WorkCover independent review office

Level 4, 1 Oxford Street, Darlinghurst NSW 2010
T: 13 9476
contact@wiro.nsw.gov.au
www.wiro.nsw.gov.au

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 12 July 2013.

2. There is no dispute that the applicant was injured in the course of his full-time employment with the insured on 4 May 2012. The applicant returned to work in suitable duties, but was made redundant on 30 June 2013. The Insurer made weekly payments as required under the provisions of the *Workers Compensation Act* 1987 (1987 Act).

3. It is unclear as to whether the applicant was in receipt of compensation by way of weekly payments immediately before 1 October 2012. If he was then 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.

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 (see, relevantly, section 54(2)(a) of the 1987 Act).

[1] Or cessation of weekly benefits.

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Submissions by the applicant

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".* He makes the following points:

    - The fair notice provisions of *Guideline* 5.2 were not properly followed;

    - The legislation has not been properly referenced as required by *Guideline* 5.4.2;

    - The line of reasoning for the decision is not explained as required by *Guideline* 5.4.2;

    - The applicant then raises Guideline breaches in relation to the Internal Review Decision (IRD) and the Merit Review Decision (MRD), particularly as to its lateness. The application for Merit Review was lodged on 8 October 2013.

8. The Merit Review Decision was made on 19 February 2014, 133 days later. While this is a seemingly extraordinary delay, given that *Review Guideline* 10.14 as at 8 October 2013 required a decision to be made "within 30 days," there is no known remedy available to the applicant for this clear breach by the Authority of its own *Guideline*. Section 44(1)(c) of the 1987 Act states that this procedural review is only in relation to the work capacity decision, not the IRD or MRD.

Submissions by the Insurer

9. The Insurer raised matters in reply to the applicant's application:

    - A work capacity assessment began on 1 March 2013 and was completed on 12 July 2013;

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- A fair notice telephone call and letter were undertaken on 20 June 2013 and *Guideline* 5.2 was complied with;

- Section 59 rather than section 59A of the 1987 Act was referred to;

- References to sections 43(1)(a)(b)(c) and (d) of the 1987 Act were used together with the definitions set out in Section 32A of the 1987 Act to explain the decision;

- The remaining matters raised are with respect to the merits of the case and the Insurer correctly states that such matters are outside the scope of this review.

10. *Guideline* 5.2 requires the Insurer to make a "*fair notice"* telephone call to the applicant *"at least two weeks prior to the decision."* The Insurer made a fair notice telephone call and sent a letter on 20 June 2014. Neither of these advised the applicant that a *work capacity assessment* was to take place. A work capacity assessment is a requirement pursuant to Clause 8 of Part 19H of Schedule 6 to the 1987 Act. The Insurer only stated in the letter that it "*is currently assessing information from your file."* The insurer is required to make a decision "*as soon as practicable"* after the assessment is made: see Clause 23, Schedule 8, *Workers Compensation Regulation* 2010 (the Regulation). The decision notice does not reveal the date of the assessment and the applicant cannot have known when he read it if the decision was made "*as soon as practicable"* after the assessment. The legislation has also not been properly referenced as *Guideline* 5.4.2 requires, since clause 8 of Part 19H of Schedule 6 to the 1987 Act and clause 23, Schedule 8, of the Regulation are not referred to in the decision.

11. The Insurer's submissions stated that the assessment began on 1 March 2013 and was concluded on 3 June 2013. The applicant cannot have known that from the decision or IRD.

12. 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:

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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 line of reasoning for the decision.*

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

14. The decision states that weekly payments will cease on 20 October 2013 pursuant to section 54 of the 1987 Act. The correct reference is to section 54(2)(a) of the 1987 Act. Therefore legislation has not been properly referenced.

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 the Insurer *"will continue to approve"* treatment expenses as defined by section 60 of the 1987 Act but that such expenses will expire 12 months later. The date given is 20 October 2014 and the decision refers to section 59 of the 1987 Act. The correct reference is to section 59A(2) of the 1987 Act.[2]

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.

[2] Perhaps oddly, the Insurer actually included in submissions that it had referred to section 59 rather than section 59A, as though this were a point in its favour. See paragraph 9, *supra*.

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17. Under the heading "*Reasons for this decision"* is a sub-heading "*Your work capacity (in accordance with Section 43(1)(a))".* Section 32A of the 1987 Act is not referenced in relation to *"current work capacity".* The sub-heading does not state that section 43(1)(a)) is to be found in the 1987 Act.

18. The next sub-heading is *"Your ability to work in suitable employment (in accordance with Section 43(1)(b))".* Section 32A of the 1987 Act is not referenced in relation to *"suitable employment". "Suitable employment"* is an important definition as it is not in accord with how an applicant is likely to understand that phrase in common parlance.[3] The sub-heading does not state that section 43(1)(a)) is to be found in the 1987 Act.

19. *"Suitable job options"* are then set out under the sub-heading *"The amount you are able to earn in suitable employment (in accordance with Section 43(1)(c))".* Section 32A of the 1987 Act is not referenced in relation to *"suitable employment".* The heading does not state that section 43(1)(c)) is to be found in the 1987 Act.

