WiRO
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 a work capacity decision made by a specialised insurer licensed to operate under the New South Wales workers compensation scheme ("Insurer").

2. The applicant suffered injury to his lower back on 3 December 1999 in the course of his employment as a Communication Officer. There is no dispute about the injury having occurred in the course of employment.

3. The applicant remains in the same employment, performing the same role, but with the restriction that he is unable to work overtime. Liability was accepted by the Insurer and the applicant was paid for all relevant periods under section 40 of the *Workers Compensation Act* 1987 (1987 Act). As a result of litigation an agreement for the payment of a voluntary continuing award of compensation was entered into between the parties on 22 December 2008, with the Insurer agreeing to pay $275 per week on a continuing basis. Therefore the applicant was a continuing recipient of weekly payments of compensation immediately prior to 1 October 2012.

4. While the applicant was in receipt of weekly payments of workers compensation the Insurer wrote to him on 10 May 2013 purporting to confirm a telephone conversation of the same date in which it is said that the worker was given an opportunity to provide information to the Insurer to be considered in the course of a proposed assessment of his work capacity.

5. On 31 May 2013 the Insurer advised the applicant in writing of a work capacity decision. He was advised that his entitlement to ongoing weekly payments of workers compensation would reduce to "Nil" as of 10 September 2013. Whilst ostensibly giving the applicant notice under section 54 the Insurer made the following assertion:

> The change to your weekly benefit entitlements will take effect in three months with the addition of a one week allowance for

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> our postage and your receipt of this notice, i.e. your new payment rate will commence on 10 September 2013.[1]

The applicant was also told this:

> Your entitlement to reasonable and necessary medical and related treatment will also continue, however please contact your Case Manager directly to discuss approval of treatment and or services prior to commencement.[2]

6. On 27 June 2013 the Insurer wrote to the applicant advising that an Internal Reviewer had upheld the original decision. In this letter the applicant was told:

> Your entitlements to medical expenses will continue for a further 12 months from 10 September 2013 in accordance with section 59A(2) of the amendments to the Workers Compensation Act 1987.

7. A WorkCover Merit Review was completed and a Statement of Reasons issued on 10 September 2013. The Merit Reviewer upheld the original decision of the insurer. The Merit Reviewer found that the applicant has no entitlement to weekly benefits in accordance with section 38 of the 1987 Act.

8. On 8 October 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's grounds for pursuing procedural review might be fairly summarised thus:

[1] Query whether an assessment of "nil" constitutes a cessation of entitlement rather than a "payment rate".
[2] No reference was made to section 59A(2) or (3) of the 1987 Act.

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(i) The applicant seeks a review of "the entire work capacity decision and subsequent reviews" carried out by the Insurer and WorkCover.

(ii) The Insurer has made a "concession" in relation to medical expenses, purportedly noted at paragraph 30 of the merit reviewer's reasons.

(iii) He seeks "similar concessions" from the Insurer in relation to weekly payments, referring specifically to several paragraphs in the merit reviewer's reasons.

(iv) It is emphasized that the applicant was in receipt of weekly payments pursuant to a consent award entered into at the Workers Compensation Commission in 2008.[3]

Submissions by the Insurer

10. The Insurer set out at considerable length the timeframes for the work capacity assessment and decision and internal review and communication with the applicant, all of which complied with the legislative requirements. Similarly, the timelines for both the fair notice provisions and section 54 of the 1987 Act were fully complied with.

The Insurer made the following admission:

> Section 59A limitations not specified in the decision letter; however [the applicant] was advised that his entitlement to reasonably necessary medical and related treatment continued at the time the notice was issued.

The submissions were otherwise confined to an enumeration of dates when particular steps in the decision-making and notice-giving process were taken, although there is a short reference to section 38 being explained (at least in part) in the notice of the decision. There is no commentary on the relevance of medical or other evidence, which might be a serious omission given that the merit reviewer had access to more up to date medical evidence than the Insurer had at the time of the work capacity assessment and decision.

[3] While section 55 is repealed under the amendments, it may still apply to existing recipients paid pursuant to awards until they are validly transitioned. The law on this has yet to be tested.

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The Legislative Framework

11. 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.[4] 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:

[4] 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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- 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 a worker of a *decision* under section 43. The notice requirement in section 54 arises from a proposed variation in payments and

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therefore the issue of "notice" may not arise in circumstances where no variation in payments results from a work capacity decision.

12. I note that in both the first edition of the *WorkCover Work Capacity Guidelines* published on 28 September 2012, 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*."

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

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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.*

13. 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*.

