WorkCover independent review office

Level 4, 1 Oxford Street, Darlinghurst NSW 2010
T: 13 9476
contact@wiro.nsw.gov.au
www.wiro.nsw.gov.au

RECOMMENDATION FOLLOWING AN APPLICATION FOR REVIEW OF THE INSURER'S WORK CAPACITY DECISION PURSUANT TO SECTION 44(C) OF THE *WORKERS COMPENSATION ACT 1987.*

1. An injured worker is the applicant for a review of the decision made by Insurer.

2. The applicant suffered injury on or about 23 June 2010 in the course of his employment.

3. As a result of the applicant's work-related injuries liability to make weekly payments of compensation was accepted by the insurer and the payments continued until February 2013 when an attempt was made by the insurer to transition the applicant under the 2012 amendments to the *Workers Compensation Act* 1987 (1987 Act). There is no dispute that the applicant is an "existing recipient of weekly payments" as that term is defined in Schedule 6 part 19H Division 1 of the *1987 Act.*

4 The Insurer purported to issue a notice of a work capacity decision pursuant to Section 43 of the *1987 Act* on 27 February 2013. The applicant was advised that his weekly benefits would be reduced to "nil" and that the decision would come into effect 3 months after the date of the letter, being 27 May 2013..

5. On 26 April 2013 the Insurer wrote to the applicant advising of the outcome of an internal review of the decision dated 27 February 2013. The internal review upheld the original decision, but purported to alter the date of cessation of payments from 27 May 2013 to 31 May 2013, said to be for the purpose of complying with WorkCover *Guidelines* which require notice of variation of payments under section 54 to include an extra four working days for receipt of postal notice, in addition to the statutory 3 months appearing in section 54.

6. A WorkCover Merit Review was completed and a Statement of Reasons issued on 28 June 2013. The Merit Reviewer upheld the determination of the Insurer.

7. On 26 July 2013 the applicant requested the Independent Review Officer to undertake a review of the decision of the Insurer pursuant to Section

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44(c) of the *1987 Act*. I am satisfied that the applicant has made that application within the time provided by that section.

Applicant's Grounds for seeking Procedural Review

8. The applicant made lengthy submissions, which might fairly be summarised into two categories:

   a. Non-compliance with the *WorkCover Work Capacity Guidelines*, including but by no means limited to:

   - *Guideline* 5.1 – *ensuring that all reasonable opportunities to establish capacity for work have been provided to the worker;*
   - Guideline 5.1 – *ensuring that the insurer meets the responsibility of establishing and supporting an Injury management Plan tailored to the worker's injury as set out in Chapter 3 of the 1998 Act;*
   - Guideline 5.1 – *evaluating all available and relevant evidence;*
   - Guideline 5.1 – *providing opportunity for the worker to contribute additional information, especially if the decision may result in reduction or discontinuation of the worker's weekly payments;*
   - Guideline 5.2 – *the insurer must at least two weeks prior to the work capacity decision, communicate to the worker that weekly payments will be reduced or discontinued in a way that is appropriate in the circumstances of the case, and preferably by phone or in person.*
   - Guideline 5.4 – *the insurer must provide at least 3 months' notice before reducing or discontinuing the worker's weekly payments; and*
   - Guideline 6.3.2 – *on merit review, a copy of the reply lodged with the Authority should be provided to the worker together with a list of all documents relied upon.*

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b. The insurer's notice of 27 February 2013 is defective and cannot be rectified, since it is in breach of section 54 as well as the *Guidelines* and section 54 of the *Act* provides no basis for rectification.

The Legislative Framework

9. The legislative framework which governs the entitlement to and the transition from the previous benefits is complex and must be difficult for an injured worker without legal assistance to navigate through and to understand its impact. Set out shortly, there may be thought to be no less than four steps involved, all of them mandatory.

i. An insurer may make a work capacity assessment at any time (see section 44A(1)). Section 44A(3) also provides that an assessment is not necessary for the making of a work capacity decision.

ii. Section 43 provides that a work capacity decision may be made by an insurer and is binding on the parties, subject to review only under section 44 or by judicial review in the Supreme Court of NSW. Under *WorkCover Work Capacity Guidelines* published on 28 September 2012 (the version relevant for the purposes of the applicant's claim), *Guideline 5* states in part:

> "A work capacity decision is a discrete decision that may be made at any point in time and can be about any one of the factors described in section 43(1), such as the worker's capacity to earn in suitable employment. This is different to a work capacity assessment which is a review process that may or may not lead to the making of a work capacity decision or another type of decision regarding a claim."

iii. In *Guideline 5.2* a "fair notice provision" sets out the information which must be communicated to a worker "at least two weeks prior to" the work capacity decision.[1] Therefore the Insurer would have had to make an *assessment*, or be in the process of making an *assessment*, and prior to the finalisation of that *assessment* and the subsequent

[1] This of course means that a decision cannot be made "at any point in time," (*contra Guideline 5)* since it cannot be made until the fair notice period has elapsed.

