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RECOMMENDATION FOLLOWING AN APPLICATION FOR REVIEW OF THE INSURER'S WORK CAPACITY DECISION PURSUANT TO SECTION 44BB(1)(c) OF THE *WORKERS COMPENSATION ACT* 1987.

SUMMARY:

a. **The application for procedural review is dismissed.**

b. **Such weekly payments as the applicant is receiving by virtue of the stay pursuant to Section 44BC of the *Workers Compensation Act* 1987 are to continue until receipt by the applicant of this recommendation.**

c. **Pursuant to Section 44BB(3)(h) of the *Workers Compensation Act* 1987 these recommendations are binding upon the Insurer and the Authority.**

Introduction and background

1. The applicant seeks procedural review of a Work Capacity Decision made by the Insurer on 23 November 2015. The Decision informed the applicant that her weekly payments of compensation would cease on 29 February 2016. The applicant sought internal review by the Insurer and the Internal Review Decision was dated 7 January 2016 and confirmed the original Work Capacity Decision.

2. The applicant sought Merit Review from the Authority by way of application received 4 February 2016. The Authority delivered its Findings and Recommendations dated 4 March 2016. The Authority made a finding the applicant has current work capacity and her ability to earn in suitable employment is $1,071.00 per week. In accordance with Section 38(7) of the *Workers Compensation Act* 1987 (1987 Act) the applicant's entitlement to weekly payments of compensation is calculated to be nil.

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3. The applicant then made an application to this office for procedural review dated 29 March 2016. I am satisfied that the application has been made within time and in the proper form.

4. On 22 March 2002 the applicant suffered injury to her lower back in the course of her employment as a teacher. At the time of the Work Capacity Decision the applicant was working 3 days per week and has current earnings of $1070.97 per week.

5. Section 44A of the 1987 Act provides that a work capacity assessment must be conducted in accordance with the WorkCover Work Capacity Guidelines (Guidelines).

Submissions by the applicant

6. 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 has applied for a procedural review.

7. The applicant has provided five pages of submissions in support of her application which are addressed in the decision below.

Submissions by the Insurer

8. The Insurer has not made submissions in response to the application.

Decision

9. The relevant Guidelines are dated 4 October 2013 and came into effect on 11 October 2013.

10. I shall firstly respond to the submissions from the applicant (in *italics* below) reproduced as they appear in her application for procedural review. The applicant has made the following submissions:

    - *The notice of the current work capacity decision to terminate weekly payments dated 23 November 2015: Once again, I was never issued with a written Advice of the Work Capacity Decision*

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and Outcome. The WorkCover (Guidelines 5.3.2) have again been unheeded; not complied with by the decision makers.

I note that the applicant has been sent a **"Notice of work capacity decision to terminate weekly payments"** dated 23 November 2015 which is the subject of this procedural review.

- *Decision makers failed to provide me appropriate reference to all the relevant laws – which they did not explain in the decision - they did not identify or inform me of all relevant sections of the WorkCover guidelines/ legislations and their application, nor how MY weekly compensation entitlement is calculated under the new requirements in relation to myself .*

The Insurer has provided reasons for its decision commencing at page 2 of the Work Capacity Decision. At page 5 of the Decision the Insurer has explained and showed the working algorithm in Section 38 of the 1987 Act which results in the applicant's entitlement to weekly benefits being calculated at nil.

- *Decision makers did not fully explain the entitlement periods- for example the Workers Compensation Act 1987 section 38 (1-8)Special requirements for continuation of weekly payments after second entitlement period (after week 130) Nor did they State the decision and the reasons underpinning the decision.*

The applicant was informed at page 2 of the Worker Capacity Decision that she had received 802 weeks of compensation payments. The applicant was informed by the Insurer that any ongoing entitlement to weekly payments was subject to Section 38 of the 1987 Act. The special requirements of that section are set out at page 2 of the decision. The Insurer has complied with the Guidelines.

- *I have been denied procedural fairness because the decision makers did not properly take into account all my evidences and or outline all relevant evidence (including medical evidences {(in either of the work capacity/ and merit decisions}) – not just that*

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which supports the decision of the insurer. This is what appears to have happened.

The applicant has failed to particularise the evidence which she says was not referred to or considered by the Insurer. I do note that the evidence for the basis of the Work Capacity Decision being the Certificate of Capacity from the nominated treating doctor, the applicant's actual working hours and the applicant's payslips from the employer is evidence which is not contentious and is factual. The relevant evidence which forms the basis of the Insurer's decision has been referred to including other evidence such as previous Certificates of Determination and Statements of Reasons for Decision from prior Workers Compensation Commission proceedings.

