WiRO
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. The injured worker is the applicant for a review of the decision made by the Insurer.

2. The applicant was injured on 9 April 2010 in the course of his employment. The applicant was getting out of his car when he twisted his back, thereby sustaining injury to the lumbar spine. There is no dispute about the injury having occurred in the course of employment. The applicant was at the time of injury a director of the company which employed him.

3. In October 2011 the applicant commenced work as a disability support worker. That employment lasted until 2 October 2012. For the duration of that employment the applicant was a continuing recipient of weekly payments of workers compensation under section 40 of the *Workers Compensation Act 1987* ("1987 Act").

4. Since leaving that employment the applicant has worked 3 hours per day, 5 days per week in his pre-injury employment. The applicant was in receipt of weekly payments of workers compensation until the Insurer completed an assessment of the work capacity of the applicant and purported to issue a notice of a work capacity decision pursuant to Section 43 of the *1987 Act* on 4 March 2013. As a result of the work capacity decision, he was advised that his weekly payments would be reduced to "nil."

5. The Insurer did not give the applicant notice pursuant to Section 54 of the *1987 Act* of the reduction of his weekly payments to "nil," in that there was no reference to section 54, nor was there specific reference to a date

6. On 4 April 2013 the applicant sought internal review by the Insurer of the decision dated 4 March 2013. The Insurer wrote to the applicant on 10 May 2013 advising that the internal review had upheld the original decision.

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

7. A WorkCover Merit Review was completed and a Statement of Reasons issued on 13 June 2013. The Merit Reviewer varied the original decision of the insurer, finding that the applicant was entitled to ongoing weekly payments .

8. On 5 July 2013, the applicant requested the Independent Review Officer to undertake a review of the decision of the Insurer pursuant to Section 44(c) of the *1987 Act*. I am satisfied that the applicant has made that application within the time provided by that section.

The Applicant's Stated Grounds for Procedural Review

9. The applicant cites five bases for pursuing procedural review:

(a) He queries the correct salary rates for an adult Real Estate Sales Person relied upon by the Insurer.

(b) He disputes that he has the relevant professional qualifications to be employed as a Real Estate Sales Person.

(c) Internet searches he has conducted for employment as a real Estate Sales Person show that there are no jobs available or advertised for a person who is only capable of working for three hours per day, albeit five days per week.

(d) In the ominously titled "Return to Work Plan No. 10" issued on 11 July 2011, the plan at that time was for the applicant to be able to run his own two businesses, rather than to go to work for a third party as a Real Estate Sales Person. This was apparently given insufficient consideration by the Merit Reviewer in the opinion of the applicant.

(e) The Merit Reviewer made no reference to "back-dated payments," the applicant noting that his section 40 payments had been varied under that section on a date in 2012.

The Legislative Framework

10. 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

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

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] So far 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 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;

[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.

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

- 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 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.

11. 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:

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

"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*."

Due to the non-existence of the *Best Practice Decision-Making Guide*, I am unable to confirm that the insurer has complied with all 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, together with such of the *Guidelines* as may be published and capable of comprehension in the absence of the *Best Practice Decision-Making Guide.*

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

12. The *Guidelines* which were gazetted on 28 September 2012 set out the necessary requirements of "a Work Capacity Decision Notice" at 5.4.2 thus:

> **5.4.2. Requirements of a Work Capacity Decision Notice**
>
> The **Work Capacity Decision Notice** must:
>
> • reference the relevant legislation
>
> • explain the relevant entitlement periods
>
> • 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
>
> • 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
>
> • advise when the decision will take effect
>
> • detail any support, such as job seeking support, which will continue to be provided during the notice period
>
> • advise that any documents or information that have not already been provided to the worker can be provided to the worker on request to the insurer
>
> • advise of the process available for requesting review of the decision and how to access the required form, *Application for review of a work capacity decision by insurer*.

There is no reference to compliance with any section of the legislation, which may well be due to there being no statutory requirement for a Notice of a work capacity decision. The only statutory requirement for a Notice to be issued comes under section 54, when a worker's payments are to be varied.

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

Process of the Insurer

13. The decision reached by the Insurer was varied as a result of the Merit Review process undertaken by the WorkCover Authority. As a result of that variation, the applicant is now to receive an amount per week, rather than "nil" as originally assessed and decided by the Insurer. The reasons for the Merit Reviewer varying the original decision need not be repeated in the process of procedural review. It is enough to say that the Merit Reviewer calculated the earnings of the applicant for the purposes of section 38 on the basis of his capacity to work only 15 hours per week, not 38 hours per week.

14. I am satisfied that the Insurer had regard to relevant medical evidence, including no less than 24 certificates from the applicant's Nominated Treating Doctor a "capacity to earn assessment" from (in addition to the earlier numerous return to work plans from the same provider), a letter certifying the applicant as capable of working on restricted duties as either an employment consultant, travel consultant or real estate sales person.