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making of a *decision*, “at least two weeks” notice must be given to the worker of the following matters:

- inform the worker that a review of their current work capacity is being undertaken and that a work capacity decision is going to be made;
- an explanation that this review may include further discussions with other parties such as their employer, nominated treating doctor or other treatment providers;
- advise the potential outcome of this review and detail the information that has led the insurer to their current position;
- provide an opportunity for the worker to supply any further information to the insurer for further consideration and the date that this information is to be provided by; and
- tell the worker when this decision is expected to be made.

This pentalogue of bullet points is prefaced with the following words (emphasis added):

> “...the insurer must ... communicate this to the worker in a way that is appropriate in the circumstances of the case, and *preferably by telephone* or in person.”

In a workers compensation system where the overwhelming majority of claimants are manual workers with limited education, and a high percentage do not have English as a first language, it is surprising that it would be thought appropriate to try to communicate important and complex information concerning a workers livelihood over the telephone rather than in writing. Further, in the process of determining whether or not a worker has been afforded procedural fairness, it is impossible for a reviewer to know the adequacy or even the accuracy of any information communicated verbally to a worker by an insurer over the telephone.

iv. In the event of a decision resulting in a variation of the weekly benefits payable to a worker, section 54 requires that the worker be given at least 3 months notice of that proposed variation, which must be notice delivered either in person or by post. I should emphasize here that there is no statutory requirement for a “notice” to be given to

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a worker of a *decision* under section 43. The notice requirement in section 54 arises from a proposed variation in payments and therefore the issue of "notice" may not arise in circumstances where no variation in payments results from a work capacity decision.

10. I note that in both the first edition of the *WorkCover Work Capacity Guidelines* published on 28 September 2012 and those more recently published on 8 August 2013, reference is made to the *Best Practice Decision-Making Guide. Guideline 5* concludes with this sentence:

"Work capacity decisions should be made in line with the *Best Practice Decision-Making Guide.*"

Guideline 5.1 says in part:

"When making a work capacity decision the insurer should follow the *Best Practice Decision-Making Guide* .. "

and then goes on to list certain characteristics of what is apparently thought to be "best practice." I advisedly used the word "apparently" in the previous sentence, since it is impossible to check whether or not the items listed in *Guideline 5.1* are "best practice" due to there being in existence no such document as the *Best Practice Decision-Making Guide.*

The *Guidelines* are made pursuant to section 376(1) of the 1998 Act and section 44A of the 1987 Act. They purport to give guidance and instruction to insurers as to how to conduct work capacity reviews and how to make work capacity decisions. In paragraph 2.3 they say this:

> "All decisions made in relation to a worker's recovery and work capacity should be timely, informed and evidence based. Decisions should be made and communicated in a transparent and robust manner free from preference and prejudice ensuring that effective outcomes are achieved and due process is followed. Decisions should be made in line with the *Best Practice Decision-Making Guide*."

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Due to the non-existence of the *Best Practice Decision-Making Guide*, I am unable to confirm that the insurer has complied with the relevant *Guidelines* when making its decision. My enquiry is therefore limited to an examination of the compliance with the rules of natural justice, procedural fairness, and the timeframes which appear to be set out in relevant sections of the legislation, in addition to compliance with such *Guidelines* as are published and relevant.

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Process of the Insurer

11. The decision reached by the Insurer appears to be appropriate in the circumstances of the case. As far as the process undertaken by the Insurer in making an assessment and reaching the work capacity decision is concerned, I am satisfied that there was no breach of procedural fairness and that the rules of natural justice were fully complied with. The Insurer had regard to (i) three statements signed by the applicant; (ii) tax records of the applicant; (iii) medical reports, including radiological reports, from no less than ten (10) different practitioners; (iv) numerous medical certificates; and (v) a Functional Capacity Evaluation Report prepared by an exercise physiologist in September 2012.

12 It is noted that the assessment and decision must be made by *the Insurer* and the purpose of the reports is only to inform and assist in that process (or perhaps more accurately, those processes). The opinion of no individual doctor or other provider can be thought determinative, although it is open to the insurer to give more or less weight to the varying opinions being considered as they think appropriate.

