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(1)(c) OF THE *WORKERS COMPENSATION ACT* 1987*.*

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

2. The applicant suffered injury to his lower back in the course of his employment as a truck driver on or about 26 February 2003. He worked on suitable duties for approximately six months before his employment was terminated. He has had no paid employment since that time. There is no dispute about the injury having occurred in the course of employment.

3. The insurer accepted liability and made continuing weekly payments for all periods of incapacity until 2013. Accordingly the applicant was an "existing recipient of weekly payments" of compensation (as that term is defined in Schedule 6, Part 19H Division 1 of the *Workers Compensation Act* 1987 [1987 Act]) immediately prior to 1 October 2012. As at May 2013 the applicant was in receipt of $565.70 per week pursuant to the former section 40 of the 1987 Act.

4. On 22 May 2013 the Insurer, having completed an assessment of the work capacity of the applicant, issued a notice of a work capacity decision pursuant to Section 43 of the 1987 Act. The Insurer also gave the applicant notice pursuant to Section 54 of the 1987 Act of the reduction of his weekly payments to "nil." The cessation of weekly payments was said to be effective from 29 August 2013.

   Relevantly, the applicant was advised in the following terms:

   > As a result of this decision your weekly payments will cease from 29/08/2013. Up until recently you have been paid weekly benefit compensation under section 40 at the rate of $565.70. In accordance with section 54 your weekly benefits will continue at the current rate for three months plus one week (to allow for delivery of this notice) to 28/08/2013. The change in your benefit rate will become effective following this notice period.

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> CGU will continue to approve reasonable and necessary treatment expenses as defined by Section 60 of the *Workers Compensation Act* 1987. However, under section 59 of the Act your entitlement to medical benefits is limited to a period of 12 months after weekly benefits cease. Your entitlement to medical treatment[1] will therefore expire on 29/08/2014.

5. On 27 June 2013 the Insurer wrote to the applicant advising of the outcome of an internal review of the decision dated 22 May 2013. The internal review upheld the original decision.

   Relevantly, the applicant was further advised in the following terms:

   > As you have a current .work capacity but are currently not working at least 15 hours per week or earning at least $155 per week, you do not meet the criteria set out in section 38(3)(b) and are, therefore, not entitled to ongoing weekly benefits.
   >
   > 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.**

6. A WorkCover Merit Review was completed and a Statement of Reasons issued, dated 19 August 2013. The Reviewer upheld the determination of the Insurer.

7. On 29 August 2013, application was made to 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 30 day time-limit imposed by section 44(3)(a), and the *WorkCover Work Capacity Guidelines* and on the relevant form.

Applicant's Stated Grounds of Review

[1] More correctly, entitlement to *payment for medical treatment expenses.*

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8. The applicant takes issue with the decision of the insurer on the following two grounds:

(a) They expect him to leave his home town and seek employment and live elsewhere; and

(b) The applicant lives in a small country town with limited employment opportunities, particularly so for a person of the applicant's age and with his back injury and concomitant restrictions.

Submissions in Reply from Insurer

9. In response to the application, the Insurer submitted the following timeline and list of documents:

Below is a brief summary/timeline of work capacity events on this claim to date:

- A fair notice call was delivered to [the applicant] on 26/04/2013. [The applicant] was advised that the reason for the telephone call was to discuss changes in the legislation and how this would impact his claim. [The applicant] was invited to send in any further information for [the Insurer] to review prior to a WCD being made.
- A WCD was made on this claim on 21/05/2013. [The applicant] was contacted on this date and advised that a WCD had now been made on his claim which would have an adverse affect on his entitlement to ongoing weekly benefits. This decision was based on various medical reports on file which confirmed that [the applicant] does have a current capacity for work, has been in receipt of weekly benefits for more than 130 weeks and is not currently in employment. [The applicant] was advised that his weekly benefits would continue for 3 months and 1 week and that reasonably necessary medical treatment will continue for 12 months after the last date he received weekly benefits from [the Insurer]. [The applicant] was advised of his right to request a review of our decision and that this information would be included in a letter sent to him on 22/05/2013.
- [The applicant] completed an Application to Insurer for Internal Review on 28/05/2013 which was received by [the Insurer] on 31/05/2013. No

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further information was provided by [the applicant] with his application form.

- Phone call to [the applicant] on 05/06/2013 acknowledged receipt of his Application to Insurer for Internal Review. An acknowledgement letter was also sent to [the applicant] on 05/06/2013 advising that a decision will be made by 28/06/2013.
- P/C to [the applicant] on 27/06/2013 advising outcome of the internal review. He was advised that he has no ongoing weekly benefit entitlements as evidence on file supported that he has a current work capacity but is not currently working, therefore does not meet the criteria to receive ongoing weekly benefits. A letter was also sent to [the applicant] on this date explaining the reasons for the decision and also provided information on how to request a review of this internal decision.
- A Work Capacity – Application for Merit Review by the Authority form was completed by [the applicant] on 15/07/2013 and received by [the Insurer] on 23/07/2013. No further information was provided with his application form.
- [The Insurer] completed a Work Capacity – Reply to an Application for Merit Review on 30/07/2013 with a copy being sent to merit review and also [the applicant] on this day.
- A merit review was completed on 19/08/2013 by the Merit Review Service which found that in accordance with section 38 of the Workers Compensation Act 1987, [the applicant] is not entitled to compensation after the second entitlement period due to him being assessed as having a current work capacity and not currently working/employed.
- WIRO Application for Review of Work Capacity Decision completed by [the applicant] on 29/08/2013.

