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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 2 September 2013 is set aside.

b. The applicant is to be reinstated to her weekly payments at the rate applicable at 2 September 2013.

c. The payments are to be back-dated to 6 December 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 2 September 2013. The decision stated that payments were to cease on 6 December 2013. The applicant sought internal review. The Internal Review Decision (IRD) was issued on 10 December 2013. The applicant sought Merit Review by the Authority. That decision issued on 15 May 2014.

2. The applicant injured his lower back on 3 September 2003 while employed as a labourer. The applicant found suitable employment with another employer at one stage. He is currently not working. 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 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.

Submissions by the insurer

7. Some of the Insurer's submissions went to the merits of the matter and as such are not relevant. Other submissions went to procedural matters particularly reference to the fair notice telephone call and that *"a notice of intent to make a work capacity decision letter together with fact sheets explaining changes in legislation were forwarded to"* the applicant. The submissions state that the decision was sent on 30 August 2013. The decision is dated 2 September 2013. Perhaps the decision was dated 2 September 2013, but posted on 30 August 2013. Nothing substantive turns on this temporal anomaly, however curious.

The Decision

8. The Insurer does not disclose what was in the fact sheet sent to the applicant. The relevant information must be sent to the applicant as part of or with the decision. The applicant might not keep a fact sheet sent before the decision is sent as he may not at that time understand its relevance.

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9. It is not stated when the assessment was undertaken. The decision is silent as to a date, and the submissions do not refer to the assessment. Clause 23 of Schedule 8 to the *Regulation* requires the decision to be made as soon as practicable after the assessment. It is unclear in this case as to whether that has occurred.

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.*

    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. The decision does not state that an assessment must be made within 18 months of the commencement of the 2012 amendments pursuant to Clause 17 of Schedule 8 of the Regulation and that the amendments commenced on 1 October 2012.

12. *Guideline* 5.3.2 requires the Insurer to reference the legislation. The decision's heading states that Notice is given in accordance with section 54 of the 1987 Act. The proper reference is to section 54(2)(a) of the 1987 Act. It also states that the weekly payment will be $0.00 from 6 December 2013. It is not stated that this 3 months notice is also required to be given pursuant to section 54(2)(a) of the 1987 Act. It is also not explained how $0.00 will be paid, whether by cheque or direct deposit.

13. The decision refers to the *"Workers Compensation Amendment Act 2012 (the Act)".* Had the applicant perused that Act he would be

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concerned to see that schedules 1 to 7 and 9 to 12 of that Act have been repealed. An applicant should not be expected to have expert knowledge of the intricacies of New South Wales legislation to understand that the repealed schedules are now part of the 1987 Act. By use of a shorthand reference to *"the Act"* the incorrect reference to the legislation flows through the rest of the decision.

14. The applicant is not advised that he is an *"existing recipient"* of weekly payments. Reference should be made to clause 1 of Part 19H of Schedule 6 to the 1987 Act and the definition of *"existing recipient of weekly payments"* and that it refers to an applicant who was in receipt of weekly payments of compensation immediately before 1 October 2012.

15. The applicant is advised that his claim *"falls within the 261 Weeks+ period".* Further down the page reference is made to section 38 of the Act (the 2012 Amending Act) and the special requirements after the *"second entitlement period (after 130 weeks)".* The IRD states that the applicant has as at 4 December 2013 received 189.8 weeks of weekly payments. A decimal point suggests that the Insurer has calculated the weekly payments to 189 weeks, 5 days, 14 hours and 24 minutes. Such precision seems unlikely. Having 3 different numbers of weeks, and being referred to an incorrect Act would leave the applicant with little idea as to what his entitlements may be.

16. If the applicant was able to discover that the legislation is in the 1987 Act he may be concerned by section 39 and cessation of payments after 5 years, more than 260 weeks. The applicant is unlikely to discover Clause 4 of Schedule 8 to the Regulation and that "*no regard is to be had to any weekly payment of compensation paid or payable to the worker before 1 January 2013".*

17. The applicant's entitlements are stated to have been calculated on his current work capacity, that he is working less than 15 hours per week, and he is *"not currently engaged in suitable employment and/or earning more than $155".* This is an attempt to set out the test in section 38(3) of the 1987 Act, although no legislation is referred to. The decision continues that based *"on the above assessment we have calculated your weekly entitlement as follows: Ceasing Benefits".* This is not a calculation, it is a statement that would leave anyone baffled as to what its true meaning is.

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18. The decision states that it *"considered the meaning of **current work capacity** and **suitable employment** under section 32A of the Act".* The applicant would not find a section 32A in the Amending Act. It would help to have these terms explained as neither means what they would in normal usage of the words. The phrase *"current work capacity"* is itself defined by reference to *"suitable employment".* That phrase includes work which may not be available. Despite that, the decision states that the definition of current work capacity *"focuses on your capacity to work in a role that is not your pre-injury role but is one where there are genuine job prospects is Australia. This is known as **suitable employment**".*

19. The decision states that the Insurer has *"determined your weekly entitlements based on the following section/s of the Act: a) s38 Special requirements for continuation of weekly payments".* What the special requirements are is not expressed, and the applicant will not find section 38 in the Amending Act.

20. Only 3 documents are referred to in the decision. After almost exactly 10 years there is likely to be more than 3 documents. An Earning Capacity Assessment is one of these documents and it is dated 23 February 2010, over 3 years before the decision. There is a WorkCover NSW Medical Certificate dated 24 April 2013 which sets out suitable employment options, but an Earning Capacity Assessment of that age may no longer be relevant. *Guideline* 5.3.2 states that all evidence considered should be referred to whether or not it supports the decision. On the face of the decision it seems that not all documents that are relevant have been considered.

21. The applicant is advised that he is entitled to claim medical expenses for 12 months after weekly payments cease. No reference is made to section 59A(2) of the 1987 Act. 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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22. The applicant is advised that he may seek an internal review within 30 days from the date of the decision. Section 44(1)(a) of the 1987 Act does not impose any time limit. *Guideline* 7.2.2 only refers to *"timely lodgement".* The true effect of *"timely lodgement"* is yet to be tested curially.

FINDING

23. 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

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

25. I recommend that the Insurer pay the applicant the weekly benefit to which he was entitled prior to 2 September 2013 until such time as he is properly transitioned. Those payments should continue from 6 December 2013 being the date on which they ceased.

26. 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 6 December 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
7 July 2014