My Reasons:

13. The grounds upon which the applicant seeks to rely can be dealt with using the numbering by letter (a-b) appearing in paragraph 8 above:

(a) The *Guidelines* form a part of the assessment and decision-making process and, in so far as they are valid, must be adhered to. The

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general power to make Guidelines emanates from section 376 of the *1998 Act* which is reproduced in full below:

> **376 Issue of guidelines**
>
> (1) The Authority may issue guidelines with respect to the following:
>
> (a) the assessment of the degree of permanent impairment of an injured worker as a result of an injury,
>
> (a1) the professional or other requirements (including qualifications, training or membership of professional bodies) for a medical practitioner to be permitted to assess (or carry out any function related to assessing), for the purposes of the Workers Compensation Acts, the degree of permanent impairment of an injured worker as a result of an injury,
>
> (b) the giving of interim payment directions by the Registrar under Part 5,
>
> (c) such other matters as a provision of the Workers Compensation Acts provides may be the subject of WorkCover Guidelines.
>
> (2) The Minister may issue guidelines with respect to the procedure for assessment under Part 7 (Medical assessment).
>
> (3) The Authority may amend, revoke or replace WorkCover Guidelines made by the Authority, and the Minister may amend, revoke or replace WorkCover Guidelines made by the Minister.
>
> (4) WorkCover Guidelines may adopt the provisions of other publications, whether with or without modification or addition and whether in force at a particular time or from time to time.[2]
>
> (5) WorkCover Guidelines (including any amendment, revocation or replacement) are to be published in the Gazette and take effect on the day of that publication or, if a later day is specified in the Guidelines for that purpose, on the day so specified.

[2] I note parenthetically that section 376(4) refers to other publications "whether with or without modification and whether in force at a particular time or from time to time." There is no provision for reference to documents which do not *exist* (see paragraph 10 *supra*).

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(6) The regulations may make provision for or with respect to any matter for which the WorkCover Guidelines can provide.

The more specific power to make the *WorkCover Work Capacity Guidelines* is said to come from section 44A of the *1987 Act* which refers to *Guidelines* in section 44A(1),(2)and (5) thus:

44A Work capacity assessment

(1) An insurer is to conduct a work capacity assessment of an injured worker when required to do so by this Act or the WorkCover Guidelines and may conduct a work capacity assessment at any other time.

(2) A ***work capacity assessment*** is an assessment of an injured worker's current work capacity, conducted in accordance with the WorkCover Guidelines.

.....

(5) An insurer may in accordance with the WorkCover Guidelines require a worker to attend for and participate in any assessment that is reasonably necessary for the purposes of the conduct of a work capacity assessment. Such an assessment can include an examination by a medical practitioner or other health care professional.

For completeness only I should mention that on 2 December 2012 *Guidelines* were issued pursuant to section 44(1)(a) of the *1987 Act* and section 376(1)(c) of the *1998 Act* purporting to apply to "work capacity decision Internal Reviews by insurers and merit reviews by the WorkCover Authority."[3]

The applicant asserts that the *WorkCover Work Capacity Guidelines* were not adhered to by the scheme agent in several respects, including: failure to assist him with return to work plans; establishment of a proper (or any) injury management plan or return to work plan; the evaluation of all relevant considerations, including the worker's age, experience, qualifications and psychological sequelae to his injuries. In my view all of those considerations are more appropriately the subject of merit review

[3] There does not appear to be any statutory basis for *Guidelines* relating to merit reviews by the WorkCover Authority, but since my procedural review can only look at the work capacity decision by the Insurer, it is not necessary to have regard to either the merit review or the bases on which it was conducted.

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than procedural review and I will have no regard to them for present purposes. It is further alleged that in the course of merit review by the WorkCover Authority the applicant was not provided with a copy of any reply lodged by the Insurer. I can have no regard to that allegation, since it does not concern the work capacity decision of the Insurer.

A breach is alleged of *Guideline 5.1 – providing opportunity for the worker to contribute additional information, especially if the decision may result in reduction or discontinuation of the worker's weekly payments.*

On this issue the applicant says that he was not provided with the opportunity to seek and obtain an opinion from his treating doctors specifically addressing any work restrictions which might be imposed on him if he were to pursue "suitable" employment as a salesman, as suggested by the Insurer. Since the decision resulted in the discontinuation of the applicant's weekly payments, *Guideline 5.1* would clearly apply.