- *They did not explain the line of reasoning for the decision; nor how the material /information actually used support the decision.*

  The Insurer has provided Reasons for the decision commencing at page 2 of the Work Capacity Decision. At page 5 of the Decision the Insurer notes that the applicant's pre-injury average weekly earnings (PIAWE) are $993.70 per week (being the *transitional rate* – explained at page 3 of the Decision); the applicant is able to earn $1,071 per week in suitable earnings (based upon actual earnings); when the algorithm in Section 38 is used the applicant's ongoing entitlement is calculated to be nil. The Insurer has adequately explained the reasoning for the decision.

- *Mr S reviewer of work capacity; my case manager following transition from [different Insurer] in April 2011 – previously failed to reply to my communications denying me my documentations – I reported this to SIRA & investigators- matter(s) are currently with Investigators pending decisions, and Mr M did not explain or state the impact of the work capacity decision – not just on the weekly payments – (I was to be paid) -"1 days' pay a week" ongoing.*

The impact of the Work Capacity Decision is explained to the applicant on pages 1 and 2 of the Decision including the cessation of weekly payments and the effect on her medical and related treatment expenses. The Insurer has adequately complied with the Guidelines. The remainder of the submission is not relevant to this procedural review.

- *I consider that the Decision maker does not properly advise the relevant notice requirements. Which one did they determine to use? August or October. I have no idea? Of (two) 2 'fair' notices by the insurer dated 28 August 2015 and then 28 October 2015 I do not know which fair notice was applied for the purpose of a current work capacity assessment.*

  Guideline 5.2 requires the Insurer to provide fair notice of the Work Capacity Decision at least two weeks prior to the Decision being made. In this instance the Decision was made on 23 November 2015 so either the August or October letter would have been sufficient notice. The Insurer has not failed to comply with the Guidelines by issuing two notices prior to the Decision being made.

- *I consider decision maker wrong/ out of the scope of the legislation and the amendments with the August notice because I was existing recipient of I days' pay and I had a work capacity decision before 1 September 2015. I received I believe the subsequent October 2015 notification because the insurer obscured- would not admit that it had carried out a first work capacity decision in Oct 2013 and internal review (feb 2014)* (sic).

  From the applicant's initial submission it would appear that the Work Capacity Decision dated October 2013 was set aside at Internal Review in or about February 2014. If so, that is not relevant to this Work Capacity Decision. The submission is not relevant to this procedural review.

- *Confusingly , after having made the Work capacity decision 23 November 2015 On correspondence dated 13 January 2016 received by me 16 January 2016 - the insurer wrote to me*

regarding " NSW Government have notified an amendment regarding 'transitioning' of existing recipients of weekly payments where a work capacity assessment has not been conducted"

I can only review the Work Capacity Decision dated 23 November 2015 and not any subsequent correspondence issued by the Insurer.

- *I have had work capacity assessments as aforementioned…so I did not understand why the insurer infers that I had not. I consider that the insurer's intention was to deny liability, deny procedural fairness.*

  The only relevant Work Capacity Decision for the purposes of this procedural review is the Decision dated 23 November 2015. That is the most recent Work Capacity decision made by the Insurer. The decision does not deny liability. The Insurer has accepted the Certificate of Capacity of the applicant's nominated treating doctor that the applicant can work three days per week. Furthermore, the applicant's ongoing entitlement to reasonable medical and related treatment expenses will not cease until 1 March 2021 in accordance with Section 59A of the 1987 Act.

- *The decision makers (insurers) letter further states: "where a work capacity assessment has not been conducted by 31 August 2015…As you are in currently receiving weekly payment as of 31 August 2015 and have NOT had a work Capacity decision conducted before September 2015, you will be deemed to have been assessed as having no work capacity …" That is factually erroneous - and My work capacity certifications show this to be incorrect.*

  I am only in a position to review the Work Capacity Decision dated 23 November 2015. This submission is not relevant to procedural review.

- *I do not understand – I had a work capacity assessment Oct 2013 (substantial medical evidences submitted and internal review 2014 – again substantial medical evidences submitted), and then*

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the 23 November 2015 work capacity assessment with an internal review underway. There is an abjuration of and clear avoidance by decision makers of procedural fairness. I consider this abusing due process to deny me liability; That there was no requirement for the insurer to conduct a work capacity assessment for my claim to be transitioned.