My Reasons:

15. The applicant's stated grounds for seeking procedural review can be dealt with shortly:

    (a)-(e) - All five grounds cited by the applicant tend to go to the merits of the original decision or even the "merits" of the Merit Review. My only role is to determine whether or not the Insurer followed the correct procedure in reaching the work capacity decision. I do not have to decide whether or not the decision reached was correct, or even desirable in the circumstances of the case. While I note the outcome of the Merit Review process, which was favourable to the applicant, I can have no regard to that decision or the means by which it was reached.

16. Accordingly I find that none of the grounds sought to be relied upon by the applicant are relevant to the procedural review process.

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

17. I note that the worker was an "existing recipient of weekly payments" at the time that the work capacity decision was made. It was therefore appropriate for the Insurer to apply the transitional rates allowable under section 38 for a worker who has received more than 130 weeks of weekly payments.

18. Nevertheless, it cannot be overlooked that the Insurer has breached the *Guidelines* and the *1987 Act* in more than one respect.

(i) In the letter to the applicant dated 9 April 2012, the Insurer advised the applicant that his weekly payments would be reduced to "nil." He was not advised that his payments would be ceased on any particular date in the future, nor was he advised that under section 54 of the *1987 Act* the Insurer is obliged to give him 3 months notice of any reduction or cessation of weekly payments. Knowing nothing more than the contents of that letter, the applicant would have been in no position to understand the significance of the decision made by the Insurer.

(ii) According to the first bullet-point of the decalogue in *Guideline 5.4.2* extracted at paragraph 12 above, the Insurer is required by the Authority to "reference the relevant legislation." In the letter to the applicant references are made to "Subdivision 3 of the Workers Compensation Legislation Amendments 2012," "sections 37(3)(a), 43(1)(a),(b),(c),(d) and (e) of the Workers Compensation Legislative Amendments," and to nothing else of a legislative character. Such allusive hints at the legislative basis for decision-making are not what might more usually be thought of as "references" to the relevant legislation. The Insurer in using the words "Subdivision 3 of the Workers Compensation Legislation Amendments 2012" is probably making a cryptic allusion to Part 3, Division 2, Subdivision 3 of the *Workers Compensation Act* 1987, but the applicant would have no way of knowing that. It is no more likely that he would be well placed to locate a copy of "sections 37(3)(a), 43(1)(a),(b),(c),(d) and (e) of the Workers Compensation Legislative Amendments" without calling in aid a search party of legally trained assistants who, armed with some foreknowledge, might be able to adduce an intention to cite sections 37(3)(a), 43(1)(a),(b),(c),(d) and (e) of the *Workers Compensation Act* 1987.

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

(iii) To continue with the decalogue, the Insurer is required to "explain the relevant entitlement periods." The letter of 4 March 2013 makes no reference to the relevant entitlement periods.

(iv) The Insurer is required to advise the worker of the evidence used in making the decision, "noting the author, the date and any key information." In the letter dated 4 March the following information is conveyed to the applicant:

"Evidence used for making our decision.
"In reaching our decision, we have considered all the rerlevant documents, which are outlined as follows:
"Workcover (*sic*) medical certificate issued
Capacity to Work Report dated 21.09.12.
"Letter dated 20.08.12.
"closure report dated 05.06.12."

I have searched in vain for any "key information" thought to be contained in the listed documents and repeated in the letter for the benefit of the applicant.

(v) The Insurer is required to "clearly explain the line of reasoning for the decision." In the letter of 4 March 2013 the applicant is advised that the Insurer has determined that he has a capacity to work in suitable employment and that they have made the decision that he has a capacity to work full time in suitable employment. This determination and consequent decision are said to have followed the Insurer "carefully considering the documentation" on the applicant's file. There is no similarly careful elucidation of the information in the Insurer's file on which the applicant could base any view as to the merits of the position reached by the Insurer. He is not told that any doctor or other person thinks he could work "full time in suitable employment," and is certainly not given the identity of any such opinion holder.

(vi) The Insurer is required by the *Guidelines* to advise the applicant "when the decision will take effect." The applicant was not so advised. This is also a requirement of section 54 of the *1987 Act*, since the

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

decision made by the Insurer results in a cessation of the applicant's entitlements. A breach of section 54 is an offence.

(vii) The first sentence of the letter dated 4 March 2013 has a vagueness which may be fatal to the Insurer's endeavour. Relevantly, the following words appear:

" ... GIO wishes to confirm that ***we have recently undertaken an assessment*** of your work capacity ..." (Emphasis added.)

