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.

1. The injured worker is the applicant for a review of the decision made by a licensed scheme agent of the Workers Compensation Nominal Insurer ("Insurer").

2. The applicant was injured on 4 September 2003, resulting in partial incapacity (as it was then known). There is no dispute about the injury having occurred in the course of employment. Liability was accepted by the Insurer, which made weekly payments pursuant to section 40, most recently at the rate of $447.70 per week. The applicant was still in receipt of weekly payments immediately prior to 1 October 2012, thereby qualifying as an existing recipient of weekly payments for the purposes of Schedule 6, Part 19H, Division 1 of the *Workers Compensation Act* 1987 (1987 Act).

3. The Insurer conducted a work capacity review and subsequently made a work capacity decision in April 2013. The applicant was informed by telephone of the decision on 5 April 2013, but the letter advising of the decision was dated 8 April 2013.

4. In the letter dated 8 April 2013 the Insurer advised the applicant as follows:

   "Up until recently you have been paid weekly benefit compensation payments[1] under section 40 at the rate of $447.70. This decision will mean you no longer have any weekly benefit entitlement. In line with the notice period [the Insurer] is required to give under section 54, your weekly benefits will continue at the current rate for 3 months to 7/07/2013. The change in your benefit rate[2] will become effective following this notice period.

   "This decision is only related to weekly benefit compensation payments on your claim. However, under section 59 (sic) entitlement to medical

[1] A biadic redundancy
[2] That is, no "weekly benefit compensation payments" at all (see note 1).

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treatment only extends for a 12 month period after weekly benefit payment ceases. Your entitlement to medical treatment will therefore cease from 4/07/2014.[3]

"Approval for any medical treatment should be requested from [the Insurer] via a referral from your Nominated Treating Doctor or Specialist."

Whether the last reference to seeking approval via the treating doctors was meant to apply before or after July 2014 is not made clear. This is ambivalent particularly since the applicant would already be required to seek such approval even before a work capacity decision were made.

5. The Insurer did not give the applicant adequate notice pursuant to Section 54 of the 1987 Act of the reduction of his weekly payments to "nil," since no allowance was made for postal service of the letter in accordance with section 76(1)(b) of the *Interpretation Act* 1987. The correct date would have been 15 July 2013. It follows that the correct date for the cessation of entitlement to payment of medical and related treatment expenses would have been 15 July 2014.

6. The Insurer wrote to the applicant on 12 June 2013 advising that an Internal Review had upheld the original decision. In the same letter, the Insurer purported to extend the date for notice under section 54, saying that the decision to reduce weekly benefits to nil would be effective "from 14 July 2013." In the same letter, a familiar paragraph appeared in the following terms:

"We can confirm that ***the work capacity decision only relates to your entitlements to weekly benefits*** and ***does not affect other entitlements*** that you may be entitled to under the Act."[4]

Having digested that sentence, the applicant might have noted a parataxic anomaly recalling the contents of the letter dated 8 April 2013 which said that his medical expenses would no longer be paid after a date in July 2014.

[3] Note – date of letter is 8 April 2013, and notice under s 54 was purportedly given until 7 July 2013. The date of 4 July 2014 might be explained by a telephone call on 5 April 2013 – see paragraph 9 *infra*.
[4] Cf: paragraph 4 and note 3.

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7. A WorkCover Merit Review was completed and a Statement of Reasons issued on 18 July 2013. The Merit Reviewer confirmed the original decision of the insurer.

8. On 19 August 2013, the applicant requested the Independent Review Officer to undertake a review of the decision of the Insurer pursuant to Section 44(1)(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 various bases for pursuing procedural review:

(a) The work capacity decision has had an immense impact on the living standard of his whole family due to the sudden drop in weekly income.

(b) He believes a fairer and more reasonable outcome might have arisen if weekly payments had continued at a lower rate, thereby lessening the impact.

(c) There is a suspicion that one medical provider had more influence over the decision-making process than others. The first suggestion from the Insurer that weekly payments might cease came shortly after the applicant had seen that medical provider.

(d) A report was obtained from Dr K, who the applicant has never met. This report was relied on by the insurer. (Dr K is not the same doctor alluded to in paragraph (c) above.)

(e) Due to his age and physical restrictions caused by injury, the applicant finds considerable difficulty in securing employment. He also notes that he is not eligible for a Newstart allowance from Centrelink.

