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 seeks procedural review of a work capacity decision made by the Insurer on 3 October 2013. The applicant sought internal review. That decision was issued on 28 November 2013. The applicant sought Merit Review by the Authority. That application was received by the Authority on 17 December 2013. The Merit Review recommendation on was issued on 14 March 2014, some 87 days later.[1]

2. The applicant was injured on 24 August 2002. She returned to suitable employment with the employer in November 2004, until her employment was terminated on 1 April 2005. A return to suitable employment with another employer was attempted in March 2008, but that employer closed its business soon after. 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.

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[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. Section 44(1)(c) of the 1987 Act states that procedural 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 to the merits of the decision, that is, the judgement or discretion of the Insurer and are to that extent not relevant to a procedural review.

Submissions by the insurer

8. The Insurer made submissions. The submissions largely deal with the matters raised by the applicant, and therefore also go to the merits of the case. The final point is in relation to some confusion as to the date weekly payments would cease. The decision is clear that payments would cease on 11 January 2014, which provides 3 months notice as required by section 54(2)(a) of the 1987 Act plus adequate time for delivery of the decision by post as required by section 76(1)(b) of the *Interpretation Act* 1987.

The Decision

9. The decision states that a work capacity assessment was completed on 21 August 2013. 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;*

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- *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.

10. 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.

11. *Guideline* 5.3.2 requires the decision to *"reference the relevant legislation."* This would require any interpretation of the legislation (including delegated legislation) to be accurate. It is clearly inaccurate to say (as this Insurer has said) that the claim "must transition to the new benefits system in 2013." What Clause 8(2) of Pt 19H of Schedule 6 to the 1987 Act requires is for the Insurer to conduct a work capacity assessment (for the purposes of transitioning a claim) *"no later than 12 months (or such longer period as may be prescribed by the regulations) after the commencement of the weekly payments amendments."* While the amendments commenced on 1 October 2012, the *Workers Compensation Regulation* 2010 says at Clause 17, Schedule 8 that *"a period of 18 months is prescribed for the purposes of Clause 8(2) of Part 19H of schedule 6 to the 1987 Act."* It follows that there was no requirement for the Insurer to conduct a work capacity assessment and for the claim to be transitioned *"in 2013."*

12. *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 *"any entitlement you may have to payment of pre-approved reasonable and necessary medical and other expenses will be limited for up to 12 months after your entitlement to weekly payments cease. Please refer to: Section 59A"* of the 1987 Act. The legislation has not been properly referenced as required by *Guideline* 5.3.2. The correct reference is to section 59A(2) of the 1987 Act. The manner in which such medical expenses will be limited is not stated. An applicant may believe that certain types of

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treatment, such as skiagrams or treatment by a remedial gymnast (to give only two illustrative examples), are not permitted during the 12 month period. Section 59A(2), however, placers no limits on types or amount of treatment. That section provides that payment for medical treatment *per se* ceases 12 months after weekly payments cease.

13. The next sentence in the decision is "*this means that your entitlement to medical and related expenses will cease on 11 January 2015. Please refer to: Section 59A"* of the 1987 Act. The legislation has, again, not been properly referred to. More significantly, the applicant is likely to be left with the view that payment of medical expenses will cease after 12 months, and during that 12 month period there are certain limits on types or amount of treatment to which she is entitled.

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. *Guideline* 5.3.2 requires the Insurer to *"reference the relevant legislation".* The decision states that weekly payments cease on the expiry of the second entitlement period. The decision states that the applicant has received 521.7 weeks of weekly payments. The decision sets out the criteria to be applied pursuant to section 38(3)(b) and (c) of the 1987 Act, but the legislation has not been referred to as required by *Guideline* 5.3.2. That would have also required a reference to the definition of "*second entitlement period*" in section 32A of the 1987 Act.

16. 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 decision then states that the "*following occupations have been identified as suitable employment 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. That section defines "*current work capacity",* which is itself defined by reference to *"suitable employment*". These are very important references and, in particular,

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"suitable employment" is a term with a specific meaning which may have little relationship to an understanding of the term in common parlance.

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 – 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.

18. The decision states that "*we have reviewed and considered the following information"* and then sets out 53 documents. *Guideline* 5.3.2, which has not been referred to, 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 has the opportunity to peruse such other documents.

19. The decision states that the *"information that supports our decision indicates"* at the commencement of 2 pages of reasoning. *Guideline* 5.3.2 states that *"All evidence should be referred to, whether or not it supports the decision".* The decision is silent as to whether there is evidence that does not support the decision. It may be that there is no contrary evidence, but the decision is silent as to that matter. The decision appears to be making it clear that only evidence which supports the decision will be relied upon by the decision maker, whoever that may be, and that evidence that does not support the decision will be ignored.

[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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20. The applicant is advised that she may request an internal review. The Insurer has not referred to section 44(1)(a) of the 1987 Act. This is a breach of *Guideline* 5.3.2 and the need to *"reference the relevant legislation".* The Insurer states that the request can be made by facsimile or email. The Insurer does not say that such a request can be made by post.

21. The advice as to the internal review states that the application form should be completed and "*returning it 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 required by *Guidelines for work capacity decision Internal Reviews by insurers and Merit Review by the WorkCover Authority* 6.2.

22. 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 87 days. It seems that *Guideline* 10.14 is one for breach of which there exists no current remedy.[3]

23. The decision states that the decision was made by the "*Technical Specialist*" and that it was reviewed and confirmed by the *"Work Capacity Team".* The "*Work Capacity Team"* is the signature block for the decision. This confusion leaves it quite unclear as to who made 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*

[3] See footnote 1.

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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 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".* In this case not only whoever made the decision is not identifiable, it is unclear as to whether it was the Technical Specialist or the Work Capacity Team.

24. 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. 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

25. 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

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

27. I recommend that the Insurer pay the applicant the weekly benefit to which she was entitled prior to 3 October 2013 until such time as she is properly transitioned. Those payments should continue from 11 January 2014 being the date on which they ceased.

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28. Whether or not the applicant can now be transitioned is a vexed issue. Clause 8(2) of Part 19H of Schedule 6 to the 1987 Act states *"The insurer who is liable to make weekly payments of compensation to an existing recipient of weekly payments must conduct a work capacity assessment of the worker no later than 12 months (or such longer period as may be prescribed by the regulations) after the commencement of the weekly payments amendments*". The *Workers Compensation Regulation* 2010 Clause 17 of Schedule 8 states that *"A period of 18 months is prescribed for the purposes of clause 8 (2) of Part 19H of Schedule 6 to the 1987 Act".* This means that the assessment must be made by 31 March 2014. As this can no longer be achieved it is difficult to see how the applicant can now be transitioned. It may very well be the case that clause 17 itself has no operation beyond the stated deadline.[4]

29. Since the applicant is not currently in receipt of weekly payments, clause 21 of schedule 8 of the *Regulation* cannot apply and payments may resume immediately. The applicant is not required to produce work capacity certificates for the period from 11 January 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
24 April 2014

[4] Perhaps more inferred than clearly stated.