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 made by the Insurer on 18 September 2013.

2. The applicant was injured on 10 May 2007. The applicant has not been able to return to his pre-injury employment. 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* came into effect on 12 August 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 then the Insurer is required to give proper notice to the worker (Section 54(2)(a) of the 1987 Act).

Submissions by the applicant

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7. The applicant raised various 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 submits that the insurer failed to advise him of information provided by his nominated treating doctor as a result of requests made to the doctor in 2012. These documents do not appear to be listed in the decision and therefore it is difficult to know how the applicant became aware of this information. It is also symptomatic of Insurers regularly failing to list all relevant documents, including those which do not support the decision as required by *Guideline* 5.3.2.

8. The Insurer made no submissions.

The Decision

9. 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* 5.3.2 requires. The insurer in the Internal Review Decision (IRD) of 12 November 2013 states that the applicant was advised about the assessment on 27 August 2013 and that was confirmed in writing the same day. While laudable, there is no evidence as to when the assessment was undertaken. 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. 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;*

   - *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.*

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

10. 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.

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".* 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 25 December 2014, will not be affected".* This statement gives no information to the applicant about the effect of section 59A(2) on such entitlements beyond 25 December 2014. The effect of section 59A(2) of the 1987 Act has therefore been disguised, if not misrepresented.

12. 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.

13. *Guideline* 5.3.2 requires the Insurer to *"reference the relevant legislation".* 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.

14. The decision states that section 38 provides that weekly payments cease on the expiry of the "*second entitlement period"* unless certain criteria are met. Reference should be made to section 32A of the 1987 Act and the definition of "*second entitlement period"*. The criteria in section 38(3)(b) and (c) of the 1987 Act are then set out but the section is not referenced.

15. The decision states that as a result of the assessment that the applicant has *"a current capacity to work". "Current work capacity"* is defined in

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section 32A of the 1987 Act. The legislation has not been referenced. That definition refers to "*suitable employment*" which is itself defined in section 32A of the 1987 Act. It is unlikely that an applicant would know that "*suitable employment"* is a technical term that bears little resemblance to the usual meaning of that phrase. The terms of section 38(3)(b) of the 1987 Act is then set out again, but once more the legislation is not referenced. The decision then states that *"you are no longer entitled to weekly payments under the new benefits system – please refer to: Section 38 of the Workers Compensation Act 1987."* The proper reference is to section 38(3)(b). It is again unlikely that an applicant would be able to comprehend such an allusive reference to section 38(3)(b) of the 1987 Act in order to deduce why payments are to cease.

16. Reference is then made to section 54(2)(a) of the 1987 Act and that *"weekly payments at your current rate must cease within 3 months of this decision".* On this occasion the applicant has been referred to the correct section. Upon reading that section the applicant would see that 3 months is the minimum period and not a maximum period as the Insurer has stated. This is a demonstrable error.[1]

17. The applicant is told that he can earn a certain amount in suitable employment, and what that employment is. Section 43(1)(b) of the 1987 Act is referred to. Again, this reference will not assist the applicant. Further down *"suitable employment*" is explained in 2 paragraphs. At the end of the second paragraph a reference is made to section 32A of the 1987 Act. The applicant would be unlikely to know that both paragraphs set out the definition of *"suitable employment"* and not just the second paragraph.

18. *Guideline* 5.3.2 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 7 documents. Further down the Insurer refers to 3 more documents *"that have been considered but which have not previously been provided to you".* The earliest document is dated 13 December 2012. The applicant was injured on 10 May 2007.

[1] See see *New South Wales Police Force v Registrar of the Workers Compensation Commission of New South Wales* [2013] NSWSC 1792 (11 December 2013) at paragraphs 39-56.

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It would be extraordinary if no documents existed between 2007 and 2012. No reasoning is given for the decision, 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.

19. *Guideline* 5.3.2 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 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* 5.3.2, which has not been referred to.

20. 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* 5.3.2 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.

21. The advice as to the internal review states that the application form should be completed and "*returned to us with <u>the</u> 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(1)(a) of the 1987 Act whether or not further evidence or information is available or submitted. The applicant is only required to provide "*grounds"* in an application for internal review as required by *Guidelines for work capacity decision Internal Reviews by insurers and Merit Review by the WorkCover Authority* 6.2.

22. The decision states that the request for internal review must be sent within 30 days of receiving the decision. The *Guidelines for work capacity decision Internal Reviews by insurers and Merit Review by the WorkCover Authority* 6.5 which came into effect on 1 January 2013

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states that the application for internal review must be lodged within 30 days of receiving the decision. Section 44(1)(a) of the 1987 Act does not impose any set time limit. The iteration of the *Guideline* which came into effect on 11 October 2013 correctly sets out that there is no time limit, and that the application for internal review must be lodged *"as soon as practicable after receiving"* the decision. The lack of a set time limit leaves what is an appropriate time most unclear. A guide to a time limit is that an application for merit review under section 44(3)(a) of the 1987 Act must be made within 30 days of the applicant receives notice of the IRD.

23. The decision states that "*frivolous and vexatious applications may be rejected".* The *Guidelines for work capacity decision Internal Reviews by insurers and Merit Review by the WorkCover Authority* 6.7 that came into effect on 1 January 2013 supports this view. The next iteration of the *Guideline* which came into effect on 11 October 2013 is silent on this point, for the very reason that an Insurer cannot refuse to carry out an internal review even where it decides that an application is frivolous or vexatious. The Authority and WIRO may decline to review a matter where the application is frivolous or vexatious (not frivolous <u>and</u> vexatious as the decision says) pursuant to section 44(3)(c) of the 1987 Act.

24. 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(1)(b) 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 2 December 2013 and issued the review on 26 February 2014, some 86 days later. It seems that *Guideline* 10.14 is one for breach of which there exists no current remedy.

25. 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*

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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.[2] By way of example sections 36 and 37 of the 1987 Act are included, and neither is 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.

FINDING

26. 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

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

28. I recommend that the Insurer pay the applicant the weekly benefit to which he was entitled prior to 18 September 2013 until such time as he is properly transitioned. Those payments should continue from 25 December 2013 being the date on which they ceased.

29. 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 25 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.

[2] It is possible that an autodidactic polyhistor could, given considerable time, divine the import of the legislation. No-one else would have a clue, since there is no commentary provided by the Insurer.

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