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 3 June 2013 is set aside.

b. The applicant is to be reinstated to his weekly payments at the rate applicable at 3 June 2013.

c. The payments are to be back-dated to10 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 3 June 2013. The decision stated that payments were to cease on 10 September 2013. The applicant sought internal review. The Internal Review Decision (IRD) was issued on 6 August 2013. The applicant sought Merit Review by the Authority. That application was received by the Authority on 30 August 2013. The Merit Review decision was issued on 8 May 2014, some 91 days later.[1] The application for procedural review was made on 28 May 2014.

2. The time frame for seeking procedural review is 30 days: section 44(3)(a) of the *Workers Compensation Act* 1987 (1987 Act). The 30 days runs from the time when the applicant receives the Merit Decision in the approved form. That form did not exist as at 29 November 2013, and it does not appear that the Merit Decision was served again in the approved form (which came into effect on 4 April 2014). I am satisfied that the application is therefore not time-barred, since time cannot run until the decision is received in the approved form.[2]

3. The applicant was injured on 5 January 1994. He underwent spinal fusion in 1995 and further surgery a year later to remove pins. The applicant has not been able to return to work with the employer. The

[1] Cf: *Review Guideline* 10.14 (as amended).
[2] See paragraph 7, *infra*.

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applicant has been able to work in suitable employment in a family accommodation business. The Insurer made weekly payments as required under the provisions of the *Workers Compensation Act* 1987 (1987 Act).

4. 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 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 transitioning process to be completed *"within 18 months"* of 1 October 2012.

5. The relevant version of the *WorkCover Work Capacity Guidelines (*Guidelines*)* is the one dated 27 September 2012, which came into effect on 1 January 2013. 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 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

7. 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 first submission 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. The second submission was an explanation of the delay in seeking procedural review. He states that he sent his submissions *"to the wrong place which have been ignored."* Some would accord this the status of an admission rather than a submission, but it neither enhances nor diminishes his prospects of

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success since it is irrelevant. The want of a form at the relevant time accorded all workers the status of being "within time."

Submissions by the insurer

8. The Insurer's only submission was with respect to the time frame in which to lodge the application for Procedural Review. That submission must fail for the reasons set out in paragraphs 2 and 7 above.

The Decision

9. The decision states that a work capacity assessment was undertaken but not when it took place. The Insurer is required 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":* see clause 23 of Schedule 8 of the Regulation. Without the date of the assessment the applicant cannot know if the decision was made "*as soon as practicable after the first work capacity assessment."*

10. 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.

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11. 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.

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."*

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 10 September 2014, will not be affected."* This statement gives no information to the applicant about the effect of section 59A(2) on such entitlements beyond 10 September 2014. The effect of section 59A(2) of the 1987 Act has therefore been disguised, if not misrepresented.

14. 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.

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15. The applicant has received 963.2 weeks of weekly payments as at the date of the decision. The decision states that as a result weekly payments are to be assessed pursuant to section 38 of the 1987 Act. Reference is made to 130 weeks and the *"second entitlement period."* The applicant should be referred to the definition of *"second entitlement period"* in section 32A of the 1987 Act.

16. The decision then attempts to set out section 38(3)(b) and (c) of the 1987 Act, without referring to that section. The decision states that as a result of the assessment the applicant has a *"current capacity to work: Please refer to Section 43(1)(a) of"* the 1987 Act. Section 43(1)(a) would be of no assistance in explaining *"current work capacity."* Section 32A of the 1987 Act defines *"current work capacity"* which is itself defined by reference to *"suitable employment*." 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."*

17. The applicant is advised that he has returned to work *"for at least 15 hours per week and [is] in receipt of current weekly earnings (or current weekly earnings together with a deductible amount) of at least $155 per week."* The relevance of 15 hours and $155 is not explained by reference to section 38(3)(b). It would also help the applicant to be advised that $155 is indexed and what the figure is at the time of the decision. Failure to do this must lead to error, since the information being given to the applicant is out of date to the point of being incorrect.

18. The decision then arrives at section 38(3)(c) and the applicant is advised that *"you have returned to work but are capable of undertaking further additional employment or work that would increase your current weekly earnings."* No reference is made to the legislation. Section 38(3)(c) is an important paragraph in the test as to whether an applicant is entitled to weekly payments and it should be explained that this test is not a policy of the Insurer but part of the legislation the Insurer is required to take heed of.

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19. As a result of the decision setting out the provisions of section 38(3)(b) and (c) the applicant is advised that *"you are no longer entitled to weekly payments under the new benefits system – please refer to: Section 38"* of the 1987 Act. This is an uninformative and obscure allusion to section 38(7) but it is not referred to in the decision. No calculation is set out to explain why payments will cease. If that were done it would be necessary to explain the *"transition rate"* and refer to clause 1 (the definition of "existing recipient of weekly payments"), clause 2 (the transitional amount as indexed), and clause 9(3) (the deeming provision) of Part 19H of Schedule 6 of the 1987 Act.

20. The applicant is then advised that *"your entitlement to 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".* Pleasing though it is to be referred to the correct legislation, it is disappointing to see that it has been misconstrued and wrongly applied. A licensed scheme agent of the Workers Compensation Nominal insurer should know better than to treat the 3 month period set out in section 54(2)(a) as a maximum payment period. It is of course a minimum notice period. To add to this applicant's likely confusion, the decision is dated 3 June 2013 and states that payments will cease on 10 September 2013, more than 3 months later, despite his having been told that they "must cease within 3 months." A more indefensible instance of demonstrable error is hard to imagine.

21. The decision advises that 6 documents have been reviewed and considered. After 19 years it seems most unlikely that there are not considerably more than 6 documents. The next heading is: *"The information which supports our decision indicates:" Guideline* 5.4.2 requires the Insurer to refer to all evidence whether or not it supports the decision. A reference to "*information which supports our decision"* appears to be stating that any contrary evidence will, and has, been ignored.

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

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made by post. This error by omission is the more unusual for the decision itself being only capable of service either in person or by post.

23. 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* 6.2.2 (as in force at the time of the decision) stated that there was a 30 day time limit. The next iteration of the Guideline which came into effect on 12 August 2013 (*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."*

24. 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."* The *Guidelines for work capacity decision Internal Reviews by Insurers and Merit Reviews by the Authority* 10.14 then in force stated *"The Authority must shall* (sic) *write to the worker and insurer within 30-days of receiving the application advising of the outcome of the merit review".* The next iteration of *Review Guideline* 10.14 which came into effect on 11 October 2013 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 91 days. It seems that *Guideline* 10.14 is one for breach of which there exists no current remedy.[3]

25. 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 32A is set out in full. Many definitions in that section are of no relevance to the applicant.

[3] See footnote 1.

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FINDING

26. 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

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

28. I recommend that the Insurer pay the applicant the weekly benefit to which he was entitled prior to 3 June 2013 until such time as he is properly transitioned. Those payments should continue from 10 September 2013 being the date on which they ceased.

29. 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 September 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
20 June 2014