A breach is alleged of *Guideline 5.2 – the insurer must at least two weeks prior to the work capacity decision, communicate to the worker that weekly payments will be reduced or discontinued in a way that is appropriate in the circumstances of the case, and preferably by phone or in person.*

The applicant disputes that this requirement was fully or adequately complied with. He says that he received a telephone call from the Insurer prior to the issuing of the work capacity decision but that the call did not address the matters required by *Guideline 5.2*. The applicant says he was told that the insurer believed his condition was degenerative and accordingly all further payments (including medical treatment expenses) would be stopped. The applicant's understanding following the telephone conversation was to the effect that he would be required to pay for all medical expenses from 27 February 2013.

This allegation highlights the difficulties which are bound to arise when communications are done in a way which is not recorded or even recordable and which cannot be verified by either party.

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(b) It is further said that the insurer's notice of 27 February 2013 is defective and cannot be rectified, since it is in breach of section 54 of the *1987 Act* as well as *Guideline 5.4* and section 54 of the *Act* provides no basis for rectification.

In my view there can be no dispute that this *Guideline* has been breached, and of more importance is that section 54 of the *1987 Act* has been breached. The letter dated 27 February 2013 purported to give 3 months notice that the applicant's weekly payments would cease on 27 May 2013. Following the internal review, the Insurer advised the applicant that the proper date for the cessation of his payments would be 31 May 2013. The date of this second letter was 26 April 2013. In my view, this would mean that in order for valid notice under section 54 to be given in a letter dated 26 April 2013, the applicant would have had to be given notice that his payments would stop no earlier than 2 August 2013. This is because the postal service rule in section 76(1)(b) of the *Interpretation Act* 1987 requires that four working days be added to the date of posting in order to properly allow for receipt. It is not possible to somehow "extend" notice given in an earlier letter in the way attempted in this case.

14. The question which arises is whether strict compliance with the provision of the proper notice is required such as to render a non compliant notice invalid. In my view strict compliance is required for three reasons:

(a) The effect of a Work Capacity Decision to reduce weekly benefits payable to the injured worker has the potential to impact on that worker's ability to meet financial obligations and the time period was important to ensure that the worker could reorganise his or her affairs.

(b) Failure to give the proper notice is regarded so seriously in the legislation that it is an offence.

(c) There is no provision in the legislation which enables an insurer to amend the notice. The attempt to amend notice in this matter by the letter of 26 April 2013 is therefore of no legal effect.

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15. In addition to the breaches of the *Guidelines* and legislation already noted, I observe that in the original letter of 27 February 2013 the Insurer told the applicant that, after his weekly benefits ceased on 27 May 2013, his entitlements to medical expenses would cease on 31 December 2013. No explanation for this "information" is given, and it is wrong, since section 59A(2) allows for receipt of medical expenses for 12 months following the cessation of weekly payments, which would have been 27 May 2014 if 27 May 2013 had been a valid date of cessation of weekly payments.

16. In considering the facts and circumstances of this application I have had regard to the provisions of section 44(3)(a) of the 1987 Act which provides a timeframe of 30 days for the worker to seek a review by the merit reviewer of the decision, however the timeframe only commences from the receipt by the worker of the insurer's decision on internal review which must be contained in *the form approved by the authority.*

As at the date of this decision there was no such form approved by the Authority and therefore the worker has yet to receive the proper notice of the decision of the internal reviewer and it appears that time has not started to run for him to seek a merit review.

A question of some nicety arises as to whether in that circumstance there was any jurisdiction for the WorkCover Authority to conduct a merit review and therefore whether there was any jurisdiction for me to consider a procedural review.

Given that my role is to make recommendations concerning outcomes in particular matters, this general issue may not arise, but it remains a matter of concern in relation to all applications to the Authority for merit review.

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My Recommendation:

17. I recommend that the Insurer undertake a further Work Capacity Assessment, in compliance with the *WorkCover Work Capacity Guidelines.*

18. I recommend that the applicant be given an opportunity to make further submissions prior to any further decision being made and issued and that he be permitted to submit medical evidence concerning any limitations he might experience in working as a salesman.

19. In the issuing of the next decision I recommend that the Insurer advise the applicant of the date of the new work capacity *assessment*, for the purposes of Schedule 6, Part 19H Division 2 clause 9 of the 1987 Act.

20. Since the applicant was an existing recipient as at 1 October 2012, he remains entitled to receive his pre-transition rate of weekly benefits until such time as he is validly transitioned under the Act. This cannot happen until a valid notice under section 54 is issued. Accordingly he remains entitled to his former rate of weekly payments until such time as he is validly transitioned and a section 54 notice issues.

21. I recommend that the insurer take my views into account, and I recommend that the insurer immediately give effect to them.

Wayne Cooper
Delegate of the WorkCover Independent Review Officer
22 August 2013