Schedule 6, Part 19H Divsion 2 Clause 9 of the *1987 Act* opens with the well-known words:

> "(1) ***On the expiration of a period of 3 months after an insurer first conducts a work capacity assessment*** of an existing recipient of weekly payments (as required under this Division or otherwise), the weekly payments amendments apply to the compensation payable under Division 2 of Part 3 of the 1987 Act to the worker in respect of any period of incapacity after the expiration of that period." (Emphasis added.)

This applicant's weekly benefits cannot be subject to the 2012 amendments until three months have elapsed from the date of a capacity assessment. Since neither the applicant nor (apparently) the Insurer know the precise date of that assessment, it is impossible to know when the amendments can take effect in this case.

19. It is therefore clear that the Insurer has breached the *Guidelines* in 5.4.2, may have committed an offence under section 54 of the *1987 Act* and has not provided any information to the applicant which might tell him when a work capacity assessment was made, thereby rendering the applicability of the 2012 amendments to his case questionable, at best. For the latter reason, in my view the worker has been denied procedural fairness, since he is unable to determine the precise date upon which the amendments to the legislation begin to apply to his weekly benefits.

20. A breach of the *Guidelines* issued by the Authority must by definition be a breach of procedural fairness. That more *Guidelines* appear to have been breached than observed is a matter of concern.

21. Section 54 of the *1987 Act* requires 3 months notice to be given to injured workers who are having their weekly payments varied by insurers. Relevantly, the section provides as follows:

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

> **54 Notice required before termination or reduction of payment of weekly compensation**
>
> (1) If a worker has received weekly payments of compensation for a continuous period of at least 12 weeks, the person paying the compensation must not discontinue payment, or reduce the amount, of the compensation without first giving the worker not less than the required period of notice of intention to discontinue payment of the compensation or to reduce the amount of the compensation.
>
> Maximum penalty: 50 penalty units.

I am aware of the letter sent by the Insurer to the applicant on 10 May 2013 advising of the outcome of internal review. That letter (unlike the letter dated 4 March 2013) advised the applicant that his entitlements would cease "on 3 June 2013." Even if a notice under section 54 had been given on 4 March 2013, it would have been invalid, since 3 June 2013 is not 3 months plus the required time for postage (four working days, excluding weekends and holidays under s 76(1)(b) of the *Interpretation Act* 1987). The applicant applied for merit review on 22 May 2013 and a decision was released on 13 June 2013. Since a merit review does not operate as a "stay" on the work capacity decision of the insurer it is likely that the Insurer in this case actually reduced the weekly payments to the applicant on 3 June 2013, in clear breach of section 54 of the *1987 Act.*

22. Although I am mindful that the applicant had the Insurer's work capacity decision reviewed by the Merit Review service of the Authority and that as a result his weekly payments were reinstated, at a lower rate than before, my only role is to review the original decision of the Insurer. In this case that decision is the one referred to in the letter to the applicant dated 4 March 2013. For this reason, my following remarks may be of only passing interest to the applicant. Section 44(3)(a) begins with the following words:

> (3) The following provisions apply to the review of a work capacity decision when the reviewer is the Authority or the Independent Review Officer:
>
> (a) an application for review must be made within 30 days after the worker receives ***notice in the form approved by the Authority of the insurer's decision on internal review***

As at the date of this recommendation there does not exist any such

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

form. Therefore it appears that the letter dated 10 May 2013 is an attempt by the Insurer to approximate such a form. The Insurer's shortcomings in relation to their notice of decision might be solved by the production of such a form by the Authority.

An alternative reading of the clause in section 44(3)(a) is not possible, without rendering the language a nonsense. It has been suggested that the wording should be emphasized as follows:

> (3) The following provisions apply to the review of a work capacity decision when the reviewer is the Authority or the Independent Review Officer:
>
> (a) ***an application for review must be made within 30 days*** after the worker receives notice ***in the form approved by the Authority*** of the insurer's decision on internal review

The complete absence of punctuation in this sub-section renders such a reading impossible. The sentence can only be referring to the "*notice* in the form approved by the Authority *of the insurer's decision on internal review."*

My Recommendation:

23. I recommend that the Authority investigate a potential breach of section 54 of the *Workers Compensation Act* 1987 as set out in paragraphs 5, 18(vi) and 21 above.

24. I recommend that the Insurer undertake another work capacity assessment and, if it arises, make another work capacity decision, according to the *Guidelines* as gazetted by the Authority and according to the relevant legislation.

25. 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 weekly payments until such time as he is validly transitioned and a section 54 notice issues.

WiRO
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

26. I recommend that the Authority create and make available to all stakeholders the form referred to in section 44(3)(a) of the *1987 Act* which might facilitate insurers complying with the *Guidelines* and legislation when advising injured workers of the outcome of decisions made following internal review.

27. I recommend that the Insurer and the Authority take my views into account, and I recommend that the Insurer and the Authority immediately give effect to them.

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