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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 subjunctive mood of the word "must" immediately prior to the first bullet point.[5] It would follow that a breach of even a single element of this decalogue similarly 'must' result in invalidity of the notice. This position is fortified by the status of the *Guidelines* as delegated legislation.

Process of the Insurer

14. The decision reached by the Insurer was certainly within the range of available decisions, and was upheld by the merit review service. The applicant has been paid for more than 130 weeks, has returned to work for more than 15 hours per week and earns considerably more than $155 per week. Being an existing recipient of weekly payments immediately prior to 1 October 2012, the applicant is subject to the transitional rate in Schedule 6, Part 19H, clause 2 of the 1987 Act, as amended rather than the maximum amount set out in section 34(1). However, such considerations are of no interest on procedural review where the main relevant consideration is not *why* a decision is made, but *how* it is made.[6]

15. The Insurer had regard to relevant medical evidence, which is set out in the letter of 31 May 2013 thus:

- Medical report of Dr F (Orthopaedic Surgeon) dated 7 December 2000
- Medical report of Dr V (Orthopaedic Surgeon) dated 5 April 2001
- Medical report of Dr S (Consultant Surgeon) dated 29 November 2007, 26 March 2008 and 31 October 2008
- Medical Report Dr B (Nominated Treating Doctor) dated 9 October 2012

In the letter dated 27 June 2013 advising the outcome of internal review all of the above reports were referenced, with the exception of the report from Dr B. In addition to those set out above, the following documents were said to have been relied on:

[5] "Must" also qualifies the pentalogue in *Guideline* 5.2.
[6] For a related discussion of the distinction see *Minister for Immigration and Citizenship v Li* (2013) 297 ALR 225 per Gageler, J at 253.

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- Medical certificate dated 20 February 2013 Dr B, NTD.[7]
- Certificate of Determination dated 22 December 2008 – Workers Compensation Commission
- Confirmation of earnings [employer]
- Earning Capacity Assessment from EVA dated 9 October 2007

16. In the course of the letter dated 27 June 2013 the Insurer referred to Professor S, described as a "pain specialist." The full reference was in these terms:

> Treatment for your back injury to date has consisted of physiotherapy, hydrotherapy, home based exercises, analgesics, review with pain specialist Dr Professor S.

This is the first and only reference to Professor S in the Insurer's correspondence with the applicant. It is instructive that the Insurer thought reports dated 2000 - 2008 to be relevant for the purposes of a work capacity assessment and decision, but did not take the trouble to seek a report from the applicant's current treating specialist at any stage in the assessment and decision-making process. Professor S did ultimately produce a report dated 3 September 2013, which was considered by the merit reviewer. The report post-dated the original work capacity decision by more than 3 months.

17. A further twist to the issue of medical expenses is provided by a comment made in the Merit Review reasons. Paragraph 30 purports to incorporate a submission by the Insurer in the following terms:

> 30. In respect of the issue of ongoing entitlement to medical expenses the Insurer states that as they have calculated [the applicant's] entitlement in accordance with section 38(7) of the 1987 Act, he will continue to receive reasonably necessary medical expenses and this will not cease as at 10 September 2014 as previously advised.

My Reasons:

[7] Note different surname spelling.

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18. The applicant's stated grounds for seeking procedural review can be dealt with using the numbering in paragraph 9 (i)-(iv) above:

(i) My only power is to review the procedures of the insurer in making the work capacity decision and do not extend to examining the procedures of the merit review service.

(ii) The "concession" made by the Insurer concerning medical expenses, as reflected in paragraph 30 of the merit review decision[8] is really no such thing. It proceeds from a reading of the legislation which allows that a worker may have an "entitlement" to weekly payments of $0.00 per week and that such an entitlement persists to the detriment of the worker. It is detrimental since it uses up the weeks in which workers would otherwise be entitled to compensation payments at a later stage. On this reading of the Act two problems arise: first, it would be possible to say that a person who has never been paid after the first entitlement period due to the operation of the algorithms in ss 37-38 has used up their full entitlement after 130 weeks post-injury have elapsed, which is contrary to the purpose of the legislation, and secondly, it does not answer the question of when section 59A(2) begins to operate. Since this applicant has already received over 130 weeks of payments, is he to understand that his "entitlement" of $0.00 per week will continue indefinitely, or until 260 weeks have elapsed, or for some other period? It is not clear and it follows that his rights are uncertain as to duration.

(iii) There cannot be "similar concessions" in relation to weekly payments, since (a) there was no concession in the first place in relation to medical expenses, and (b) a concession cannot be determined by a procedural reviewer, or any reviewer.

