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(1)(c) OF THE *WORKERS COMPENSATION ACT* 1987.

1. The applicant, an injured worker, has applied for procedural review of a work capacity decision (the decision) made by the Insurer on 16 July 2013.

2. In 1999 the applicant worked for the insured on a full-time basis, and had concurrent part-time employment with a different employer in a related field. There is no dispute that the applicant was injured in the course of his full-time employment with the insured on 11 June 1999. The applicant attempted a return to that work, but was unsuccessful. That employment was terminated in 2000. The applicant still works on a casual basis in his part-time position, which he has held since before 1999. 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. 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.

4. Section 44A of the 1987 Act provides that a work capacity assessment is an assessment of the injured worker's current work capacity and must be conducted in accordance with the *WorkCover Work Capacity Guidelines* (Guidelines).

5. The relevant version of the *Guidelines* is the one published on 27 September 2012 which applied to all claims from 1 January 2013. That publication stated that the *Guidelines* provide instructions and guidance to Insurers regarding the appropriate and consistent application of work capacity assessments and decisions.

6. Once the Insurer has conducted an assessment then the Insurer is required to make a work capacity decision. Where that decision involves

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a reduction in the weekly benefits payable to the injured worker[1] then the Insurer is required to give proper notice to the worker (Section 54(2)(a) of the 1987 Act).

7. The applicant raised certain matters in the Application for Procedural Review. 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 believes that a close personal relationship between the Insurer and WorkCover has created a biased decision. The applicant provides no evidence to support his contention and I dismiss it.[2] The next issue is that *Guideline* 5 and 5.1 requires the Insurer to use something described as the *"Best Practice Decision-Making Guide".* This is a difficulty which faced the Insurer in making its work capacity decision. *Guideline* 5 and 5.1 is in the following terms:

   "Clause 5

   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.*"

8. That Guide did not exist and has never existed. It follows that through no fault of its own the Insurer has not followed the *Guidelines.*

9. The other issues raised by the applicant go to the merits of his matter which are matters for the judgement and discretion of the insurer. They are therefore not relevant to this review.

10. The decision states that a work capacity assessment has been made. The decision does not state that this is a requirement pursuant to Clause

[1] Or cessation of weekly benefits.
[2] It is not disclosed how corporate or statutory persons can have a personal relationship, let alone a "close" one, but for the purposes of procedural review particulars need not be sought.

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8 of Part 19H of Schedule 6 to the 1987 Act. As such the legislation has not been properly referenced as *Guideline* 5.4.2 requires. The insurer is required to make a decision "*as soon as practicable"* after the assessment is made: Clause 23, Schedule 8, *Workers Compensation Regulation* 2010. The Insurer advised the applicant *"about the pending Work Capacity Assessment by phone call and letter on 13/06/2013"* according to the Internal Review Decision of 20 August 2013. There does not appear to be any legislative requirement to notify the applicant of the outcome of the assessment. However, *Guideline* 5.4.2 states 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 reasoning for the decision.*

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

11. In this case the applicant does not know when the assessment took place. The applicant cannot know whether the decision was made "*as soon as practicable"* after the assessment

12. *Guideline* 5.2 requires the Insurer to make a *"fair notice"* telephone call to the applicant "*at least two weeks prior to the decision*." A pentalogue of procedural bullet-points are then set out, thus:

    - *inform the worker that a review of their current work capacity is being undertaken and that a work capacity decision is going to be made*
    - *explain that this review may include further discussions with other parties such as their employer, nominated treating doctor or other treatment providers*

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- *advise the potential outcome of this review and detail the information that has led the insurer to their current position*
- *provide an opportunity for the worker to supply any further information to the insurer for further consideration and the date that this information is to be provided by*
- *tell the worker when this decision is expected to be made.*

13. The decision notes that "*We attempted to contact you on the 15th and 16th of July 2013 to discuss the following",* that is, the decision. It is not stated how the Insurer attempted to make contact. *Guideline* 5.4. states that the insurer shall:

    • *telephone and speak to the worker at the time of the decision to:*
      - *inform the worker that a work capacity decision has been made*
      - *explain the outcome and consequences of this decision and the information that has led the insurer to their current position*
      - *explain the internal review process and that a review application will be sent with the notice*
      - *confirm that the decision will be conveyed in writing.*

14. In this matter the failure to follow the *Guidelines* on 2 occasions, which amounts to 3 breaches, has meant the applicant was unaware of the decision until he received it. This has meant that the applicant was not given the opportunity to provide further information.

15. *Guideline* 5.4.2 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".* Section 59A(2) of the 1987 Act states that treatment expenses and related expenses are no longer payable 12 months after a worker ceases to be entitled to weekly payments of compensation. The decision states that "*any entitlement you may have to payment of pre-approved reasonable and necessary medical and other expenses, until 22 October 2014, will not be affected".* This statement gives no information to the applicant about the effect of section 59A(2) on such

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entitlements beyond 22 October 2014. The effect of section 59A(2) of the 1987 Act has therefore been disguised, if not misrepresented.

16. 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. This was not disclosed by the Insurer.

17. The decision states that weekly payments are to be calculated pursuant to section 38 of the 1987 Act. The proper reference is to section 38(6) of the 1987 Act. The decision states that for the purposes of this "*formula"* the applicant has a current capacity to work and has returned to work for not less than 15 hours. The decision then refers to section 43(1)(a) of the 1987 Act. That reference would not assist the applicant. The correct reference is to section 38(3)(b) and (c) of the 1987 Act.