Guideline 4.2 notes that a work capacity assessment may be conducted at any stage throughout the life of a claim.

If a worker has an ongoing entitlement to weekly payments beyond 130 weeks, the Insurer must conduct a work capacity assessment at least once every two years after this point, until such time as the worker's entitlement ceases.

Guideline 5.1 notes that work capacity decisions will be made at many points throughout the life of a claim.

The Insurer is not breaching the Guidelines by making more than one Work Capacity Decision. It is not an abuse of process.

- *The decision maker- insurer states I had "a current capacity to work and are able to engage in suitable employment ", no reference is made to the appropriate law…nor what that even means. The decision makers states I have been paid 802 weeks that payments must be reassessed under section 38 – reassessing financial payment is not a medical vocational or functional assessment. So why a work capacity assessment where a financial reassessment is required…confusing. Not properly explained.*

  I note that the Insurer has provided an explanation of suitable employment at page 4 of the Work Capacity Decision. Reference is also made to Section 32A of the 1987 Act. The purpose of a Work Capacity Assessment is an assessment of the applicant's work capacity in order to ascertain their entitlement to ongoing weekly compensation payments.

  Section 43 of the 1987 Act states:

43 Work capacity decisions by insurers

(1) The following decisions of an insurer (referred to in this Division as work capacity decisions) are final and binding on the parties and not subject to appeal or review except review under section 44BB or judicial review by the Supreme Court:
(a) a decision about a worker’s current work capacity,

(b) a decision about what constitutes suitable employment for a worker,

(c) a decision about the amount an injured worker is able to earn in suitable employment,

(d) a decision about the amount of an injured worker’s pre-injury average weekly earnings or current weekly earnings,

(e) a decision about whether a worker is, as a result of injury, unable without substantial risk of further injury to engage in employment of a certain kind because of the nature of that employment,

(f) any other decision of an insurer that affects a worker’s entitlement to weekly payments of compensation, including a decision to suspend, discontinue or reduce the amount of the weekly payments of compensation payable to a worker on the basis of any decision referred to in paragraphs (a)-(e).

In this instance the Insurer has made a Work Capacity Decision in accordance with the relevant legislation.

- *Work capacity decision 23 November 2015- did not clarify state the actual hours I worked. I work 16.5 hours a week (9:30 m – 3pm); with agreed contractual adjustments for over 14 years, and I comply with my NTD medical directives- certification Dr M has been my NTD for 16 years before and after the 22 March injury 2002. The 16 of May 1994 is unrelated to my spinal injury of 22 March 2002. The date is wrong. The insurer has not properly*

clarified this/ explained this and has also not followed the guidelines by not properly referencing the relevant sections of the laws for me – they just write section 38.

The Insurer has accepted the applicant's capacity to be that which has been certified by the nominated treating doctor, Dr M. The Insurer has informed the applicant of the special requirements of Section 38 which must be complied with at page 2 of the Decision. I note that the Insurer has not specified the sub-section of Section 38 but they have reproduced the relevant parts.

- *The decision maker in relation to section 38 is confusing. The decision maker states on page 2 "new Section 38 "…"A worker who is assessed as having current work capacity is only entitled to weekly benefits beyond the second entitlement period , i.e. 130 weeks , if….*
  Then makes points (1) and (2). Does not properly explain the requirements as section 38(3c), have not been met. It is inadequately and inappropriately explained. What criteria do they use to in determining compliance and noncompliance with s 38 (3)? I am confused. Point 2 to me seems to be a s 38 3c ?
  And then, Subsequently on page 5 states criteria of (b) and (c) under section 38. States criteria met.
  None properly and adequately explained in compliance with WorkCover guidelines.

The Insurer has reproduced Sections 38(3)(b) and (c) of the 1987 Act at page 2 of the Decision as correctly pointed out by the applicant. I note that they have not referred to the sub-sections but they have reproduced the relevant parts in writing. Again the applicant has pointed this out. The Insurer has accepted the capacity assessment from the applicant's nominated treating doctor and the applicant is working to that capacity, as she has again pointed out. Therefore the Insurer has correctly informed the applicant at page 5 of the Decision that she has complied with the special requirements of Section 38(b) and (c).

