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 3 July 2013. The applicant sought internal review on 30 July 2013. That decision was issued on 26 August 2013. The applicant sought Merit Review by the Authority. That application was received by the Authority on 19 September 2013. The Merit Review decision was issued on 20 February 2014, some 154 days later.[1]

2. The applicant was injured on 21 April 1997. The applicant returned to suitable employment with the employer until his employment was terminated in 2008. A return to suitable employment with another employer was attempted in 2009 which was unsuccessful. 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.

[1] Cf: *Review Guideline* 10.14 (as amended).

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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

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 partly go to the merits of the decision and are to that extent not relevant to a procedural review. His other submissions were prepared by his union and address procedural matters. The submissions are that the decision breaches *Guideline* 5.2, the fair notice provisions, as follows:

    - The notice does not tell the worker when the decision is expected to be made. There is no date or approximate date for when the decision is expected to be made;

    - The notice merely states a range of outcomes that may occur without being specific to the individual. The worker is not aware of the potential outcome in respect of his particular claim.

    The next submission is that *Guideline* 5.3 is breached. I believe that the reference is meant to be to *Guideline* 5.4.2. The points raised are:

    - The insurer does not indicate the date in which the work capacity assessment was made;

    - The insurer does not explain the relevant legislation. It means states (*sic*) the applicable sections of the Act without explaining how they apply to the individual;

    - The insurer has listed several documents that it has relied upon in making the decision without highlighting the key information;

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- The insurer has not referenced or explained material that may not support the outcome they seek to achieve;

- The insurer fails to detail the ongoing support that will be provided to [the worker] during the notice period;

- The insurer fails to detail the effect the decision will have on medical and treatment expenses.

8. I will deal with these submissions in the decision.

Submissions by the insurer

9. The Insurer made no submissions.

The Decision

10. *Guideline* 5.2 sets out the requirements of the *"Fair notice provision*". The fair notice telephone call and letter both occurred on 31 May 2013. The *Guideline* sets out the following in relation to a fair work contact:

    - *inform the worker that a review of their current work capacity is being undertaken and that a work capacity decision is going to be made*

    - *explain that this review may include further discussions with other parties such as their employer, nominated treating doctor or other treatment providers*

    - *advise the potential outcome of this review and detail the information that has led the insurer to their current position*

    - *provide an opportunity for the worker to supply any further information to the insurer for further consideration and the date that this information is to be provided by*

    - *tell the worker when this decision is expected to be made.*

    There does not appear to be any record of the conversation of the fair notice telephone call although I accept that it occurred as it is referred to

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in the fair notice letter. I assume it provided no further information than the letter. The letter states that the *"review and work capacity decision may result in a recalculation or discontinuation of your weekly compensation under Section 36, 37 or 38 of the 1987 Act."* It is not stated what else may occur. One outcome could be that there is no change to weekly payments. The letter fails to advise as to *"the potential outcome of this review".*

As the applicant has been paid for over 300 weeks as at the date of the decision, sections 36 and 37 of the 1987 Act are not relevant and would only lead to confusion for the applicant.

The applicant is correct that no time frame is set out as to when the decision is expected to be made as required by the *Guideline* 5.2.

11. The decision states that a work capacity assessment was made, but not when. As the fair notice letter was sent on 31 May 2013, and the decision was sent on 3 July 2013 the applicant is able to assume that the assessment took place during that period. I do not consider it a requirement that the date of the assessment be set out explicitly, but I consider that the assessment be revealed to the applicant. This would mean that the date of the assessment would be revealed, as it seems improbable that such an important document would not be dated. 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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12. The decision does not state that the assessment is required 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.

13. *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 weekly payments cease. 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;"* What happens after that date is left unsaid by the wording of the decision, and as such the legislation has not been properly referenced as required by *Guideline* 5.4.2. More significantly, the *effect* of the legislation has been disguised by omission. Picayune though the point may seem to some, the failure to state that the entitlements come to an end after the expiration of 12 months represents a "half-truth" in the most pejorative sense in which that term is commonly understood.

14. 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 and for such time as those weekly payments continue. This was not disclosed by the Insurer.