Insurer's Reply

See paragraph 12 below. In addition to the timeline and incidental submissions reproduced and referred to in paragraph 12, the Insurer sent an email to the Independent Review Office on 26 August 2013 seeking to extend time for compliance with section 54. Relevantly, the Insurer made the following submission:

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> Please note that at the time of the decision being made, CGU made reference to the *WorkCover Work Capacity Guidelines* dated 28/9/2012 which indicate that Insurer's (sic) are required to provide 3 months notice before reducing or discontinuing weekly benefits. (I have attached page 16 of this document for your reference.)
>
> As a result of these *Guidelines*, you will note that Mr Daly was provided a Fair Notice call on 6/3/2013 and received an extended fair notice period of 4 weeks and 5 days. The Work Capacity Decision was made on 8/4/2013 and Mr Daly was informed that the decision would be effective from 8/7/2013.
>
> We note that WorkCover have now given direction that work capacity decision notices must include a 3 month, 1 week and 2 day notice period before the effective date. As a result of these recent changes to timeframes for work capacity decisions CGU are prepared to provide a payment to Mr Daly for weekly benefits for 1 week and 2 days.

In the letter dated 8 April 2013 the Insurer advised the applicant that his entitlement to "medical treatment" would cease on 4 July 2014, presumably on the basis that the work capacity decision was actually made on either 4 or 5 April 2013, which would follow from what appears in paragraph 12 below, rather than on 8 April 2013 as asserted above.

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 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

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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.[5] 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 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):

[5] 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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> "...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.[6]

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. 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. 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

[6] See paragraph 12 *infra* generally.

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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

• 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 a great deal of ground covered in those ten points, which may lead to difficulties with compliance. For instance, it is difficult to know what criteria might be applied to determine whether or not an Insurer has "clearly" explained a "line of reasoning." Recently the High Court[7] commented on the duty of decision-makers in this regard, which one publicist has summarised thus:

"*Li* reinforces that decision-makers need to demonstrate clear reasoning behind their determinations and show an engagement with submissions made on behalf of applicants. The case also highlights the need [...] to show how submissions have been weighed in the decision-making process."[8] Any decision ultimately subject to judicial review must be subject to these considerations.

[7] *Minister for Immigration and Citizenship v Li* [2013] HCA 18.
[8] See Sibley, C – "High Court revives 'Wednesbury unreasonableness'" in *Law Society Journal,* September 2013, p 37.

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Process of the Insurer

12. In terms of compliance with the *Guidelines*, and in particular *Work Capacity Guideline* 5.2 it might be thought that this is a paradigm case for telephone contact as a means of communication to be avoided, rather than recommended or required. The following list of events was provided by the Insurer in response to the application for procedural review. It reads in part like a Biblical begattery with several recurring phrases, some of which I have highlighted:

"Below is a timeline of work capacity events on this claim to date:

- **A fair notice call** was delivered to [the applicant] on 4 March 2013 – **a message was left requesting a return call**. A **second phone call** was made on 4 March 2013 and **there was no answer**, contact made with mobile which advised **not accepting incoming calls**. An email was then forwarded to [the applicant] requesting contact. **A third phone call** attempt was made on the 5 March **with no answer**, an **unable to contact letter** was then forwarded to [the applicant] requesting contact with Case Manager.

- **A fourth fair notice call** was attempted on 6 March 2013 after Case Manager received an email 8 minutes prior, **no answer**, **left message requesting a return call**. Fair Notice letter issued.

- **Contact was attempted on 18 March 2013** to discuss Work Capacity Decision and **there was no answer**. **A message was left requesting a returned call.**

- **[The applicant] contacted [the Insurer]** on 19 March 2013 **after receiving the Fair Notice letter.** [Insurer] Case Manager discussed the changes in legislation and decision/ review process. [The applicant] was also advised he was able to send in any further information for [the Insurer] to review prior to WCD being made.

- **Insurer returned a phone call to [the applicant] on 22 March 2013**, [the applicant] informed the Case Manager that he had been looking at the current WC Legislation and questioned whether he would be able to get make up pay if he works varied hours of employment. CM informed W that she would email W to provide the answer to his question. CM also confirmed with W that WCD would be completed on 26 March 2013.

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- **[Insurer] Case manager emailed [the applicant]** in response to his above questions.

- **Contact was attempted twice on the 2 April 2013** to communicate the Insurer's work capacity decision, **on both occasions messages were left requesting a return call**. **A third attempt** was made on the 5 April 2013 with **a message being left requesting a return call**. **A further attempt was made to [the applicant's] mobile and it had been disconnected.**

- Contact was received from [the applicant] **on the 5 April 2013** and **the Work Capacity Decision was delivered** and confirmed that he would receive a copy in writing. **[The applicant] understood**.

- **Insurer forwarded work capacity decision letter on 8 April 2013**.

- [The applicant]contacted [Insurer] on 6 May 2013 advising he was completing the Application for Internal Review and that as it was a bit late needed confirmation it would still be accepted. [The applicant] was advised that we would still accept his request for internal review and we were advised it would be sent in later that week.