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- *The decision maker did not fully explain the entitlement periods, does not mention indexations or that payslips and earnings are not the actual payslips and not the actual earnings purported at time - 23 November 2016 they made the decision.*
  This information appears to relate to a first notification for August 2015, but not the second notification of a impending work capacity assessment- either way I just do know?

  The Work Capacity Decision was made on 23 November 2015. The payslips relied upon in the Decision were dated 6 June 2014 to 18 June 2015 and wage reimbursement schedules for the period 24 April 2015 to 18 June 2015. These documents were *'current'* at the time of the fair notice letters and work capacity assessment being made.

- *Insurer did not comply with Guideline 5.2 Fair Notice Provisions to advise "at least two weeks prior to the work capacity decision," to advise the potential outcome of this review and detail the information that has led the insurer to their current position- it does not state which notice applies. August or October 2015. My lawyers received 2 notices.*

  This submission has been dealt with previously.

- *I consider there to be non-compliance with the Guidelines because (1) the decision maker /insurer failed to explain how the figure of $176 was derived and calculated, (or the $1427.96) or $1071 or the $993.70 and (2) failed to inform the (me) applicant worker that I may again become entitled to medical and treatment expenses if I became entitled again to weekly payments.*

  The Insurer has explained the $176 figure at page 2 of the Decision. It is the amount required to be earned by the applicant to comply with Section 38. The Insurer has not advised of the sub-section. The Insurer has explained the transitional amount of $993.70 at page 3 of the Decision. The remaining calculations and figures are explained at pages 4 and 5 of the Decision. The Insurer has adequately explained the applicant's entitlements to medical and related treatment at pages 1 and 2 of the Work

Capacity Decision including a reference to Section 59A(3) of the 1987 Act.

- *There is a formula but it just states section 38 and doesn't explain why my (I) one days' pay (awarded 2005) will be reduced or completely denied to NIL. That is - "Liability is $0.00 per week" and therefore, the insurer (decision maker) "disputed" the Liability to make weekly payments? Not just because of a commission and previous court accepted liability entitlement, but because it has been firmly accepted and established by my having been injured at work and in the course of my duties ; the injury of 22 March 2002 satisfying s 4 and s 9A of the 1987Workers Compensation Act. . This is a denial of natural justice; procedurally inequitable; and most unclear.*

  The Insurer has made a Work Capacity Decision in accordance with the relevant Guidelines and Legislation. The applicant's ongoing entitlement is subject to Section 38 of the 1987 Act. The Insurer has applied Section 38 of the 1987 Act and the applicant's entitlement is calculated to be nil. The Insurer has adequately explained this at page 5 of the Work Capacity Decision.

- *I note that the insurer removed rehabilitation service provider to me in February 2013 prior to first work capacity decision – they wrote per CRS that I has Returned to work after Significant/Major spinal surgery in August 2010 by professor O and that I no longer required rehabilitation. That was it. So I had to manage myself and attend DR M for direction and self-management to remain at work. Hence decision makers writes nothing about support or rehabilitation support .because they took it away prior to the work capacity decisions.*

  The Insurer has informed the applicant at page 2 of the Work Capacity Decision *"we will continue to provide support to assist you to return to work until 29/02/2016 if applicable."* The Insurer has adequately complied with the Guidelines.

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- *The decision states: "there is no further entitlement to weekly benefits"; that's it. Left unexplained. I consider this is a denial of liability and does not comply with the work cover guides.*
  The work capacity decision maker did not review and consider ALL (relevant) DOCUMENTS and did not comply with the work cover guidelines. Nor did the internal or merit review decision makers.

  The Insurer has adequately explained its decision. The Insurer has referred to the evidence which it has considered in making the Decision. The applicant has failed to specify the relevant documents which were not considered which may have impacted the Decision. I am unable to review any Decisions made in respect of the Internal Review or Merit Review.

- *I did not agree with the decision maker and made an internal review application- the decision maker did not follow work cover guidelines, did not refer to any section of the workers compensation Act 1987 /law for me to refer to regarding an internal review- just gave me a form to fill in and stated I had 30 days to get it lodged with information's reports that sicorp make it difficult for me to get. Quite hard.*

  Guideline 5.3.2 requires the Insurer to advise of the process available for requesting a review of the decision and how to access the required form. I note that the Insurer has informed the applicant of the review process and provided a copy of the appropriate form. The Insurer has adequately complied with the Guideline.