15. The decision states that *"we will continue to provide support to assist you to return to work until 11 October 2013 if applicable."* This is in accord with Guideline 5.4.2 and the requirement to "*detail any support, such as job seeking support, which will continue to be provided during the notice period".* In the absence of any other evidence I cannot see what other support would be appropriate.

16. *Guideline* 5.4.2 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 states that the applicant has received 305.9 weeks of weekly payments. The decision then sets out the criteria to be applied pursuant to section 38(3)(b) and (c) of the

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1987 Act, but the legislation has not been referred to as required by *Guideline* 5.4.2. That would have also required a reference to the definition of "*second entitlement period*" in section 32A of the 1987 Act.

17. The decision states that as a result of the assessment that the applicant has *"a current capacity to work: Please refer to: Section 43(1)(a) of"* the 1987 Act. The next sentence is *"suitable employment has been identified for you: Please refer to: Section 43(1)(b) of the Workers Compensation Act 1987."* These legislative references would have been of no assistance to the applicant. The proper reference is to section 32A of the 1987 Act. This is a very important reference as, in particular, *"suitable employment"* is a term with a specific meaning which may have little relationship to an understanding of the term in common parlance.

18. 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 – please refer to: Section 43(1)(f) and 54(2)(a) of the Workers Compensation Act 1987."* On this occasion the applicant has been referred to the correct section, but also an incorrect section. Upon reading the correct section, being section 54(2), 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.[2] The incorrect section is section 43(1)(f) of the 1987 Act. An applicant may have intuited that section 54(2)(a) of the 1987 Act is relevant, but many applicants unversed in the intricacies of this legislation may be puzzled by the reference to section 43(1)(f), even more so than an insurer.

19. The decision states that "*we have reviewed and considered the following information"* and then sets out 18 documents. Those 18 documents were sent to the applicant. *Guideline* 5.4.2 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 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

[2] 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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has the opportunity to peruse such other documents. *Guideline* 5.4.2 has not been referred to.

20. The applicant is concerned that the decision does not highlight key information and has not referred to information which may not support the decision as required by *Guideline* 5.4.2. Without access to all of the documents the Insurer may possess, it is difficult to determine this issue. It seems likely after 16 years that there is some information held by the Insurer which does support the injured worker's claim, particularly since he was paid for more than 300 weeks. It would follow that such information would not support the insurer's decision, as is alleged by the applicant. In any event this is a minor issue considering the other difficulties the decision faces.

21. 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.

22. The decision states that "*frivolous and vexatious"* applications for internal review 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 appears to confirm this although it uses the correct phrase "*frivolous or vexatious".* Unfortunately, section 44 of the 1987 Act does not state that. Only a Merit Review and a Procedural Review may decline a request for review on the basis that it is "*frivolous or vexatious"* pursuant to section 44(3)(c).

23. 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. 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

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

24. The decision states that the applicant is to apply for the internal review within 30 days of receipt of the decision. Section 44(1)(a) of the 1987 Act does not impose any set time limit. 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 state that there is a 30 day time limit. The *Guidelines for work capacity decision Internal Reviews by insurers and Merit Review by the WorkCover Authority* 6.5 which came into effect on 11 October 2013 corrects that mistake and 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.

25. 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 practicable and preferably within 30 days of receiving the application advising of the outcome of the merit review."* The Authority took 154 days. It seems that *Guideline* 10.14 is one for breach of which there exists no current remedy.[3]

26. The decision states that the decision was made by the "*Work Capacity Team".* The "*Work Capacity Team"* is the signature block for the decision. The *Guidelines for work capacity decision Internal Reviews by insurers and Merit Review by the WorkCover Authority* 7.2 which came into effect on 1 January 2013 states that the *"internal review is to be undertaken by a person who was not involved in the making of the original work place decision".* As this is the case it is important for the robustness of the appeal system that the person or people who made

[3] See footnote 1.

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the decision are identifiable so that an applicant can see that the internal review is being undertaken by someone "*who was not involved in the making of the original work place decision".*

27. At the end of the decision and purporting to form part of the decision are over 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.[4] By way of example sections 36 and 37 of the 1987 Act are included, and are 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

28. 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

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

30. I recommend that the Insurer pay the applicant the weekly benefit to which he was entitled prior to 3 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.

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

[4] It is possible that an enthusiastic polymath 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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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
16 April 2014