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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 8 July 2013.

2. The applicant was injured on 12 February 1993. The applicant returned to suitable employment, but as a result of a further work injury he has not worked since 17 November 2011. 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 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 or cessation of 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's submissions go the merits of his claim, that is, the judgement or discretion of the Insurer. Such matters are not relevant to a procedural review.

8. The applicant also noted that his application for procedural review is past the 30 day time limit allowed by section 44(3)(a) of the 1987 Act. That section states that the application for procedural review "*must be made within 30 days after the worker receives notice in the form approved by the Authority".* The Authority has not approved a form for the purposes of that section. As a result the applicant cannot have yet received notice as required and the 30 day time limit has not commenced to run. The applicant cannot be out of time.

9. The Insurer made no submissions.

The Decision

10. Section 54(2)(a) of the 1987 Act requires the Insurer to give 3 months notice of a reduction or cessation of weekly payments as a result of a work capacity decision. The notice provisions are subject to a penalty if the notice period is not provided pursuant to section 54(1) of the 1987 Act. The penalty is 50 penalty units. A penalty unit is $110 pursuant to section 17 of the *Crimes (Sentencing Procedure) Act* 1999.

11. In this matter the Insurer has allowed 3 months and 3 days, that is, from the date of the decision on 8 July 2013 to 11 October 2013. The *Interpretation Act* 1987 at section 76(1)(b) states that receipt of a posted letter is *"taken to have been effected on the fourth working day after the letter was posted".* Section 76(2) defines "*working day"* as any day that is not a Saturday, Sunday, public holiday or a bank holiday. Providing 3 months notice requires 3 months plus 4 days. As such, the Insurer has not provided notice as required.

12. *Guideline* 5.4.2 requires the decision to *"reference the relevant legislation."* The decision states that notice is given of the decision in

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accordance with section 54. The correct reference is to Section 54(2)(a) of the 1987 Act.

13. The decision states that *"your claim must transition to the new benefits system in 2013, following a work capacity assessment and decision."* The decision does not reference the relevant legislation which is clause 8 of Part 19H of Schedule 6 to the 1987 Act in relation to the requirement to undertake an assessment and section 43 of the 1987 Act in relation to making a decision.

14. 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.[1] 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* 5.4.2 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 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.

15. In this case the applicant was advised by telephone and letter [both of 5 June 2013] that an assessment would take place. This is required by *Guideline* 5.2, known as the fair notice provision. The applicant knows that the decision was made "*as soon as practicable"* after the assessment.

[1] Or rather, "required at the time." The relevant *Guideline* was re-numbered 5.3.2 in October 2013 and there now remains no *Guideline* with the former number 5.4.2.

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16. *Guideline* 5.4.2 requires[2] 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 11 October 2014, will not be affected".* This statement gives no information to the applicant about the effect of section 59A(2) on such entitlements beyond 11 October 2014. The effect of section 59A(2) of the 1987 Act has therefore been disguised, if not misrepresented.

17. 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.

18. The applicant is advised that he has received weekly payments for 227.2 weeks. No attempt is made to explain to the applicant the relevance or otherwise of the number of weeks for which he has been paid. The decision should explain that after 130 weeks of weekly payments different provisions apply. That would entail referring to the definition of "*second entitlement period*" in section 32A of the 1987 Act, which has not been done.

19. The decision then 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 breaches *Guideline* 5.4.2 and the requirement to *"reference the relevant legislation".* The calculation of the rate of weekly pay is then set out thus: *($938.30 x 80%) = $751.44 – (current possible earnings) $1440.78 = $0*. No explanation as to where this formula has come from is revealed. The formula is from section 38(6) which demonstrates the importance of referencing the legislation. Referring to the formula also requires that

[2] See note 1 *supra*.

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reference is made to section 35 of the 1987 Act and the definitions for the terms used in the formula.

20. The decision next states that the applicant has a *"current capacity to work"* and has returned to work for less than 15 hours per week. Reference is made to section 43(1)(a) of the 1987 Act. That reference would not help the applicant. *"Current work capacity"* is defined in section 32A of the 1987 Act. That definition is qualified by reference to "*suitable employment*." That term is also defined in section 32A. It is a definition which is unlikely to accord with any common definition of the term.[3] The reference to 15 hours is not explained. It is, however, a reference to section 38(3)(b) of the 1987 Act which the decision does not reference.

21. The next statement in the decision is that the applicant's average weekly earnings (AWE) are $1,440.78. This must confuse the applicant. The figure used is unlikely to be what the applicant regards as his AWE. This AWE is also the same figure given in the formula and referred to as *"current possible earnings".*[4] An applicant may regard this as an unlikely coincidence, or that the figure has 2 definitions. The figure is "E" in the formula pursuant to section 35 of the 1987 Act and means what the applicant *"is able to earn in suitable employment"* or his "*current weekly earnings".* It is not said whether the figure is actual earnings or capacity to earn. No explanation is given as to how the figure is arrived at. The figure is not the applicant's pre-injury AWE, nor is it the transition amount. It is not explained that for an applicant being transitioned to the new system that his AWE is a figure determined by clause 2(1), Part 19H, Schedule 6 of the 1987 Act. Reference then also needs to be made clauses 1 and 9(3) of Part 19H.