- [The applicant] completed an Application for Internal Review by Insurer on the 8 May 2013 which was received by [Insurer] on 13 May 2013. [The applicant] included a Final WorkCover NSW Medical Certificate dated 22/09/2008 with his application. An acknowledgement letter was sent on 14 May 2013 confirming receipt of Application for Internal Review by Insurer which also advised decision would be due on 12 June 2013.

- **A phone call was made to [the applicant] on 14 May 2013** to confirm receipt of Application for Internal Review by Insurer, **no answer, message was left**. **Phone call to mobile: XXXX XXX XXX. No answer, mobile disconnected**. **Phone call made to home number again** and confirmation given of receipt of Application for Internal Review by Insurer. [The applicant] was advised if any further information was to be provided to send by 28 May 2013 and that a decision would be provided by 12 June 2013.

- **Phone call to [the applicant] on 11 June 2013** advising the outcome of the Internal Review and that [insurer's] original decision had been maintained.

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- **A letter dated 12 June 2013 was sent to [the applicant] explaining the reasons for the decision** and also provided information on how to request a review of this internal decision. **This letter also advised that the original notification period date of the weekly benefits ceasing had been extended from 7 July 2013 to the 14 July 2013.**

- A Work Capacity – application for merit review by the authority form was completed by [the applicant] on 21 June 2013 and received by [Insurer] on 25 June 2013. Included in his application [the applicant] also provided a letter referencing Dr P report dated 13/11/2012, copy of one page of Dr P report, Insurers's letter dated 12 June 2013 , Notification of [Insurer] Internal Review Decision relating to Work Capacity Decision and Final WorkCover NSW Medical Certificate.

- [Insurer] completed a Work Capacity – Reply to an application for merit review on 26 June 2013 with a copy being sent to Merit and [the applicant] on this day.

- **[Insurer] received a mail marshall undelivered email** advising that the **email had not been received** by recipient on 26 June 2013 ([private name]@optusnet.com.au); [**Insurer] Case Manager forwarded an email 27 June 2013** requesting [the applicant] to confirm if he had received our response.

- [Insurer] received a phone call from [the applicant] on the 28 June 2013 advising **he had not received a response to his application for merit review** and advised **his email had been playing up**. [**Insurer] forwarded another copy to email [private name]@gmail.com**

- **Email received from WorkCover** on 1 July 2013 advising **they had not received our response** to application for merit review by the authority. Insurer resent response to wcdmeritreviewservice@workcover.nsw.gov.au and [private name]@workcover.nsw.gov.au

- **Email received from [the applicant] on 3 July 2013 advising he had not received a copy of the Merit Review response.** Case Manager resent copy of Merit Review response again on 3 July 2013.

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- A merit review was completed on 18 July 2013 by Merit Review Service which found that in accordance with Section 38 of the Workers Compensation Act 1987, [the applicant] is not entitled to weekly benefits.
- [The applicant] contacted our Case Manager on 8 August 2013 wanting further clarification around Work Capacity Decisions – please refer to attached file note.
- Wiro Application for Review of Work Capacity Decision has been completed by [the applicant] on 19 August 2013 and received by [the Insurer] via fax on 20 August 2013."

By my reckoning, the Insurer rang or tried to ring the applicant on at least 15 occasions, including twice on his disconnected mobile number, and experienced considerable difficulty with the email addresses of both the applicant and WorkCover. This did not stop the Insurer from sending the applicant an email on 27 June to the same email address from which on 26 June it had received a "mail marshall undelivered email" message, the purpose of the second email being to enquire as to whether or not the applicant had received the first. The only times when the applicant contacted the Insurer and engaged in discussions with them were immediately following his receipt of letters in the ordinary post. Despite this, the Insurer was temerarious enough to note on 5 April 2013 after supposedly "delivering" a work capacity decision over the phone that the applicant "understood." Interestingly, written notice of the decision was not sent until 8 April 2013.[9]

13. The work capacity decision of the Insurer was based on multiple medical reports (produced by four doctors), earning capacity assessment reports by PR (x2), a WFI Assessment Report, various pieces of correspondence from the applicant and updated work capacity certificates.

14. On a perusal of the documents it seems that the Insurer has had regard to the type of considerations required by the legislation and *Work Capacity Guidelines*. Both the original decision and the Internal Review decision were upheld by the merit reviewer.

My Reasons:

[9] See paragraphs 3 and 4 *supra*.

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

    (a), (b) and (e) - these grounds cited by the applicant (see paragraph 9 above) 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. For the purposes of procedural review, these grounds are irrelevant.

