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 made by the Insurer on 16 July 2013.

2. There is no dispute that the applicant was injured in the course of his full-time employment with the insured on 23 March 2010. The applicant has been able to maintain suitable employment with the insured since the injury. 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 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).

[1] Or cessation of weekly benefits.

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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 first matter is his interpretation of Part 19H of Schedule 6 to the 1987 Act. He states that Part 19H requires there to be a 3 month delay between the assessment and the decision.[2] Part 19H is quite confusing to most experienced lawyers. It is no surprise that non-lawyers might occasionally misunderstand the meaning of certain clauses which even the drafters of the legislation sought to clear up by amending a different instrument. The effect of Part 19H and in particular clauses 9 and 11 is that Division 2 of Part 3 of the 1987 Act applies to the applicant as an "*existing recipient of weekly payments"* as defined in clause 1 of Part 19H. 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.[3]

8. The decision states that a work capacity assessment has been made. The decision does not state that this is a requirement 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* 5.4.2 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 decision states that the Insurer and the applicant had discussions on 7 June 2013. The Insurer advised the applicant *"We informed you by phone on 7/06/2013 of the work capacity assessment"* according to the Internal Review Decision of 5 September 2013. 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.

9. 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:

[2] It does not. All it says (or, more accurately, tries to say) is that three months after a worker is transitioned, the weekly payments they receive are adjustable in accordance with the 2012 amendments. The insertion of cll 22-23 in Schedule 8 to the *Workers Compensation Regulation* 2010 are an apparent attempt to 'clarify' the wording in cll 6 and 9 of Part 19H, Schedule 6 to the 1987 Act; an attempt which, it has to be said, clearly enjoyed limited success in this case.
[3] See section 44(1)(c) of the 1987 Act.

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- *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.

10. *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 medical 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 17 October 2014, will not be affected".* This statement conveys no information to the applicant concerning the effect of section 59A(2) on such entitlements beyond 17 October 2014. The effect of section 59A(2) of the 1987 Act has therefore been disguised, if not misrepresented.

11. 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.

12. The decision states that the Notice is given pursuant to section 54 of the 1987 Act. *Guideline* 5.4.2 requires the Insurer to *"reference the relevant legislation".* The proper reference in this case is to section 54(2)(a) of the 1987 Act.

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13. The applicant has received more than 130 weeks of weekly payments. The decision states that as a result of section 38 of the 1987 Act that weekly payments cease for the applicant due to the expiry of the second entitlement period unless certain conditions are met under section 38 of the 1987 Act. The decision does not refer to section 32A of the 1987 Act and the definition of "*second entitlement period".* The legislation has not been properly referenced.

14. The decision then 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 but it is not stated that it is that legislation which is being set out. While section 38 of the 1987 Act is referenced, albeit improperly, the decision does not refer to Section 32A. Section 32A of the 1987 Act defines "*current work capacity*" but the decision fails to refer to that section. This term has a specific definition in the 1987 Act which makes it essential that it is referenced. These are breaches of *Guideline* 5.4.2 and the need to "*reference the relevant legislation".*

15. The decision states that weekly payments "*must cease within 3 months of this decision"* and refers to section 54(2)(a) of the 1987 Act. Were the applicant to read section 54(2)(a) he would see that 3 months is the minimum notice period, and not a maximum payment period as the Insurer would have him believe.

16. *Guideline* 5.4.2 requires the decision to set out brief reasons, outline the evidence, and explain the reasoning for the decision. See paragraph 9 above. The decision states that "*we have reviewed and considered the following information"* and then sets out 4 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 no better informed of the Insurer's reasoning process as a result reading this letter than he was before seeing it.

17. *Guideline* 5.4.2, which has not been referred to, 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

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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. Further, the Internal Review Decision of 5 September 2013 refers to documents not referred to in the decision. By that time the applicant might very well be concerned that there may be documents held by the Insurer and, perhaps, ignored by the Insurer when making the decision.

18. 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. A worker in the position of the applicant without electronic means of transmitting an application for review would be entitled to believe that there was no prospect of seeking internal review.

19. 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. Section 44(2) only requires the applicant to provide *grounds* for seeking review.

20. 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 13 September 2013 and issued the review on 14 January 2014, some 123

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days later. It seems that *Guideline* 10.14 is one for the breach of which there exists no current remedy.

21. Attached to, and forming part of the decision, are excerpts from the 1987 Act totalling nearly 6 pages. These pages have the heading "*Key Sections of the Workers Compensation Act NSW 1987 referred to within this Notice."* Nothing could be further from the truth. These pages set out, *inter alia,* sections 32A, 36, 37, 44, and 44A of the 1987 Act, none of which are referred to in the body of the Notice. The applicant can only have been confused by these sections, particularly sections 36 and 37 which do not apply to his circumstances. Not having explained and referred to the relevant sections in the body of the decision and then providing 6 pages of excerpts is far from explaining the decision in plain language as required by *Guideline* 5.4.1.

FINDING

22. 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

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

24. I recommend that the Insurer pay the applicant the weekly benefit to which he was entitled prior to 12 July 2013 until such time as he is properly transitioned. Those payments should continue from 17 October 2013 being the date on which they ceased.

25. 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 17 October 2013 to date by virtue of the operation of section 44B(2) of the 1987 Act. These

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recommendations are binding on the insurer: see section 44(h) of the 1987 Act.

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