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 22 August 2013 is set aside.

b. The applicant is to be reinstated to her weekly payments at the rate applicable at 22 August 2013.

c. The payments are to be back-dated to 29 November 2013.

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 22 August 2013. The decision stated that payments were to cease on 29 November 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 12 December 2013. The Merit Review decision was issued on 13 May 2014, some 152 days later.[1]

2. The applicant was injured on 19 September 2000. She underwent two lumbar-sacral discectomies in 2001. She returned to suitable employment with the employer until 2006. Since that time the applicant has been employed in suitable duties with other employers. 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. Accordingly 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

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

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of the amended weekly benefits provisions to the applicant's claim. Clause 17 of Schedule 8 to the *Workers Compensation Regulation* 2010 (the Regulation) required the assessment process to be completed *"within 18 months"* of 1 October 2012. While in theory an assessment is not necessary prior to making a decision[2] the transitional provisions referred to above and in clause 23 of schedule 8 to the *Workers Compensation Regulation* 2010[3] make it tolerably plain that the assessment process is more than a mere propaedeutic when dealing with claims by existing recipients. A decision must follow very soon after the assessment and it is only by making and informing the worker of the decision that the Insurer can be said to have successfully transitioned the claim to the amended benefits provisions.

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. The *Guidelines* provide instructions and guidance to Insurers regarding the appropriate and consistent application of work capacity assessments and decisions.

5. Where the work capacity decision involves a reduction in or cessation of the weekly benefits payable to the injured worker then the Insurer is required to give proper notice to the worker (see 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 went to the merits of the case, that is, the very object of judgement or discretion of the Insurer excluded by section 44(1)(c) and therefore could not be relevant to this review.

7. The applicant made a very specific allegation about a medical practitioner which, if proven, might result in action in another place.

[2] See s 44A(3).
[3] Clause 23 requires an Insurer to make a work capacity decision "as soon as practicable after the first work capacity assessment of the worker" if that worker is an existing recipient of weekly payments.

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While the applicant claims the allegation had been brought to the attention of the insurer, this was denied by the Insurer, which expressed concern about the nature of the allegation. Applicants might do well to make such allegations to the relevant authorities if they have a complaint to make. Neither WorkCover nor the Independent Review Office are relevant authorities for such purposes.

Submissions by the insurer

8. The Insurer's submissions also went to the merits of the matter and as such are not relevant.

The Decision

9. The decision states that pursuant to *"clause 8(2) of Part 19H of Schedule 6 of the Workers Compensation Act 1987 (the Act) [the Insurer] is required to make a work capacity assessment."* The decision does not state that the assessment was made. On 25 July 2013 the Insurer contacted the applicant *"to advise our intention to make a decision about your work capacity in 3 weeks."* I assume that this *"contact"* was the fair notice telephone call or letter as required by *Guideline* 5.2. This contact also does not appear to state that an assessment has or will be made.

10. 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.*

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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.

11. *Guideline* 5.3.2 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 transitioning the claim *"must occur during the 2013 calendar year."* 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) *"during the 2013 calendar year."*

12. The decision states that the Insurer has determined that the applicant has a *"current work capacity,"* and that her current employment constitutes *"suitable employment."* Reference is made to section 43(1) of the 1987 Act. A far more useful reference is to section 32A of the 1987 Act and the definitions therein of both those phrases. These definitions do not bear a great deal of relationship to how an applicant would use the words in everyday use. *"Current work capacity"* means being unable to work in pre-injury employment but being able to undertake *"suitable employment." "Suitable employment"* includes having regard to the applicant's *"age, education, skills and work experience"* but having no regard to *"the nature of the worker's pre-injury employment."*

13. The applicant has received 212 weeks of weekly payments as at the date of the decision. The decision states that in *"2012 legislative reforms were introduced to NSW Workers Compensation"* and that as a result weekly payments are to be assessed pursuant to *"Section 38 of the legislative reforms as Section 38 is for any claim that is paid between 131 and 260 weeks".* The applicant could not be expected to know that the 2012 legislative reforms relate to changes to the 1987 Act and that is where section 38 is to be found.

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14. The decision states that section 38 also requires the applicant to *"work more than 15 hours per week and earn more than $155.00 per week to be entitled to wages."*[4] The $155 figure is indexed and it would be more useful to tell the applicant the rate as at the date of the decision. Section 38(c) should also be referred to as it also requires the insurer to assess the applicant *"as being, and as likely to continue indefinitely to be, incapable of undertaking further additional employment or work that would increase the worker's current weekly earnings".* The legislation has also not been properly referenced as required by *Guideline* 5.3.2.

15. The decision sets out the relevant formula in section 38(7) of the 1987 Act, although the legislation is not properly referred to as only section 38 is mentioned. The result is that she is to receive reduced payments. The transitional rate is explained, but not that it applies to the applicant as she was in receipt of weekly payments immediately before 1 October 2012. Clause 2 of Part 19H of Schedule 6 to the 1987 Act is referred to, but clause 1 (the definition of "existing recipient of weekly payments") and clause 9(3) (the deeming provision) should also be referred to.

16. The decision then has a heading *"What happens during the three month notice period?"* It is then stated that the Insurer *"will continue to manage your claim and process your weekly payments as they are currently paid"* and *"can provide a Rehabilitation Provider if you wish to seek some permanent part time employment".* Such statements under that heading may leave the applicant with the view that such assistance ends at the expiration of the notice period. As the applicant will continue to receive weekly payments, she will continue to receive all entitlements under the legislation.

17. The applicant is advised that she may request an internal review. Section 44(1) of the 1987 Act has not been referred to as required. 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

[4] On the contrary, the worker is "entitled to wages" from the employer for work performed, as opposed to "weekly payments" from the insurer. The imprecise wording used by the insurer is extremely unfortunate and may mislead a worker to believe that there is a minimum threshold for earnings of $155 per week (i.e. no wages are to be paid by an employer unless the worker earns at least $155 per week).

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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."*

18. The decision states that the Insurer has considered *"all relevant information available to me at the time of the decision".* Payslips are listed as are 3 WorkCover Certificates of Capacity. The IRD lists 15 documents, including a number of specialist medical reports. The original decision-maker has clearly not reviewed all documents whether or not the documents support the decision, as required by *Guideline* 5.3.2. This is a further clear breach of the *Guidelines*.

FINDING

19. 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

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

21. I recommend that the Insurer pay the applicant the weekly benefit to which she was entitled prior to 22 August 2013 until such time as she is properly transitioned. Those payments should continue from 29 November 2013 being the date on which they ceased.

22. 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 November 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.

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Wayne Cooper
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