16. Grounds (c) and (d) in paragraph 9 above are not strictly speaking grounds at all. The worker suspects that Dr P had an undue influence on the Insurer, but can cite no evidence for this beyond saying that the first time the insurer foreshadowed reducing or ceasing payments was very proximate to the time of the appointment with that doctor. Similarly with Dr K, who the applicant never saw: the insurer is entitled to have regard to all available evidence but is not bound by any of it. The Insurer is just as entitled to have regard to the report of Dr K as it is to disregard the same report. There being no evidence of irregularity, no grounds are made out.

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) The Insurer has given inadequate notice under section 54. By their own admission in the letter dated 12 June 2013 the Insurer conceded that inadequate notice was originally given in the earlier letter dated 8 April 2013. On 12 June 2013 the Insurer purported to extend notice for a further seven days to 14 July 2013. This cannot succeed, since a new notice with a new notice period is required when the first notice is invalid. In order for this remedial action to work, notice would need

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to be given for three months and seven days after the date of the letter giving the new notice, in this case 19 September 2013. In the email sent to the Independent Review Office on 26 August 2013 the Insurer repeated the admission of inadequate notice, and noted that it was prepared to pay an extra one week and two days of compensation to the applicant.

(ii) According to the first bullet-point of the decalogue in *Guideline 5.4.2*, the Insurer is required by the Authority to "reference the relevant legislation." In the letter dated 8 April 2013 the reference to cessation of medical expenses 12 months after the cessation of weekly payments was said to arise under "section 59." This is inaccurate. The correct section is 59A(2). Further, it was not explained to the applicant that the entitlement to payment for medical and related treatment expenses would once again arise in the event of further payments of weekly compensation, in accordance with section 59A(3).

(iii) The Insurer is required to "clearly explain the line of reasoning for the decision." In this case the Insurer has not even explained the effect of the decision, since the letter of 12 June 2013 contradicts the letter of 8 April 2013 on the question of cessation of medical benefits.[10] There is lengthy recitation of the extracted comments of some report providers, beyond which the applicant is to content himself with assurances that the Insurer has "carefully considered" his claim and the following "reasons" (from the letter of 12 June 2013):

"The reason(s) for the decision are:

"A Work Capacity Decision is required in order to determine your ongoing entitlement to weekly payments of compensation. On the basis of the Work Capacity Decision (detailed above), your entitlement to weekly payments has been calculated in accordance with the *Workers Compensation Act* 1987.

"As you have been in receipt of weekly payments of compensation for a cumulative period of more than 130 weeks, your entitlement is determined in accordance with section 38. You are fit for full hours

[10] See paragraphs 3, 4 and 6 *supra.*

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and are currently not working therefore your entitlement to ongoing weekly benefits is nil."

If the final sentence above were true, the reader can only marvel that the applicant was ever paid by the Insurer, since he is told that he is "fit for full hours."

This conclusion probably followed on from the garbled reasoning inherent in this paragraph:

"Medical Case Conference report from OHN, dated 23/07/2006 states that a final permanently modified duties certificate for 4hrs/day, 5days/week will be issued. The report indicates that you have been attending job seeking, independently and with assistance you had been able to attend numerous job interviews across Sydney using public transport and had been able to attend an exercise program on a regular basis ***it would certainly indicate that you are capable of sustaining full hours.***"

I think I am right in saying that the Insurer is here asserting that because the applicant was capable of job-seeking seven years ago then, despite being certified ***permanently*** as suitable only to work 4 hours per day, he is ***therefore*** capable of working full-time. Presumably the "work" he is capable of doing on a full-time basis would consist of either job-seeking or catching public transport. On no basis could this be thought to be a suitable or satisfactory attempt to explain the "line of reasoning" used in making the work capacity decision.

19. It is therefore clear that the Insurer has breached the *Guidelines* in 5.4.2, and may have committed an offence under section 54 of the 1987 Act.

20. A breach of the *Guidelines* issued by the Authority must by definition be a breach of procedural fairness. Multiple breaches are inexcusable.

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:

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> **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 that the letters sent by the Insurer to the applicant specified dates in July 2013 for the cessation of weekly benefits. It is therefore likely that the Insurer in this case actually stopped paying weekly payments to the applicant on or about 14 July 2013, in clear breach of section 54 of the 1987 Act.

My Recommendation:

22. I recommend that the Authority investigate a potential breach of section 54 of the *Workers Compensation Act* 1987 as set out in paragraphs 4-6, 9 and 21 above.

23. 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.

24. 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 payments of $447.70 per week until such time as he is validly transitioned and a section 54 notice issues.

25. 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.

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Wayne Cooper
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