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 November 2013.

2. The applicant was injured on 14 April 2010. The applicant returned to suitable employment with the employer until his employment was terminated on 6 August 2012. The applicant found further suitable employment in November 2012, and was then able to find alternative suitable employment in January 2013. The applicant remains in that suitable 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's submissions mostly go to the merits of the decision and are therefore not relevant to a procedural review. His other submission is that the Merit Review took some 90 days. The *Guidelines for work capacity decision Internal Reviews by insurers and Merit Review by the WorkCover Authority* 10.14, which came into effect on 11 October 2013, states that "*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 delay is lamentable, and the complaint understandable, but I have no jurisdiction to review decisions by the Merit Review Service and so the issue has no relevance for present purposes.

8. The Insurer made no submissions.

The Decision

9. The decision states that a work capacity assessment was made on 11 November 2013. 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. 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.*

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

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10. *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 weekly payments cease. The decision states that fact. 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.

11. *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. The decision, however, states that the applicant has received 122.2 weeks of weekly payments. This number of weeks is within the "*second entitlement period*" as defined in section 32A of the 1987 Act. In that case section 37(2) of the 1987 Act should be relied upon to calculate the rate of pay. Perhaps as the decision was not to come into effect until 26 February 2014, which would be after 130 weeks and the second entitlement period, that is the reason that section 38 was being relied upon. Whatever was being done in the decision should have been explained to the applicant. That would have also required a reference to the definition of "*second entitlement period*".

12. This issue becomes more confused by the Internal Review Decision (IRD) of 2 January 2014 stating that there has only been 92 weeks of weekly payments. The IRD then proceeds to apply section 37(2) of the 1987 Act. The applicant must have been very confused by this time.

13. The decision states that as a result of the assessment that the applicant has *"a current capacity to work and have returned to work for not less than 15 hours per week: Please refer to Section 43(1)(a) of"* the 1987 Act*. "Current work capacity"* is defined in 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

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usual meaning of that phrase. Referring to section 43(1)(a) would not assist the applicant. The proper reference is to section 38(3)(b) and (c) of the 1987 Act.

14. To add to the confusion as to suitable employment the decision states that the applicant has *"been assessed as earning $1,447.52 in suitable employment: Please refer to: Section 43(1)(c) & (d) of the Workers Compensation Act 1987."* The definition of suitable employment in section 32A of the 1987 Act should be referred to.

15. The transitional rate is then set out and reference is made to section 43(1)(d) of the 1987 Act. The correct reference is to clauses 1, 2(1), 2(2) and 9(3) of Part 19H of Schedule 6 of the 1987 Act. It is also necessary to explain that the transitional rate is indexed which is why the figure in the decision of $948.50 is higher than the figure in clause 2(1) of Part 19H of Schedule 6 of the 1987 Act.

16. Eventually the decision refers to suitable employment in 2 paragraphs. The reference to section 32A of the 1987 Act is given in the second paragraph. The applicant may well assume that only the second paragraph is relevant to section 32A, and that the first paragraph is irrelevant. It is a confounding piece of prose.

17. 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] In addition, reference is made to section 43(1)(f) of the 1987 Act. An applicant may have uinderstood that section 54(2)(a) of the 1987 Act is relevant, but those many applicants unversed in the intricacies of legislation may be puzzled, even more so than an insurer.

18. The decision states that "*we have reviewed and considered the following information"* and then sets out 6 documents. Those 6 documents were sent to the applicant. *Guideline* 5.3.2 states that the work capacity

[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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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 also 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. *Guideline* 5.3.2 has not been referenced.

19. 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.

20. The advice as to the internal review states that the application form should be completed and "*returned to us with the extra information, reports and/or documents you rely upon"* (emphasis added). This statement conveys the impression that an applicant must provide further evidence or information in order to make an application for internal review.[2] 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.

21. 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."* The *Guidelines for work capacity decision Internal Reviews by Insurers and Merit Reviews by the Authority* 10.14 states "*The Authority will write to the worker and insurer as soon as*

[2] In Greek "the" (in various shapes as "o," "os," etc) frequently precedes a noun form of a word, but even that would not excuse this usage, since a correct transliteration would result in "extra the information" rather than "the extra information." This would also follow in Modern Greek, apparently.

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practicable and preferably within 30 days of receiving the application advising of the outcome of the merit review." As stated in paragraph 7 the Authority took 90 days. It seems that *Guideline* 10.14 is one for the breach of which there exists no current remedy.

22. At the end of the decision and purporting to form part of the decision are 4 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 *Workers Compensation Regulation* 2010 (Regulation). Setting out large swathes of the 1987 Act under a misleading heading is not helpful.[3] By way of example section 36 of the 1987 Act is included, and is not 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

23. 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 *Regulation.*

RECOMMENDATION

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

25. I recommend that the Insurer pay the applicant the weekly benefit to which he was entitled prior to 18 November 2013 until such time as he is properly transitioned. Those payments should continue from 26 February 2014 being the date on which they ceased.

26. Since the applicant is not currently in receipt of weekly payments, clause 21 of schedule 8 of the *Regulation* cannot apply and payments may

[3] Or not helpful to everyone. It is possible that an autodidactic polyhistor could, given considerable time, resources and the inclination, 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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resume immediately. The applicant is not required to produce work capacity certificates for the period from 26 February 2014 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
15 April 2014