and communicated to injured workers in a transparent manner.[4]

19. The applicant is advised that he may seek an Internal Review which may be lodged by facsimile or email. He is not advised that may also be lodged by post or by hand. This is also unusual as the decision can only be served by post or in person.

20. At the end of the decision and purporting to form part of the decision are 6 pages of extracts from the 1987 Act under the heading "Key Sections of the Workers Compensation Act NSW 1987 referred to within this Notice". That is incorrect as some parts of the extract are in the decision, some are not and there is no reference to the Regulation. Setting out large swathes of the 1987 Act under a misleading heading is not helpful. By way of example sections 36 and 37 of the 1987 Act are included, and are not relevant to the applicant's case. Section 32A is set out in full. Many definitions in that section are of no relevance to the applicant.

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[1] At least by implication.
[2] A "technical" objection in the most literal sense.
[3] See also 7.2-7.5 of the *Review Guidelines*.
[4] See for instance *Work Capacity Guideline* 2.3.

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FINDING

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

RECOMMENDATION

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

23. I recommend that the Insurer pay the applicant the weekly benefit to which he was entitled prior to 10 January 2014 until such time as he is properly transitioned. Those payments should continue from 10 January 2014 being the date on which they ceased.

24. 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 10 January 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
2 September 2014