- *For the purpose of this application I ask why all the relevant evidences from the work capacity decisions were not examined- including AMS medical reports and NTD DR M reports;*
  The 2 most recent IMPs are subject to an investigative complaint because the insurers officers deleted and omitted NTDs medical information's /directives and detailed wrong diagnosis of my injures. NTD DR M wrote to the insurer about this. The NTD has also provided correspondence to investigative officers regarding non compliances with medical certifications and creation of

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dummy" certifications "by the employer who then submitted to insurer- which I learnt from GIPA releases. So there is no accurate medical IMP.

Section 44BB of the 1987 Act allows me to review the Insurer's procedures in making the Work Capacity Decision and not of any judgment or discretion exercised by the Insurer in making the Decision. The above submission is not relevant to procedural review.

- *I was an existing recipient of 1 days' pay entitlement per a Workers compensation commission decision in February 2005. I had had a work Capacity decision (October 2013) and an internal review decision (February 2014). The subsequent original decision makers of 23 November 2015 and the internal and Merit review decision maker failed to take all relevant information's (including expert independent medical evidences) into account in their decision making.*

  This submission has been dealt with previously.

- *I note that The Decision makers can only guesstimate at income/ entitlement payments as employer has stuffed this up completely(serious maladministration and fraud since 2005) – failing to provide workers compensation schedules to insurer for over 5 years, falsified and retrospectively created schedules, dummy medical certificates and payslips- stating I was on 14 days workers compensation when I did in fact attend/work my 3 days adjusted duties- (and at the concurrent time of the decision November 2015) all now in the hands of Impartial investigative officers, also reported to NSW Tax office , NSW Ombudsman since 2010 and to HRC commission. Insurer collaborated and accepted false medicals (not written by my NTD) and retrospective false schedules…Authorities are informed of this. (SRWD, SIRA).*

  I am only able to perform a procedural review of the Work Capacity Decision dated 23 November 2015. This submission is not relevant to procedural review.

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- *Relevant to my application - there is no forensically precise properly audited calculation of my income since 2005 (MR R NSW Deputy Director affirmed the "discrepancies". My workers compensation benefit…it is all guesswork Insurer forensic audit confirms their payment to employer (with generic cheque numbers given me to examine) The employer is a different matter- GIPA exposes DEC officers stating "who is funding her" This can be found on SICORP review files. I note I provided my own schedule of incomes I received (compiled by me with bank statements and all questionable payslips of employer) to WorkCover and again in second investigation to the new SIRA as well as currently to impartial investigators; and my lawyers (Mr J/Ms G). I consider the matter a denial of procedural fairness as the WorkCover Guides cannot logically be complied with because income cannot be accurately confirmed due to unprecedented circumstance beyond my or the insurers control.*

  I am only able to perform a procedural review of the Work Capacity Decision dated 23 November 2015. This submission is not relevant to procedural review.

- *I note however, decision makers accepted without regard for my view, without reasonable examination of the facts – the employers (erroneous) financial records. Any calculation of incomes; benefit per workers comp guidelines and regulations are at best a "guess". My employer reduced my income / benefit immediately upon the work capacity decision of November 2015 and significantly before an internal or merit review decision was made. When merit review decision came 4th March 2016 the employer unlawfully removed me from the payroll- suspended my income to $ 0.*

  In respect of the submission as to financial records I can only note that the Insurer has advised that they have relied upon the applicant's payslips to calculate her actual earnings. Any issues in respect of the employer and erroneous financial records cannot be dealt with at procedural review. In respect of the cessation of the applicant's weekly payments during the *'review process'* I

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refer the Insurer to Section 44BC of the 1987 Act and I shall address the issue of *"the Stay"* later in this decision.

- *These matters have been raised at Ministerial level; .And with the NSW DEC Secretary, Senior employer officers. They simply ignore and deny.*

  This submission is not relevant to procedural review.

- *In my view – a Conflict of Interest was not declared by Merit Reviewer- previously an employee of Allianz. It is procedurally unfair not to do so. Perception of Bias.*

  I am not able to review any aspect of the Merit Review. I am only able to review the procedures of the Insurer in making the Work Capacity Decision.

- *23 November 2015 Original Work Capacity decision makers (names withheld) were not in impartial, not unbiased- they were my case managers.*

  The Guidelines or legislation does not prevent case managers from making Work Capacity Decisions.

