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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 24 June 2013. The decision determined to cease weekly payments. The applicant sought internal review. The Internal Review Decision (IRD) was issued on 14 October 2013. The applicant sought Merit Review by the Authority. That application was received by the Authority on 23 October 2013. The Merit Review decision was issued on 9 April 2014, some 168 days later.[1]

2. The applicant was injured on 12 June 1991. He was not able to return to his pre-injury employment but returned to suitable employment with his employer. That employment was terminated in 2000. The applicant subsequently secured further, suitable employment with different employers. His current employment has lasted since 2003. The Insurer made weekly payments as required under the provisions of the *Workers Compensation Act* 1987 (1987 Act) for all relevant periods.

3. The applicant was in receipt of compensation by way of weekly payments immediately before 1 October 2012 and is therefore able to be styled as an "existing recipient of weekly payments" as that term is defined in the 1987 Act.[2] 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

[1] Cf: *Review Guideline* 10.14 (as amended).
[2] See clause 1, division 1, part 19H, schedule 6 to the 1987 Act.

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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

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 submits that he relies upon a WIRO decision dated 27 August 2013 particularly paragraphs 5 and 11. Paragraph 5 of the decision of 27 August 2014 refers to the work capacity decision in that matter not referring to section 54 of the 1987 Act and no reference to a date the decision is to take effect. The decision under review correctly refers to section 54(2)(a) of the 1987 Act. Paragraph 11 refers to the *"Best Practice Decision-Making Guide"* which is referred to in *Guideline* 5.1. I have considered the remainder of that decision and, while a number of matters in that decision are similar to this matter, that matter turns on its facts as does the matter now under consideration.

8. The Insurer made no submissions.

The Decision

9. The decision does not follow the *"Best Practice Decision-Making Guide"* which is referred to in *Guideline* 5.1. As such, this is a breach of the *Guidelines.* This breach cannot have been avoided because the *"Best Practice Decision-Making Guide"* has never existed. It would appear that the author of the *Guidelines* failed to make a simple inquiry as to whether that document existed before completing the *Guidelines*.

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10. Here it might be apposite to note the approach of the High Court in *SZFDE v Minister for Immigration and Citizenship*[3] which affirmed the view of French, J (as he then was) at first instance in the Federal Court[4] that a failure to apply correct procedure (even, as in that case, to the extent of failing to provide a fair hearing) does not "depend on any finding of fault on the part of the decision-maker."[5]

11. The decision states that a work capacity assessment has been made. 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* 5.4.2 requires. There is no evidence as to when the assessment was undertaken. The Insurer is required to make a decision "*as soon as practicable"* after the assessment is made: see Clause 23, Schedule 8, *Workers Compensation Regulation* 2010. 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 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.

12. In this case the applicant does not know when the assessment took place. The applicant cannot know whether the decision was made "*as soon as practicable"* after the assessment.

[3] (2007) 232 CLR 189.
[4] (2006) 154 FCR 365, at 391-2.
[5] See Pearson, L. – *'Fair is Foul and Foul is Fair': Migration Tribunal and a Fair Hearing* – Chapter 19 of Groves, M (Ed.) *Modern Administrative Law in Australia,* CUP, Melbourne 2014, at page 436.

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13. *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."*

14. *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 2 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 2 October 2014. The effect of section 59A(2) of the 1987 Act has therefore been disguised, if not misrepresented.

15. 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. This is compounded by the IRD stating correctly the effect of section 59A(2) of the 1987 Act, but then stating the *"effect of this section is that compensation will be not be payable to [the applicant] for any treatment, service or assistance given or provided to him on or after 2 October 2014."* Section 59A(3) of the 1987 Act has been ignored by the Insurer.

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16. *Guideline* 5.4.2 requires the Insurer to *"reference the relevant legislation".* The applicant is advised that he has received 1,144 weeks of weekly payments and that as a result weekly payments are to be calculated pursuant to section 38 of the 1987 Act. The proper reference is to section 38(7) of the 1987 Act. The calculation in section 38(7) is set out and the decision states that for the calculation the applicant has a *"current capacity to work". "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 usual meaning of that phrase. Reference is made to section 43(1)((a) of the 1987 Act. That reference would not assist an applicant in understanding *"current work capacity"* particularly as he would have no reference to *"suitable employment".*

17. The applicant is told that he can earn a certain amount in suitable employment, and what that employment is. Section 43(1)(b) of the 1987 Act is referred to. Again, this reference will not assist the applicant. Further down *"suitable employment*" is explained in two paragraphs. At the end of the second paragraph a reference is made to section 32A of the 1987 Act. The applicant would be unlikely to know that both paragraphs set out the definition of *"suitable employment"* and not just the second paragraph.

18. The reference to 1,144 weeks does not attempt to explain the relevance of a number of weeks of weekly payments. Reference should be made to section 32A of the 1987 Act and the definition of "*second entitlement period"*. The decision should then explain that section 38 of the 1987 Act deals with weekly payments after the second entitlement period.

19. The transition amount is referred to and the applicant is advised that it *"must be used for any workers who made their claim prior to 1 October 2012"* and the applicant is referred to section 43(1)(d) of the 1987 Act. That reference is of no use to the applicant. The correct reference is to the definition of *"existing recipient of weekly payments"* in clause 1, Part 19H of Schedule 6 to the 1987 Act. An existing recipient is an applicant who was in receipt of weekly payments immediately before 1 October 2012. The reference to applicants "*who made their claim prior to 1*

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October 2012" is incorrect. Making a claim before 1 October 2012 is essential to being in receipt of weekly payments immediately before 1 October 2012, but it is not a determinative criterion.

20. The decision states that the *"information that supports our decision indicates"* at the commencement of a page 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. *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 sets out 4 documents. The Insurer 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.

22. 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. As the decision can only be served personally or by mail this is a strange omission.

23. The advice as to the internal review states that the application form should be completed and "*returned to us with <u>the</u> 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

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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.

24. The decision states that the request for internal review must be sent within 30 days of receiving the decision. The *Guidelines for work capacity decision Internal Reviews by insurers and Merit Review by the WorkCover Authority* 6.5 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. 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 receiving notice of the IRD.

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

26. 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."* This time frame is set out in the *Guidelines for work capacity decision Internal Reviews by Insurers and Merit Reviews by the Authority* dated 11 October 2013. *Guideline* 10.14 states "*The Authority will write to the worker and insurer as soon as practicable*

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and preferably within 30 days of receiving the application advising of the outcome of the merit review." The Authority received the application for review on 23 October 2013 and issued the review on 9 April 2014, some 168 days later. It seems that *Guideline* 10.14 is one for breach of which there exists no current remedy.

27. It is stated that the decision was made by the *"Work Capacity Team,"* and reviewed and confirmed by *"a Work Capacity Specialist".* The applicant has no way of knowing who made the decision. Does *"Work Capacity Team"* mean that the decision was made by a group of people? If so, who was the convenor or leader of the team? The identity of none of these people can be ascertained. This is an important issue as the *Guidelines for work capacity decision Internal Reviews by insurers and Merit Review by the WorkCover Authority* 7.2 states that the *"internal review is to be undertaken by a person who was not involved in the making of the original work capacity decision".* The applicant cannot know if that *Guideline* is adhered to if he cannot know who made the decision.

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. 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*

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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 1 April 2014. As this can no longer be achieved it is difficult to see how the applicant can now be transitioned.

31. I recommend that the Insurer pay the applicant the weekly benefit to which he was entitled prior to 24 June 2013 until such time as he is properly transitioned. Those payments should continue from 2 October 2013 being the date on which they ceased.

32. 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 2 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
5 May 2014