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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 23 January 2014 is set aside.

b. The applicant is to be reinstated to her weekly payments at the rate applicable at 23 January 2014.

c. The payments are to be back-dated to 30 April 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 23 January 2014. The decision stated that payments were to cease on 30 April 2014. The applicant sought internal review. The Internal Review Decision (IRD) was issued on 13 March 2014. The applicant sought Merit Review by the Authority. The Merit Review recommendation was issued on 26 May 2014. Application was subsequently made to this office on 29 May 2014. I am satisfied that the applicant has applied within time and on the correct form.

2. The applicant was injured on 18 November 2002. He returned to suitable employment with the employer until 2005 when he was medically retired following a restructure. 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 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.

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4. The relevant version of the *WorkCover Work Capacity Guidelines (Guidelines)* is the one dated 4 October 2013, which came into effect on 11 October 2013. 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 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 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 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.

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 on 23 January 2014. 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.

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 stated that the decision must:

    - *state the decision and give brief reasons for making the decision;*

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- *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. *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 makes no reference to section 59A(2) or to medical expenses. This must constitute demonstrable error on the part of the Insurer.[1]

11. 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, possibly because the Insurer was unaware of section 59A(3), or at least unaware of its effect. This issue becomes more complex as it is unclear as to whether the weekly payments will cease or only be reduced. That may also change on a weekly basis due to his variable income.

12. The applicant cannot return to his pre-injury employment but is able to work in suitable employment. There is no attempt to explain that an inability to return to pre-injury employment but being able to work in suitable employment is what the 1987 Act defines as *"current work*

[1] For a recent discussion of "demonstrable error," see *NSW Police Force v Registrar of WCC of NSW* [2013] NSWSC 1792 at paragraphs 39-56. Demonstrable error in the context of medical appeals was earlier discussed by Hoeben, J in *Merza v Registrar of WCC of NSW* [2006] NSWSC 939 (at 39) and the Court of Appeal in *Pitsonis v Registrar of WCC of NSW* [2008] NSWCA 88.

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capacity" in section 32A. That term is defined by reference to *"suitable employment".* In the same way *"suitable employment"* is also defined in section 32A. That definition is very important as it bears little relationship to the ordinary meaning of that phrase. The concept that suitable employment includes work that may not be readily available would be alien to an untutored reader hoping to get by using no more than common sense and the ordinary meaning of words.

13. The applicant is advised that his deemed Pre-Injury Average Weekly Earnings (PIAWE) is $948.50. The reference given is *"Schedule 6 Part 19H Clause 2 of the Workers Compensation Act 1987."* Clause 2 sets out the transitional rate, but it should be stated that it is indexed which is why the rate is now higher. The decision should also refer to clause 1 (the definition of *"existing recipient of weekly payments")*, and clause 9(3) (the deeming provision) of Part 19H of Schedule 6 of the 1987 Act. It is not explained that the transitional rate applies to him as he was in receipt of weekly payments immediately before 1 October 2012. All that is said is that he *"is transitioning to the new weekly payment arrangements."*

14. The decision refers to the 3 months notice pursuant to section 54 of the 1987 Act. The correct reference is to section 54(2)(a) of the 1987 Act. The applicant is advised that from *"the 30/04/2014 this decision will come into affect"* (sic).It is not clear as to how the decision will be affected on 30 April 2014.

15. *"You have demonstrated your ability to work with evidence shown with your payslips",* the decision states. The plural *"payslips"* is at odds with the decision stating that the *"documents relied upon to make the decision are"* and only 1 document is listed: a payslip dated 23 April 2013. What other payslips have been taken into account is not known.

16. The applicant has received 241 weeks of weekly payments. Section 38 is said to apply and that the applicant satisfies the *"criteria set out in Section 38 of the Act as you are currently working more than 15 hours a week and you are earning over $168.00".* The proper reference is to section 38(3)(b) of the 1987 Act. That reference should also point out that the figure therein of $155 is indexed. The decision should also refer to section 38(3)(c) of the 1987 Act. It is unclear as to whether the applicant could undertake *"additional employment or work that would*

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increase the worker's current weekly earnings". The Insurer does not turn its mind to that issue.

17. The benefits periods are set out by reference to sections 36, 37, 38, and 39. It is stated that section 39 is in relation to ceasing payments after 5 years. As the applicant has nearly reached the 5 year limit he would be rightly concerned that his payments will cease. He may also be concerned as to why the Insurer has gone to the extent of making a decision when the effluxion of time in the near future would achieve the desired result. The Insurer must reference the legislation and advise that pursuant to Clause 4 of Schedule 8 to the *Regulation* that in the counting of 5 years *"no regard is to be had to any weekly payment of compensation paid or payable to the worker before 1 January 2013".*

18. The decision states that pursuant to *"section 38 the formula to calculate benefits is explained below"*. The correct reference is to section 38(7). The calculation is then set out as the *"Transitional rate $948.50 x 80% = $758.80 less your current earnings".* He is then told that payments *"can only be made on receipt of payslips and ongoing medical certificates".* No attempt is made to explain as to why payslips are required, and whether they are required as received by him or on some other basis. The decision should explain that the applicant has a variable weekly income which is why all payslips are required so that each pay period the correct rate can be determined. As the applicant is a self-employed contractor, he may also have business expenses which are a tax deduction. This may mean a recalculation of each week of pay once he has prepared his tax return.

19. The decision states that the Insurer has considered *"all relevant information available to me",* and that *"the documents relied upon to make the decision are".* Only 1 document is listed, the payslip. It is noted that the applicant also sent in an email. What that email reveals is not said. After 11 years there would be a large number of documents. The decision-maker has clearly not reviewed all documents and evidence whether or not the documents and evidence support the decision, as required by *Guideline* 5.3.2. This is a further clear breach of the *Guidelines.*

20. The decision states that the *"documents"* have been sent to the applicant. *Guideline* 5.3.2, which has not been referred to, states that

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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 he has the opportunity to peruse such other documents.

21. *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".* The applicant is advised that during *"the three month notice period I will continue to manage your claim and process your weekly payments as they are currently paid".* Processing payments cannot be regarded as support in the way the *Guideline* envisages. What *"managing"* the claim entails is not explained.

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* 5.3.2 and the need to *"reference the relevant legislation."*

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* 7.1.2 refers to *"timely lodgement."* The true effect of *"timely lodgement"* is abstruse.

FINDING

24. I find that the Insurer has failed to follow the procedures as set out in the WorkCover *Guidelines* which is a requirement of 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

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capacity decision. The relevant guidelines will be those gazetted on 8 October 2014, or such newer iteration of the *Guidelines* as may be gazetted between the date of this recommendation and the new assessment being completed.

26. I recommend that the Insurer pay the applicant the weekly benefit to which he was entitled prior to 23 January 2014 until such time as he is properly transitioned. Those payments should continue from 30 April 2014 being the date on which they ceased.

27. 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 30 April 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
26 June 2014