- *The reasons stated and evidences provided in my application for work capacity, merit review and my internal review - were not ALL considered by the reviewer.*

  This submission has been dealt with previously.

- *Work capacity decision makers, Internal and Merit reviewer decision makers did not provide me all documentation. For example I did not receive "snipping tool documents" – this was made known after the decision; I was not given opportunity to provide further information- examine or provide reply to this. Insurer ignored relevant medical evidences per WorkCover guidelines from first work capacity decision and internal review*.

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The Insurer advised the applicant at page 5 of the Decision that she can request copies of documents. The applicant was also informed at page 5 of the Decision that she could seek internal review and to complete the form and return it "with any information, reports and/or documents you rely upon." The Insurer has adequately complied with the Guidelines.

- *Further I was informed by Sicorp if I was to be given information I had to make another GIPA request. I have made at least 8- my employer lost my files conveniently for over 12 months- investigations found my files—part of them. I requested medical data reports from SIRA, SIRA/ was denied medical reports I requested, and afterwards WorkCover with intervention of IPC Privacy commission support confirmed WorkCover had destroyed vital - my documentations/information despite having an open workers compensation claim and WPI matter- information I required to provide the AMS for consideration. That prejudiced my WPI matter which has ultimately prejudiced my WPI work capacity… A mess.*

  These submsissions are not relevant to procedural review.

- *My submissions have been ignored by Work capacity decision makers and my submissions deemed too lengthy by merit reviewer?*
  The decision effects my Life- my future work, level remuneration and economic capacity to attend to my responsibilities. That My evidences and information's were not wholly considered because "too lengthy"? is unfair The insurers evidences were not considered too lengthy eg decision makers submission of Workers compensation Commission (Feb) 2005 documentation (I note the decision is defective in that I had 4 children from June 15 2003). I note insurer has been obstructive - doesn't want me to obtain DR B report either. Yet the decision maker uses all of its submissions and does not explain relevance to the decision.

  I am unable to review any aspect of the Merit Review recommendations and findings. I am unable to have regard for the personal circumstance of the applicant. I am only able to

review the procedures implemented by the Insurer in making the Work Capacity Decision dated 23 November 2015.

- *The decision maker states that "should you require further copies of documents provided to you please do not hesitate to contact Allianz". Workcover Guideline (Part 5.4.2) says that the Insurer "must advise (me) that any documents or information that have not already been provided to the worker (me) can be provided to the (me) worker on request to the insurer". The Insurer did not do so and has not complied with the guideline.*

  The applicant has already indicated that she has made several GIPA applications to obtain documents and has displayed knowledge of her entitlement to obtain documents. I do not consider the omission by the Insurer to be sufficient to set aside the Work Capacity Decision.

- *I ask that you take into consideration that the original decision maker and the subsequent decision makers failed to follow procedures of the WorkCover Guidelines (s 44 A of the 1987 Workers Compensation Act). That the Insurer(decision maker) failed to comply with or follow the 1987 Workers Compensation Act and the Workers Compensation Regulation 2010 and the regulatory amendments (transitional arrangements) of the government of August 2015.That the decision 23 November 2015 contain procedural errors.*

  I consider that my case is a one of a denial of procedural fairness and request reinstatement of the weekly benefit. I believe that the decision makers decision is a denial of liability- where an insurer basically says "no further entitlement to weekly benefits"; that is "our liability is $0.00 per week" because we have "disputed" the liability to make weekly payments". It is just wrong morally and lawfully wrong to deny procedural fairness whereby under the legislation the Insurer can make an assessment of my work capacity and then a decision about that work capacity, without complying with the legislation, the Regulation and the Guidelines in order to produce a procedurally correct result. This they did not do.

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I have considered the applicant's submission and I consider that the Insurer has adequately complied with the relevant legislation and Guidelines.

11. By way of general observation I note that Guideline 5.3.2 requires the Insurer to advise the applicant of the date of the work capacity assessment. On this occasion the Insurer informed the applicant that the work capacity assessment was performed on 23 November 2015 and a decision made the same day. The applicant was notified of the Work Capacity Decision by letter dated 23 November 2015.

12. The same Guideline requires the Insurer to advise the date when the Decision takes effect. Section 54(2)(a) of the 1987 Act requires at least three months and four working days notice be given if payments are being reduced or ceased. This notice period takes into account Section 76(1)(b) of the *Interpretations Act 1987*. As a result the applicant was advised that her payments would cease on 29 February 2016. This is the appropriate notice period.

