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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.

SUMMARY:

a. **The work capacity decision of the Insurer dated 26 July 2013 is set aside.**

b. **The applicant is to be reinstated to her weekly payments at the rate applicable at 26 July 2013.**

c. **The payments are to be back-dated to 29 March 2014.**

d. **The payments are to continue until such time as a further work capacity decision is made and comes into effect.**

1. The applicant seeks procedural review of a work capacity decision (decision) made by the Insurer on 26 July 2013. The decision stated that payments were to cease on 4 November 2014. The applicant states that she did not receive the decision until she contacted the Insurer on 14 October 2013. The applicant received the decision on 21 October 2013. The applicant sought internal review. The Internal Review Decision (IRD) was issued on 20 December 2013. The IRD purported to extend the date for cessation of weekly payments to 29 March 2014. The applicant sought Merit Review by the Authority. That application was received by the Authority on 20 January 2014. The Merit Review decision was issued on 4 April 2014, some 74 days later.[1]

2. The applicant was injured on 15 September 1999. The applicant returned to suitable employment with the employer and has remained with the employer undertaking suitable duties. The Insurer made weekly payments as required under the provisions of the *Workers Compensation Act* 1987 (1987 Act).

3. Because 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

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

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work capacity assessment for the purpose of facilitating the application of the amended weekly benefits provisions to the applicant. This process had be done "within 12 months" of 1 October 2012, unless otherwise stated in the Regulations.[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*).*

Submissions by the applicant

5. 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 are directed at the fact that she did not receive the decision until 21 October 2013 and therefore she did not receive 3 months notice as required by section 54(2)(a) of the 1987 Act. The Insurer does not appear to doubt that the applicant did not receive the decision until 21 October 2013.

Submissions by the insurer

6. The Insurer made no submissions.

The Decision

7. The decision gives adequate notice as required by section 54(2)(a) of the 1987 Act. The applicant states that she did not receive the decision until she had contacted the Insurer. The Insurer appears to have accepted the applicant's explanation that she did not receive the decision until much later. This acceptance is illustrated by the Insurer allowing further time in the IRD. The Insurer has attempted to solve a problem by allowing the further time, but there is no procedural fault arising out of the applicant's late receipt or non-receipt of the decision in

[2] But see paragraph 10 *infra*.

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the absence of evidence to the contrary. It follows that this is not a basis for challenging the validity of the original decision.

8. The decision states that a work capacity assessment was undertaken. The IRD states that the fair notice telephone call and letter both took place on 30 May 2013.That is a requirement pursuant to *Guideline* 5.2. It is reasonable to assume that the assessment took place between that date and the date of the decision. It is unsatisfactory for the applicant not to know the date of the assessment. There does not appear to be any legislative requirement to notify the applicant of the outcome of the assessment. However, *Guideline* 5.4.2 stated 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 which would involve showing the date of the assessment.

9. 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.

10. *Guideline* 5.4.2 required 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*

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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."*

11. *Guideline* 5.4.2 required 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".* The decision states that *"any entitlement you may have to payment of pre-approved reasonable and necessary medical and other expenses, until the 4th of November 2014, will not be affected."*[3] Section 59A(2) of the 1987 Act states that treatment and related expenses are no longer payable 12 months after weekly payments cease. The decision does not make that clear. Section 59A(2) has not been referenced as required by *Guideline* 5.4.2.

12. 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.

13. The applicant has received 450.4 weeks of compensation as at the date of the decision. The decision states that as a result weekly payments are to be assessed pursuant to section 39 of the 1987 Act. Section 39 deals with weekly payments after 260 weeks of payments. The applicant has received more than 260 weeks of payments, but section 39 does not apply to periods of payments made before the commencement of the 2012 amendments: see Clause 13, Part 19H of Schedule 6 to the 1987 Act.

14. The decision sets out the relevant formula for payments after 260 weeks, but fails to refer to the fact that the formula is in section 38 of the 1987 Act, and not in section 39.

[3] A litotes, at best.

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15. 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. Section 32A of the 1987 Act 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. Further in to the decision the applicant is advised that she has been assessed as earning a certain amount in suitable employment. Suitable employment is then described in 2 paragraphs. At the end of the second paragraph reference is made to section 32A. It would not be clear to an applicant that both paragraphs are relevant in relation to section 32A, not just the second paragraph.

16. The applicant is then advised that her "average weekly earnings" is the transitional amount. The decision does not refer to Clause 2, Part 19H of Schedule 6 to the 1987 Act which is where the transitional amount is set out. It is then stated that the transition amount *"must be used for any workers who made their claim prior to 1 October 2012 to transition to the new benefits system: Please refer to: Section 43(1)(d) of the Workers Compensation Act 1987".* That is erroneous. The transition amount must be used for an applicant who was in receipt of weekly benefits immediately before 1 October 2012 pursuant to clause 1, Part 19H of Schedule 6 to the 1987 Act.[4]

17. The decision states that "*we have reviewed and considered the following information"* and then sets out 4 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 she has the opportunity to peruse such other documents.

[4] By chronological force an applicant must have made a claim before 1 October 2012 in order to be in receipt of weekly payments as at that date. Hence the making of a claim is a necessary pre-condition to the receipt of payments, the latter being the only sufficient condition for being styled an "existing recipient of weekly payments" under the 1987 Act.

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18. The decision states that the *"information that supports our decision indicate that your injury does not fulfil the requirements to continue onto Section 39 entitlements as you have not suffered a WPI above 21%". 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, and that evidence that does not support the decision will be ignored. All of this is exacerbated by reference to section 39 which is not relevant to the applicant. The reference to section 39 is incorrect, in any event. The whole person impairment is relevant when it is more than 20%, not *"above 21%."*

19. 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* 5.4.2 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. This is an unusual omission when it is realised that the decision can only be served in person or by mail.

20. The application for internal review is said to be required to be lodged within 30 days of receipt of the decision. That is not correct. Section 44(1)(a) of the 1987 Act does not set any time limit in which the application for internal review is to be made. *Guideline* 7.2.2 refers to *"timely lodgement".* A time frame of 30 days may well be appropriate, but no assistance is given as to what may constitute *"timely lodgement".* The decision states that "*frivolous and vexatious applications may be rejected".* The Insurer does not have the ability pursuant to section 44 of the 1987 Act to refuse a request for internal review on that basis. The Authority and the Independent Review Officer may refuse to entertain an appeal where it is frivolous or vexatious, not frivolous and vexatious.

21. The advice as to the internal review states that the application form should be completed and "*returning it 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

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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, which has not been referred to, 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 she is dissatisfied with the internal review she 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 74 days. It seems that *Guideline* 10.14 is one for breach of which there exists no current remedy.[5]

23. At the end of the decision and purporting to form part of the decision are 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 38 of the 1987 Act is set out. It is relevant but not referred to in the decision. The decision relies on section 39 of the 1987 Act, but that is not reproduced. Section 32A is set out in full. Many definitions in that section are of no relevance to the applicant.

FINDING

[5] See footnote 1.

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24. 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

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

26. I recommend that the Insurer pay the applicant the weekly benefit to which she was entitled prior to 26 July 2013 until such time as she is properly transitioned. Those payments should continue from 29 March 2014 being the date on which they ceased.

27. Whether or not the applicant can now be transitioned is unknown. 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.

28. 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 29 March 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.

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Delegate of the WorkCover Independent Review Officer
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