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*.***

**SUMMARY:**

**a. The work capacity decision of the Insurer dated 1 October 2013 is set aside.**

**b. The applicant is to be reinstated to his weekly payments at the rate applicable at 1 October 2013.**

**c. The payments are to be back-dated to 10 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 made by the Insurer on 1 October 2013. The applicant sought internal review. The Internal Review Decision (IRD) was issued on 2 December 2013. The applicant sought Merit Review by the Authority. That application was received by the Authority on 22 January 2013. The Merit Review decision was issued on 6 May 2014, some 104 days later.[1] The applicant sought procedural review on 20 May 2014.

2. The applicant was injured on 7 May 2002. He was unable to return to employment with his employer. The applicant has been able to return to suitable employment as a self-employed farmer. 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's claim. Clause 17 of Schedule 8 to the *Workers Compensation Regulation* 2010 (the

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

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Regulation) required the transitioning process to be completed *"within 18 months"* of 1 October 2012.

4. The relevant version of the *WorkCover Work Capacity Guidelines (Guidelines)* is the one dated 8 August 2013 which 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.

5. 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**

6. The applicant raised various issues 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**

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

**The Decision**

8. The decision states that a work capacity assessment was completed. It is unclear when the assessment took place. The Insurer is required by Clause 23 of Schedule 8 to the Regulation to *"make a work capacity decision in respect of an existing recipient of weekly payments as soon as practicable after the first work capacity assessment of the worker is conducted by the insurer".* The IRD states that a *"Notice of Impending Work Capacity Decision was issued on 18 June 2013."* I assume that is the fair notice letter as required by *Guideline* 5.2. That Guideline requires that the fair notice letter be sent at least 2 weeks prior to the

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decision. It gives no maximum time frame. It is unclear when the assessment was undertaken. If it took place very soon after 18 June it is arguable that the decision was not made as soon as practicable after the assessment.

9. 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.

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

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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 treatment, such as Nuclear Magnetic Resonance Imaging for instance, are not permitted during the 12 month period. Perhaps the limits only apply for 12 months. Section 59A(2), however, places no limits on types or amount of treatment. That section states that payment for such treatment 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 referenced. More significantly, the applicant may 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 he 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 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. This was not disclosed by the Insurer.

15. Guideline 5.3.2 requires the Insurer to *"detail any support, such as job seeking support, which will continue to be provided during the notice period."* Less than helpfully the decision states that "*we will continue to*

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*provide support to assist you to return to work until if applicable."* The use of such "boilerplate" wording in documents is helpful only where some consideration of their usefulness takes place.

16. The decision states that the applicant has received weekly payments for 559.4 weeks. The decision states that a *"worker who is assessed as having current work capacity is only entitled to weekly benefits beyond the second entitlement period, ie 130 weeks, if:"* The test in section 38(3)(b) and (c) of the 1987 Act is then set out. The legislation has not been referred to as required by Guideline 5.3.2. The decision should explain the *"second entitlement period"* and that it is defined in section 32A of the 1987 Act.

17. While the decision states that 559.4 weeks of compensation have been paid, the IRD just 9 weeks later states that payments have been made for 606.8 weeks. A disinterested reader may conclude that the Insurer has been less than careful in making what is a very important decision. In addition, 559.4 weeks may mean 559 weeks and 4 days. A reference to ".8" of a week suggests a decimal marker which would be a reference to 5.6 days (5 days and 14 hours and 25 minutes). It seems unlikely that weekly compensation would be calculated to hours and minutes of a day when an applicant is not working.

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 54(2)(a) of the Workers Compensation Act 1987."* Upon reading 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]

19. The decision states that *"you have a current capacity to work".* No legislation is referred to as required by *Guideline* 5.3.2. Reference should be made 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 definitions. Current work capacity refers to the applicant not being able to return to his *"pre-injury employment but is able to return to work in suitable employment".*

[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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Suitable employment is a term with a specific meaning which may have little relationship to an understanding of the term in common parlance. The definition requires the Insurer to have regard to, *inter alia*, the applicant's *"work experience,"* but then to have no regard to *"the nature of the worker's pre-injury employment."* This definition should be explained clearly by the Insurer.

20. The decision only refers to 4 documents. *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 IRD refers to 18 documents, including medical reports. On the face of the decision, the decision maker has over-looked or ignored a number of documents. It appears that only evidence which supports the decision has been relied upon by the decision maker and that evidence that does not support the decision has been ignored. This view is supported by the decision stating that the *"information which supports our decision indicates you have the capacity to work but are not working".* There is no suggestion that the decision-maker considered any information that did not support the decision.

21. The decision states that the applicant may seek further copies of documents already provided to him. *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.

22. The decision fails to give any reasons for the decision despite having a heading *"Reasons for decision."* It is impossible to glean from the decision what type of work the applicant is assessed as able to undertake or how many hours he may be able to work. *Guideline* 5.3.2 requires the Insurer to *"clearly explain the line of reasoning for the decision."* No explanation is given. The IRD asserts that the applicant is able to work on his farm, although he needs assistance in more physically demanding tasks such as *"carving."* Attempting that task on live, unseasoned cattle could only be extremely physically demanding.[3]

[3] In contradistinction to the more traditional task of "calving."

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23. 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. This is peculiar as the decision may only be served in person or by post.

24. The decision states that the request for internal review must be sent within 30 days of receiving the decision. *Guideline* 6.5 of *Guidelines for work capacity decision Internal Reviews by insurers and Merit Review by the WorkCover Authority (Review Guideline)* dated 2 December 2012, gazetted 7 December 2012, and 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. *Work Capacity Guideline* 7.2.2 states that the application for internal review should be lodged within 30 days. 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.[4] Section 44(1)(a) of the 1987 Act does not impose any set time limit. The lack of a set time limit leaves what is an appropriate time most unclear.

25. The decision states that "*frivolous and vexatious applications may be rejected". Review Guideline* 6.7 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, but not an Insurer, 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 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

[4] 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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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* 6.2.2, *Review Guideline* 6.2 and section 44(2) of the 1987 Act.

27. 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." Review Guideline* 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 104 days. It seems that *Guideline* 10.14 is one for the breach of which there exists no current remedy.[5]

28. 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**

29. 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**

[5] See footnote 1.

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

31. I recommend that the Insurer pay the applicant the weekly benefit to which he was entitled prior to 1 October 2013 until such time as he is properly transitioned. Those payments should continue from 10 March 2014 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 10 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.

Wayne Cooper
Delegate of the WorkCover Independent Review Officer
10 June 2014