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 28 November 2013 is set aside.

b. The applicant is to be reinstated to her weekly payments at the rate applicable at 28 November 2013.

c. The payments are to be back-dated to 5 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 28 November 2013. The decision stated that payments were to cease on 5 March 2014. The applicant sought internal review. The Internal Review Decision (IRD) was issued on 14 March 2014. The applicant sought Merit Review by the Authority. The Merit Review was issued on 22 May 2014.

2. The applicant was injured on 24 July 2012. The injury was to her legs and feet. She has suffered psychological sequelae. She has returned to suitable employment with the same employer. 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 transitioning 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, published on 8 October 2013, and 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. 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."* Some of 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. The applicant made other submissions related to procedural matters. Firstly, the IRD purports to be a fresh decision, and admits to errors in the original decision. Secondly, there is no date given for the assessment, and the IRD states that another assessment was undertaken on 14 March 2014. Thirdly, the reasoning behind the amount which it is said the applicant can earn in suitable employment is not explained.

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 undertaken. No date for the assessment was provided. The Insurer is required to make a decision "*as soon as practicable"* after the assessment is made: see Clause 23, Schedule 8, *Workers Compensation Regulation* 2010. The applicant cannot know whether that has occurred. The decision does not state that the assessment is required pursuant to Clause 8 of

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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;*
    - *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.

10. *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 the claim *"must transition to the new benefits system in 2013."* What Clause 8(2) of Part 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."*

11. *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*

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work obligations." Section 59A(2) of the 1987 Act provides 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 some medications or treatment by a podiatrist (to give only two illustrative examples), are not permitted during the 12 month period. Perhaps there is a financial limit on treatment that may be received. Section 59A(2), however, places no limits on types or amount of treatment. That section provides that payment for medical treatment *per se* ceases 12 months after weekly payments cease.

12. The next sentence in the decision is "*this means that your entitlement to medical and related expenses will cease on 5 March 2015. Please refer to: Section 59A"* of the 1987 Act. The legislation has, again, not been properly referred to. More significantly, the applicant is likely to 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 cost of treatment to which she is entitled.

13. 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.

14. The applicant has received 61.6 weeks of compensation as at the date of the decision. The decision states that as a result weekly payments are to be assessed pursuant to section 37 of the 1987 Act. The correct reference is probably to section 37(2) of the 1987 Act, although the decision does not state whether the applicant is working and if so the extent of any work. The formula in section 37(2) is set out and uses the

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transitional rate. The decision states that *"this amount ("the transition amount") is specified in the legislation and must be used for any workers who made their claim prior to 1 October 2012 to transition to the new benefits system: Please refer to: Section 43(1)(d) of the Workers Compensation Act 1987".* The errors in such a statement are many. Having made a claim prior to 1 October 2012 is essential. But the test is to be in receipt of weekly payments immediately before 1 October 2012. The Insurer should have referred 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. Section 43(1)(d) states that the Insurer may make *"a decision about the amount of an injured worker's pre-injury average weekly earnings or current weekly earnings".* The Insurer has stated that the transitional amount must be used *"irrespective of your real earnings prior to injury",* and that the Insurer can make a decision about average weekly earnings. Which of these 2 options is to be used is left unsaid.

15. The decision does not refer to the *"second entitlement period"* and its definition in section 32A of the 1987 Act. Without that reference the relevance of the number of weeks is obscure.

16. The decision states that the applicant has been assessed as earning $[xxx] in suitable employment or as having capacity to earn the same amount in suitable employment. Where this figure comes from is not said. Perhaps the Insurer does not know. Reference is made to section 43(1)(c) and (d) of the 1987 Act. That reference would not assist the applicant. That legislation is with respect to the Insurer's ability to make decisions about the applicant's ability to earn in suitable employment and the applicant's pre-injury average weekly earnings or current weekly earnings. None of that explains where the Insurer obtained the figure relied upon as the figure it says the applicant is able to earn. *"Suitable employment"* is set out in 2 paragraphs. The second paragraph refers to section 32A of the 1987 Act. What is not made clear is that both paragraphs describe the definition in section 32A, not just the second paragraph. The decision does not refer to *"current work capacity"* which needs to be explained as it is itself defined by reference to *"suitable employment".*

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17. The decision states that *"Applying the above formula and the information outlined below"* it has been calculated that the applicant is no longer entitled to weekly payments. The information outlined is 6 documents. In what way any of those documents assists the decision maker to arrive at any conclusion is not said. *Guideline* 5.3.2 states that the Insurer must *"clearly explain the line of reasoning for the decision".* The Insurer has clearly not even attempted to undertake this task.

18. While the decision lists 6 documents, the IRD lists 13 documents. Guideline 5.3.2 requires the Insurer to "*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".* The decision maker has clearly not considered all the evidence. This is a demonstrable error. This may be confirmed with the decision stating that the *"information which supports our decision indicates".* This is a clear statement that only evidence that supports the decision has been considered and any evidence that does not support the decision has not been taken into account.

19. The applicant is advised that she 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."* 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 error by omission is the more unusual for the decision itself being only capable of service either in person or by post.

20. 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"* and that the application should be lodged *"as soon as practicable after receiving the work capacity decision".* A time frame of 30 days may well be appropriate, but no assistance is given as to what may constitute *"timely lodgement."*

21. The advice as to the internal review states that the application form should be completed and "*returning it to us with the extra information, reports and/or documents you rely upon"* (emphasis added). This

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statement conveys the impression that an applicant must provide further 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, which has not been referred to, 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.

22. The decision states that "*frivolous and vexatious applications may be rejected".* 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 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.

23. 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 38 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.

24. This review is in relation to the decision, not the IRD. Some comments in relation to the IRD are, however, worthwhile. It is difficult to know how an applicant, or anyone, could understand this document. It may be attempting (as the applicant submits) to repair errors in the decision. The IRD cannot repair errors in the decision. It is a review of the decision, not a *"second go".* The IRD states that an assessment was conducted on 14 March 2014. When the assessment referred to in the decision took place is still not revealed. Then follows a remarkable paragraph: *"As you are not currently in receipt of any weekly payments under the old Section 40 of the 1987 Act, when your claim is to be transitioned to the new Section 37(2) of the 1987 Act by 21 June 2014 as per required notice under Section 54(2)(a), you are still not entitled to receive any weekly benefits".* The late Terence Milligan may have marvelled at such a paragraph.

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FINDING

25. 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

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

27. I recommend that the Insurer pay the applicant the weekly benefit to which she was entitled prior to 28 November 2013 until such time as she is properly transitioned. Those payments should continue from 5 March 2014 being the date on which they ceased.

28. 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 5 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
8 July 2014