Please find attached copies of the following:

- Fair notice letter and file note dated 26/04/2013
- WCD file note dated 21/05/2013
- WCD letter dated 22/05/2013
- Application to Insurer for Internal Review dated 28/05/2013
- File note dated 05/06/2013
- Acknowledgement of Application to Insurer for Internal Review letter dated 05/06/2013
- File note dated 27/06/2013

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- Notification of [Insurer] Internal Review Decision letter dated 27/06/2013
- Work Capacity – Application for Merit Review by the Authority form completed by [the applicant] dated 15/07/2013
- Work Capacity – Reply to an Application for Merit Review completed by [Insurer] dated 30/07/2013
- WorkCover Merit Review dated 19/08/2013

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. There are no less than four steps in the transition process, all of them mandatory. There is also a clause in the *Workers Compensation Regulation* 2010[2] (the Regulation) which purports to amend the 1987Act[3] in a way which is both confusing and most probably invalid. A person hoping to fully comprehend the process requires an understanding of the 1987 Act, the *Workplace Injury Management and Workers Compensation Act* 1998 (1998 Act), the Regulation and up to three iterations of two separate sets of *Guidelines*[4] issued by WorkCover.

The *WorkCover Work Capacity Guidelines* which were gazetted on 28 September 2012[5] 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

[2] See schedule 8, clause 22(1) of the *Regulation*.
[3] See sched 6, Pt 19H Div 1 clause 9 of the 1987 Act.
[4] *Work Capacity Guidelines* and *Review Guidelines*.
[5] Now replaced by the *WorkCover Work Capacity Guidelines* gazetted on 8 October 2013. In this case the relevant version remains those *Guidelines* gazetted 28 September 2012.

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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. A particular difficulty is caused by the jussive temper induced by the word “must” immediately prior to the first bullet point. It would follow that a breach of even a single element of this decalogue similarly ‘must’ result in invalidity.

Process of the Insurer

11. The decision reached by the Insurer appears to be within the range of available decisions and was upheld on merit review. The Insurer had regard to the following documentary evidence when making the work capacity decision:

- Reports from IME Dr R dated 26/03/2013 and 02/04/2013
- WorkCover medical certificates/certificates of capacity from Nominated Treating Doctor [NTD] Dr Y dated 29/10/2012, 05/02/2013 and 03/05/2013

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- Earning Capacity Assessment from CASPL dated 12/04/2013 including Functional Assessment report of same date and NTD-signed agreement dated 10/04/2013 and worker agreement dated 25/03/2013
- Return to work closure report from APM dated 13/01/2011
- File note of conversation with previous case-manager dated 27/05/2011

My Reasons:

12. The reasons given by the applicant for seeking procedural review can be dealt with under the lettering used in paragraph 8:

(a) The applicant does not think it reasonable for the Insurer to expect him to leave his home town in search of suitable employment. This is an element of the legislative scheme and the Insurer is within its rights to assess the applicant's work capacity taking into account possible employment which is not close by or within commuting distance. This ground must fail.

(b) The applicant notes that he lives in a small, remote location with limited employment opportunities for a person of his age and with his restrictions. This objection only reinforces the Insurer's position and does not assist the applicant. Accordingly this ground must also fail.

13. To the extent outlined above the Insurer, in making the original work capacity decision, largely complied with the relevant legislation and the *Regulation* and the *Guidelines.* The legislation was relevantly referenced and explained, including the entitlement periods for weekly payments; the reasoning process for making the decision was set out reasonably clearly; and the Insurer even complied with the notice period for variation of payments under section 54 of the 1987 Act. However all this good work was unceremoniously defenestrated by the Insurer in the course of internal review by including the following sentence in their letter to the applicant dated 27 June 2013:

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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.**

The Insurer would be aware that in their earlier letter dated 22 May 2013 they had attempted to explain to the applicant that his entitlement to ongoing payments for reasonable medical and related expenses would cease 12 months after the cessation of weekly payments, and that this would therefore take effect from 29/08/2014.[6] The appearance of the sentence extracted above may well have induced an apoleptic double-take from an applicant who had been earlier led to believe that the work capacity decision had consequences beyond mere receipt of weekly payments. The failure to fully and accurately set out the effect of sections 59A(2) and 59A(3)[7] combined with the misleading and inaccurate statement that other rights are not affected by the work capacity decision are clearly breaches of the *Guideline* requiring the Insurer to explain the impact of the decision.

14. Under the legislation the Insurer can make an assessment of the applicant's work capacity and then a decision about that work capacity, but they must comply with the legislation, the Regulation and the *Guidelines* in order to produce a procedurally correct result. In the current instance there has been a breach the *Guidelines* which are to be treated as delegated legislation.

My Recommendation:

15. 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 43 is issued and the relevant notice period has expired. The applicant should be reinstated to his pre-work capacity assessment/pre-work capacity decision rate of compensation.

[6] But with no reference to section 59A(2) or 59A(3) of the 1987 Act.
[7] Section 59A(3) allows for the reinstatement of medical benefits if weekly benefits are reinstated, but only for as long as weekly payments are made.

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16. I recommend that a further notice of outcome of internal review be sent to the applicant giving notice of a further three month period following which payments will cease, including time for service of the notice. The notice should not include the sentence extracted at paragraph 13 above.

17. 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
23 October 2013