(iv) It is noted that the applicant was in receipt of weekly payments pursuant to an award of the Workers Compensation Commission which was entered into by consent. In my view an Insurer in transitioning a worker to the new system and making a work capacity decision can bring such an award to an end, simply because the only qualification for being susceptible to the application of the transitional

[8] Reproduced in full at paragraph 17 above.

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provisions (including the transitional amount) is that a worker be an existing recipient of weekly payments immediately prior to 1 October 2013. The Act draws no distinction between existing recipients who are subject to an award of the former Court or the Commission on the one hand, or simply recipients of voluntary payments on the other hand.

None of the grounds specified by the applicant would suffice to overturn the Insurer's work capacity decision.

19. The Insurer made submissions about compliance with the relevant statutory provisions and *Guidelines*. I cannot fault the Insurer in relation to compliance with the relevant notice provisions and I note that the Insurer went to some trouble to set out the relevant medical evidence and to discuss the reasons for the decision in a coherent way. The applicant would be in little doubt as to the reasoning process of the Insurer. Despite this there are errors of procedure which must result in invalidity for the reason that they constitute breaches of the *Guidelines* or the legislation or both.

- In the letter of 31 May 2013 the Insurer purports to set out all the relevant evidence considered in reaching the work capacity decision. Despite this, the letter advising the outcome of Internal Review listed an extra medical certificate from the applicant's NTD dated 20 February 2013, which clearly pre-dated the work capacity decision. The Internal Review letter also referred to a confirmation of earnings from the employer and an Earning Capacity Assessment dated 9 October 2007, which also clearly pre-dated the work capacity decision. The *Guidelines* require at 5.1 that an Insurer must consider "all available evidence" and at 5.4.2 that in a Work Capacity Decision Notice "[a]ll evidence considered should be referred to." It follows that the failure of the Insurer to either consider the additional documents in making the original assessment and decision was a breach of *Guideline* 5.1, or if those documents were so considered but omitted from the Notice, there was a breach of *Guideline* 5.4.2.

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- The uncertainty of the applicant's entitlement to ongoing medical benefits arises from the way this issue was dealt with by the Insurer in the notice of the work capacity decision, where the applicant was told that his "entitlement to reasonable and necessary medical and related treatment" would continue. He was not told for how long or on what basis. In the Internal Review letter section 59A(2) was referenced and the applicant was told his entitlement to medical benefits would "continue for a further 12 months from 10 September 2013." Section 59A(3) was never referred to. The confusion thus achieved a scrannel pitch of uncertainty, alleviated in no way by the Insurer submitting on merit review that under section 38(7) the applicant had an ongoing entitlement of $0.00 and that it apparently followed that he would retain his medical benefits. Again, there does not appear to have been any indication of the length of time of this continuing entitlement.

- It could scarcely be argued that the applicant has had his entitlement to medical expenses explained to him coherently or at all. This is in clear breach of *Guideline* 5.4.2.

- There is no explanation for the failure of the Insurer to obtain even one report from the treating pain specialist prior to making an assessment of the applicant's work capacity. It is clear from comments made by the merit reviewer that the pain specialist is of the view that the applicant is likely to need very serious treatment to his lumbar spine in the near future. *Guideline* 2.4 requires an Insurer to tailor a work capacity assessment "to the worker." It goes on to say that "[a]n understanding of the worker's circumstances and their injury ensures the right approach at the right time." It cannot be the case that a report from a treating specialist is obtained "at the right time" if it is not obtained until following the completion of internal review.

20. 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 more than one breach of the *Guidelines*

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which are to be treated as delegated legislation. Accordingly the work capacity decision must be found to be invalid.

My Recommendation:

21. For the reasons set out above 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.

22. 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 he is validly transitioned and a section 54 notice issues and the relevant period of notice therein has expired.

23. Because the review process does not operate as a stay of the original decision, the applicant has not received weekly payments since 10 September 2013. Therefore it cannot be said that he "is receiving" compensation. This means that clause 21 of schedule 8 to the *Workers Compensation Regulation* 2010 cannot apply. It follows that he may be restored to the correct pre-transition amount forthwith, since there is no need for the effluxion of any notice period.[9]

24. Noting the binding nature of these recommendations[10] I recommend that the Insurer takes my views into account, and I recommend that the Insurer immediately gives effect to them.

[9] To the extent that clause 21 of schedule 8 of the *Regulation* conflicts with both section 9 ("A worker ... shall receive compensation") and section 38(2) ("A worker ... is entitled to compensation"), it is *ultra vires*.
[10] See section 44(3)(h) of the 1987 Act – recommendations made by the Independent Review Officer are binding on the insurer and the Authority.

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Wayne Cooper
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26 November 2013