22. The confusion rises to new heights when the decision asks the applicant to note that "*this amount ('the transition amount') is specified in the legislation and must be used for any workers who made their claim prior to 1 October 2012 to transition to the new benefits system: Please refer*

[3] To confuse any person trying to interpret the term, section 32A requires an insurer to "have regard to" the worker's "age, education, skills *and work experience"* in paragraph (a)(ii) and also to have ***no*** regard to " .. *the nature of the worker's pre-injury employment"* in paragraph (b)(iii). While there is possibly some obscure logical reasoning process behind this, I am unaware of what it is and should not need to be apprised of it in order to understand the definition of a term, which definition itself is supposed to be an explanatory provision.
[4] I.e., CPE.

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to: Section 43(1)(d) of the Workers Compensation Act 1987". Which amount is being referred to is not specified. It may be a reference to the AWE, *"current possible earnings",* $938.30, or 80%. The legislation is not properly referenced and should refer to the clauses in Part 19H set out above. The reference to "*any workers who made their claim prior to 1 October 2012"* is incorrect in law. The transition arrangements apply to an applicant *in receipt of weekly payments* immediately before 1 October 2012. The reference in relation thereto is clause 1, Part 19H, Schedule 6 of the 1987 Act and the definition of "*existing recipient of weekly payments".*

23. The decision then states that the applicant has been "*assessed as having capacity to earn $1440.78 in suitable employment: Please refer to Section 43(1)(c) & (d) of the Workers Compensation Act 1987".* This figure has appeared again. Now it has a third name or definition being a "*capacity to earn".* By this stage any reader of this decision might be so distracted and confused by the scrannel pitch of none-too-elegantly varied cross references that he or she may well abandon any attempt to decipher the cryptic prose.

24. At this point the decision sets out in two paragraphs the definition of "*suitable employment".* The end of the second paragraph refers to section 32A of the 1987 Act. An applicant may not understand that both paragraphs set out the terms of the definition of "*suitable employment",* not just the second paragraph. The two paragraphs also do not make it clear that section 32A has the definition of "*suitable employment"* within it.

25. The next statement in the decision is that in *"Applying the above formula and the information outlined below, your entitlement to weekly payments under the new benefits system has been calculated at the rate of $0".* The formula is set out again. Once again the figure of $1,440.78 has become *"current possible earnings".* The "*information outlined below"* is most likely to be a list of 7 documents which are preceded by the sentence *"In making this decision we have reviewed and considered the following information."*

26. The earliest document is dated 13 May 2012. The applicant was injured on 12 February 1993. The applicant would be aware of documents which existed before 13 May 2013. On the face of the decision *Guideline*

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5.4.2 has been breached. That *Guideline* requires the Insurer to *"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."* 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. The applicant is merely advised that "*The information which supports our decision indicates that you have the capacity to work in suitable employment for 7 hours a day, 4 days a week*."

27. *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 applicant must be aware after 21 years that other documents exist, although he may not be aware of all documents.

28. 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."* 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. As the decision must be served in person or by post[5], it appears strange that the Insurer would not advise that the request for internal review may also be lodged by mail, or even in person.

29. 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

[5] See section 54(4) of the 1987

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required by *Guidelines for work capacity decision Internal Reviews by insurers and Merit Review by the WorkCover Authority:* 6.2.

30. 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 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.

31. 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 which 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 and vexatious as the decision says) pursuant to section 44(3)(c) of the 1987 Act.

32. 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 2 December 2012 which came into effect on 1 January 2013. *Guideline* 10.14 states *"The Authority must shall (sic) write to the worker and insurer within 30-days (sic) of receiving the application advising of the merit review."* The Authority

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received the application for review on 30 September 2013 and issued the review on 26 February 2014, some 122 days later. It seems that *Guideline* 10.14 is one for the breach of which there exists no current remedy.

33. The decision sates that it was made by *[case manager]* and reviewed and confirmed by *[team leader].* At the end of the decision it is signed *"[untitled person] on behalf of [case manager]".* It is unclear as to whom is actually responsible for the decision. It may be important to know who the decision maker is as an internal review must be undertaken by a person who was not involved in making the decision: *Guidelines for work capacity decision Internal Reviews by Insurers and Merit Reviews by the Authority:* 7.2.

34. 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.[6] 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

35. 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 and apply the 1987 Act and the *Workers Compensation Regulation* 2010*.*

RECOMMENDATION

[6] It is likely that the Insurer is seeking to comply with the requirement to "reference the legislation" in Guideline 5.4.2 by providing these pages, but the critical missing element is any commentary attempting to explain the contents. Absent the commentary, the provision of the pages is an imposition on the time of the applicant and a waste of the Insurer's resources.

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

37. I recommend that the Insurer pay the applicant the weekly benefit to which he was entitled prior to 8 July 2013 until such time as he is properly transitioned. Those payments should continue from 11 October 2013, being the date on which they ceased.

38. 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 11 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(3)(h) of the 1987 Act.

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