13. The Guideline requires the Insurer to advise the applicant of the impact the decision has on her entitlement to medical and related treatment expenses. The Insurer has referenced and explained Section 59A (2) and (3) of the 1987 Act and advised the applicant that his entitlement to medical expenses will cease five years after her entitlement to weekly payments ceases. The Insurer has adequately explained the legislation.

14. The Insurer is also required to advise the applicant of the relevant entitlement periods. The Insurer has informed the applicant that she has received 802 weeks of compensation payments. Therefore any ongoing entitlement to weekly payments of compensation is subject to Section 38 of the 1987 Act. The Insurer has explained the special requirements of Section 38(3) of the 1987 Act at page 2 of the Work Capacity Decision.

15. I do note that the Insurer has failed to make reference to the subsections of Section 38 throughout the Work Capacity Decision although they reproduced the relevant sub-sections in the body of the Work Capacity Decision. The Insurer also failed to inform the applicant that she was entitled to request any documents or information that had not already

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been provided to her. Although I note that the applicant has made no less than 8 GIPA applications to obtain copies of her own documents so she is aware of her entitlement to access.

16. In the case of *Simpson*[1], Justice Davies opined that consideration must be given to the effect the *'failure'* to comply with the Guidelines has on the Insurer's decision. In his judgement Davies J stated *"Every failure to follow the Guidelines could not result in the setting aside of the insurer's decision. Such result would be legally unreasonable."*

17. In the circumstances of this particular case I do not consider that the failure of the Insurer to specify the subsections of Section 38 or advise the applicant she is entitled to request copies of documents is sufficient to set aside the Work Capacity Decision.

18. The Work Capacity Decision of the Insurer dated 23 November 2015 has displayed a careful consideration of the requirements of the Guidelines and legislation in force at the time.

Finding

19. There are no procedural errors identifiable in the decision. The Insurer has complied with the Guidelines and relevant legislation.

The Stay

20. The applicant advised in her submissions that the Insurer had ceased her weekly payments of compensation as at 4 March 2016. This was during the review process.

21. Section 44BC of the 1987 Act operates so as to entitle a worker, during the course of a Section 44BB review, to receipt of the same compensation payments to which she was entitled to immediately prior to the making of the adverse Work Capacity Decision.

22. The entitlement has no time cap or deadline or other limitation on it beyond receipt by the worker of the review decision. This is an

[1] *The Trustees of the Sisters of Nazareth v Simpson* [2015] NSWSC 1730

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entitlement which exists irrespective of the existence or duration of any notice given to the worker under Section 54 of the 1987 Act.

23. Payments which continue under Section 54 are subject to the usual requirements of providing updated work capacity certificates and other compliance with the legislation by the worker. There is no such requirement under Section 44BC. The worker has already fully qualified to receive their ongoing payments as at the date of the work capacity decision. The applicant is automatically entitled to payments again upon application for review under section 44BB (unless the application for review is outside the *"within 30 days"* time limit).

24. Section 44BC of the 1987 Act operates so that the Work Capacity Decision is the subject of a stay during the review process. This not only stays the decision, but also prevents the Insurer taking *"any action based on the decision whilst it is stayed."* By definition the cessation of payments, which is clearly based on the decision, is such an *"action"* and may not take place during the relevant period of review.

25. There appears to be a view that if an Insurer has already stopped payments prior to an application for merit or procedural review, then payments need not be resumed during such review, since the Insurer cannot take *"any action"* during that time, which is erroneously interpreted to include a prohibition on the resumption of weekly payments. Such an analysis begs the question, since it assumes the work capacity decision was correct, and it also completely defeats the purpose of the legislative amendment, which was to ensure that workers are paid for the duration of Section 44BB review. It also follows that the resumption of payments is not an action *"based on the decision"* (since the decision resulted in a reduction or cessation) and therefore cannot be the subject of prohibition.

RECOMMENDATION

26. The application for procedural review is dismissed.

27. Such weekly payments as the applicant is receiving by virtue of the stay pursuant to Section 44BC of the *Workers Compensation Act* 1987 are to continue until receipt by the applicant of this recommendation.

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28. Pursuant to Section 44BB(3)(h) of the *Workers Compensation Act* 1987 these recommendations are binding upon the Insurer and the Authority.

Tracey Emanuel
Delegate of the Workers Compensation
Independent Review Officer
29 April 2016