20. The next sub-heading *"Your Pre Injury Average Weekly Earnings (in accordance with Section 43(1)(d))"* does not state that average weekly earnings (AWE) is defined in section 35 of the 1987 Act. It is not said that section 43(1)(d) is to be found in the 1987 Act. The applicant is told that his AWE is $938.30 and it is the transitional rate that is *"applied to all claims lodged prior to 1 October 2012. This is a result of the Workers Compensation Legislation Amendment Act 2012. The application of this rate is in accordance with Schedule 6, Part 19H, Clause 9 of the Workers Compensation Act 1987, Transitional Provisions."* The first issue is that the date of lodgement of the claim is not relevant. What is relevant is that the applicant was in receipt of weekly payments immediately before 1 October 2012, as required by *Schedule 6, Part 19H, Clause 1 of the Workers*

[3] The law regularly defines words to mean certain things as shorthand for others in legislation and documents. "When I use a word," Humpty Dumpty said, in rather a scornful tone, "it means just what I choose it to mean — neither more nor less." – see Carroll, L: *Through The Looking Glass*, Chapter 6 - http://sabian.org/looking_glass6.php

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Compensation Act 1987.[4] Clause 9 is not properly referenced as it is clause 9(3) which is relevant. The decision should also refer to *Schedule 6, Part 19H, Clause 2(1) of the Workers Compensation Act 1987* and that the figure therein given of $906.25 is indexed annually pursuant to sections 79 and 80 of the 1987 Act and that is how $938.30 is arrived at.

21. The final sub-heading is "*Calculation of Your New Weekly Benefit Rate".* The decision then refers to the applicant having received *more than* 14 weeks and less than 130 weeks of payments and that weekly payments are determined in accordance with section 37. Section 37(3) is the correct reference and the 1987 Act has not been referenced. What is missed is a reference to section 32A and the definition of *"second entitlement period".* The applicant could have then seen that 14 weeks is incorrect, and that the *"second entitlement period"* begins after 13 weeks: week 14 is the start of the *"second entitlement period".*

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 decision lists 7 documents that are relied upon. Some of those are groups of documents such as payslips. The Insurer does not state that there are no other documents. The insurer's statement suggests to an applicant that there are no other documents. An applicant may well disagree if he has the opportunity to peruse other documents. The IRD lists 13 documents, including a report from a medical specialist and a vocational assessment report not referred to in the decision. On 8 October 2013 the Insurer wrote to the applicant and stated "*I can confirm that we have also attached the following documents which have not been relied upon before in our reply."* The 4 documents listed include 2 medical reports.

23. An applicant could at this stage genuinely be concerned that there may be other documents that have not been disclosed. *Guideline* 5.4.2 states that "*All evidence considered should be referred to,*

[4] Of course, to be in receipt of weekly payments immediately before 1 October 2012 requires that the claim must have been lodged before 1 October 2012. Claim lodgement therefore is a *necessary* qualification, without being a *sufficient* one.

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regardless of whether or not it supports the decision". An applicant cannot know from the decision as to whether there is any such evidence. Considering the slow drip feed of documents from the Insurer, the applicant, even by this stage, could have had little faith that all documents had been revealed, or that all documents had been properly considered.

24. When referring to the applicant's submissions the Insurer made reference to "*the worker's marinated treating doctor."* I am unable to see the relevance of the culinary habits or even the alleged alcoholic or other cravings of a treating doctor in relation to a work capacity decision. If on the other hand "marinated" is thought to be a synonymn of "nominated," I might be bold enough to suggest more use of the latter and less of the former.[5]

25. The applicant submitted that the decision does not explain the line of reasoning, as *Guideline* 5.4.2 requires. As the decision maker did not have all relevant documents before them it can possibly be considered that there is a fundamental error in the reasoning of the decision and a breach of *Guideline* 5.4.2.

26. The applicant is advised that he may request an internal review. The Insurer has not referred to section 44(1)(a) of the 1987 Act. This is a breach of *Guideline* 5.4.2 and the need to *"reference the relevant legislation".*

27. The applicant is advised that the application for internal review must be sent within 30 days of receiving the decision. That is not what the 1987 Act says. Section 44(1)(a) of the 1987 Act allows for the applicant to seek an internal review, but with no time limit. The *Guidelines for work capacity decision Internal Reviews by insurers and Merit Reviews by the WorkCover Authority* 6.5 which came into effect on 1 January 2013 stated that the application for internal review must be lodged within 30 day of receipt of the decision. This was in conflict with the Act. The Insurer may have been comforted by that *Guideline*, but the next iteration of *Guideline* 6.5 which came into effect on 11 October 2013 corrected itself and that guideline now

[5] If, as a third alternative, it is simply a typographical error, perhaps more thorough proof-reading of decisions would be in order.

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states that the applicant should lodge the application "*as soon as practicable after receiving*" the decision.

28. The advice as to the internal review states that the application form should be completed and returned and *"include any extra information, reports and documents to support you request for review. Any new or additional matters that you would like us to consider will need to be provided as part of this application."* 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.

FINDING

29. 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

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

31. 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 20 October 2013 being the date on which they ceased.

32. 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 20 October 2013 to date

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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
13 March 2014