18. Then the decision states that the applicant's average weekly earnings (AWE) is $938.30. The decision tries to explain that the AWE is the transitional amount, and refers to section 43(1)(d) of the 1987 Act. That section is irrelevant in explaining this issue. The proper reference is to clause 2, Part 19H, of Schedule 6 to the 1987 Act which give the transitional amount. In addition Clause 9(3), Part 19H, of Schedule 6 to the 1987 Act provides that for the applicant his AWE is the transitional amount. An applicant is unlikely to have an intimate and detailed knowledge of workers compensation legislation and regulation. This is an issue which should be explained in plain language as required by *Guideline* 5.4.1 which states, *inter alia:*

> *Plain language communication requires:*
>
> - *being considerate of the nature of the worker's circumstances*
> - *communicating respectfully*
> - *communicating a clear message*
> - *presenting concise information*
> - *adapting communication style to meet the worker's needs.*

19. The applicant is told that he can earn a certain amount in suitable employment, and what that employment is. Section 43(1) (b)(c) and (d) are referred to. Again, this reference will not assist the applicant. Further down the proper reference is made to section 32A of the 1987 Act but

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no reference is made to the definition of *"current work capacity"* which is also in section 32A of the 1987 Act. The applicant in relation to *"current work capacity"* is referred to section 43(1)(a) of the 1987 Act. These terms have a specific definition in the 1987 Act which makes it essential that they are referenced. An applicant is unlikely to understand that these terms have a specific meaning in the 1987 Act and do not necessarily convey what their ordinary meaning may suggest.

20. The decision states that an applicant *"who is assessed as having current work capacity is only entitled to weekly benefits beyond the second entitlement period, ie 130 weeks, if:"* Section 38(3)(b) and (c) of the 1987 Act are then set out. While section 38 of the 1987 Act is referenced, the decision does not refer to Section 32A. Section 32A of the 1987 Act defines "*current work capacity"* and "*second entitlement period"* but the decision fails to refer to that section. These 2 terms have a specific definition in the 1987 Act which makes it essential that they are referenced. These are, therefore, breaches of *Guideline* 5.4.2 and the need to *"reference the relevant legislation".*

21. *Guideline* 5.4.2 requires the decision to set out brief reasons, outline the evidence, and explain the reasoning for the decision. See paragraph 12 above. The decision states that "*we have reviewed and considered the following information"* and then sets out 8 documents. No reasoning is given, clearly or otherwise. What evidence the documents provided is not set out. No suggestion is given that some evidence may have not supported the decision. The applicant is left completely in the dark as to how the Insurer came to its decision.

22. *Guideline* 5.4.2 also states that the work capacity decision notice must advise the applicant that any documents or information that have not already been provided to the applicant can be provided on request to the Insurer. The Insurer has failed to so advise the applicant. The Insurer states that further copies of documents already provided can be made available. The Insurer does not state that there are no other documents. The insurer's statement suggests to an applicant that there are no other relevant documents. An applicant may well disagree if he has the opportunity to peruse such other documents. Documents are to be provided as required by *Guideline* 5.4.2, which has not been referred to.

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23. In addition, the decision states that copies of documents already provided can be obtained from [the Insurer] Workers Compensation (NSW) Ltd "*on the number below".* This would confuse the applicant when the decision has been made by [the Insurer] Insurance Ltd, as agent for NSW Self Insurance Corporation. There appear to be two distinct entities involved in the decision-making process. Further, "the number below" is confusing as both a facsimile number and a telephone number are given. The applicant is not advised that he can contact the Insurer by email or ordinary post.

24. The applicant is advised that he may request an internal review. The Insurer has not referred to section 44 of the 1987 Act. This is a breach of *Guideline* 5.4.2 and the need to *"reference the relevant legislation".* The Insurer states that the request can be made by facsimile or email. The Insurer does not say that such a request can be made by post.

25. The advice as to the internal review states that the application form should be completed and "*returned to us with the extra information, reports and/or documents you rely upon"* (emphasis added). This statement conveys the impression that an applicant must provide further evidence or information in order to make an application for internal review. That is misleading. The applicant may request an internal review pursuant to section 44 of the 1987 Act whether or not further evidence or information is available or submitted.

26. The applicant is advised that if he is dissatisfied with the internal review he may seek a merit review from WorkCover. Again, the Insurer has not referred to section 44 of the 1987 Act. The applicant is also advised that WorkCover will *"provide a response to you within 30 days of receipt of your request."* This time frame is set out in the *Guidelines for work capacity decision Internal Reviews by Insurers and Merit Reviews by the Authority* dated 11 October 2013. *Guideline* 10.14 states "*The Authority will write to the worker and insurer as soon as practicable and preferably within 30 days of receiving the application advising of the outcome of the merit review."* The Authority received the application for review on 27 September 2013 and issued the review on 24 January 2014, some 119 days later. It seems that *Guideline* 10.14 is one for breach of which there exists no current remedy.

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FINDING

27. 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

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

29. I recommend that the Insurer pay the applicant the weekly benefit to which he was entitled prior to 16 July 2013 until such time as he is properly transitioned. Those payments should continue from 23 October 2013 being the date on which they ceased.

30. 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 23 October 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(h) of the 1987 Act.

Wayne Cooper
Delegate of the WorkCover Independent Review Officer
17 February 2014