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 4 July 2013. The applicant sought internal review. That decision was issued on 29 August 2013. The applicant sought Merit Review by the Authority. That application was received by the Authority on 23 September 2013. The Merit Review decision was issued on 10 March 2014, some 168 days later.[1]

2. The applicant was injured on 5 August 2004. He returned to suitable employment for most of the period since the injury. 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.[2]

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 in the weekly benefits payable to the injured worker then the

[1] Cf: *Review Guideline* 10.14 (as amended).
[2] See also clause 17, schedule 8, *Workers Compensation Regulation* 2010 which sets an 18 month time-limit. For more on this, see paragraphs 12 & 30 *infra*.

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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 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 was invited to make submissions, but did not do so.

The Decision

9. The decision states that a work capacity assessment was completed. It is unclear when the assessment took place. The Insurer sent a Fair Notice letter as required by *Guideline* 5.2 on 4 June 2013. The assessment, therefore, appears to have been made between 4 June 2013 and the date of the decision on 4 July 2013. 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[3] 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.*

[3] As at 4 July 2013 the relevant guideline was numbered 5.4.2, but it was re-numbered as 5.3.2 in the iteration of the *Guidelines* published in the Gazette on 9 August 2013, which preceded the internal review.

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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* 5.4.2 requires.[4]

11. *Guideline* 5.2 sets out the requirements of the *"Fair notice provisions*". The fair notice letter was sent on 4 June 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.*

The fair notice 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".*

[4] See footnote 3.

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As the applicant has been paid for 414.2 weeks[5] 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. Only section 38 is relevant.

No time frame is set out as to when the decision is expected to be made as required by *Guideline* 5.2.

12. *Guideline* 5.4.2 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."*[6]

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 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 12 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 12 October 2014. The effect of section 59A(2) of the 1987 Act has therefore been disguised, if not misrepresented.

[5] Clearly in excess of 130 weeks.
[6] See paragraph 30 *infra*.

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14. In addition, section 59A(3) of the 1987 Act states that the applicant may, after the entitlement to compensation for medical expenses is extinguished by the effluxion of 12 months, relumine that very entitlement to medical expenses if the entitlement to compensation for weekly benefits resumes at any stage in the future and for such time as those weekly payments continue.[7] This was not disclosed by the Insurer.

15. *Guideline* 5.4.2 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 414.2 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* 5.4.2. 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 it has been determined that the applicant has *"a current capacity to work - section 43(1)(a) of"* the 1987 Act. The decision then states that the applicant has "*capacity to earn at least [$xx] per week in suitable employment -section 43(1)(c) & (d) 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, *"suitable employment"* is a term with a specific meaning which may have little relationship to an understanding of the term in common parlance.

17. The decision states that *"weekly payments must cease within 3 months of our decision: section 54(2)(a) of the Workers Compensation Act 1987."* 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.[8]

18. The way to calculate weekly payments is set out but the reference is to section 38 of the 1987 Act. The correct reference is to section 38(7) of

[7] Some uncertainty still attends the definition of "week" or "weekly" in this context.
[8] 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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the 1987 Act. The applicant is then told that his average weekly earnings (AWE) is $938.30 and the applicant is referred to section 43(1)(d) of the 1987 Act. That reference would provide little enlightenment to the applicant.[9] The correct reference is to clauses 2 and 9(3) of Part 19H of Schedule 6 of the 1987 Act.

19. The decision states that "*we have reviewed and considered the following information"* and then sets out 23 documents. *Guideline* 5.4.2, 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.

20. The decision states that the *"information that supports our decision indicates"* at the commencement of nearly 3 pages of reasoning. *Guideline* 5.4.2 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.

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 the request for internal review must be sent within 30 days of receiving the decision. The Guideline 6.5 of *Guidelines for work capacity decision Internal Reviews by insurers and*

[9] The full text of section 43(1)(d) is as follows: "*a decision about the amount of an injured worker's pre-injury average weekly earnings or current weekly earnings*."

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Merit Review by the WorkCover Authority 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.[10] The lack of a set time limit leaves what is an appropriate time most unclear.

23. The decision states that "*frivolous and vexatious applications may be rejected".* Guideline 6.7 of *Guidelines for work capacity decision Internal Reviews by insurers and Merit Review by the WorkCover Authority* that 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.

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

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

[10] To the extent that the delegated instrument is inconsistent with the Act, the former must be *ultra vires*. Accordingly there is not *and there has never been* a 30 day time limit.

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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 168 days. It seems that *Guideline* 10.14 is one for the breach of which there exists no current remedy.[11]

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. This 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 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 capacity decision".* In this case the party who made the decision is not identifiable.

FINDING

27. 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

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

[11] See footnote 1.

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29. I recommend that the Insurer pay the applicant the weekly benefit to which he was entitled prior to 4 July 2013 until such time as he is properly transitioned. Those payments should continue from 12 October 2013 being the date on which they ceased.

30. 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.

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 resume immediately. The applicant is not required to produce work capacity certificates for the period from 12 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
29 April 2014