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26 November 2015

Anthony Lean

Chief Executive

State Insurance Regulatory Authority

By email: 2015benefitsreform@sira.nsw.gov.au

Dear Mr Lean

Regulation of legal costs for work capacity decision reviews

Please find enclosed the submission of the Construction Forestry Mining and Energy Union (New South Wales Branch).

Yours faithfully

[redacted]

Rita Mallia

State President

Introduction

The Construction Forestry Mining and Energy Union (**CFMEU**) welcomes the opportunity to make submissions to the State Insurance Regulatory Authority on the issue of 'Legal costs for Work Capacity Decision.' In addition to these submissions we also support the submissions compiled by Unions NSW.

The CFMEU represents approximately 16,000 members in the building and construction industry. A large proportion of our members are workers who come from non-English speaking backgrounds with little or no education beyond the age of 15. A huge proportion of our members have very few transferrable skills and qualifications outside their industry. More often than not, once these workers are injured they cannot secure alternative employment because they lack the ability to read and write in English.

Since the introduction of work capacity process the CFMEU has been working hard to assist our members throughout the review process attempting to fill the gap normally reserved for legal representation. Through its experience the CFMEU has come to appreciate the complexity of the system and the necessity for persons with legal training to be available to navigate the system.

These submissions will argue that legal representation in the work capacity process is necessary and long overdue. Attached to these submissions are a series of work capacity review examples which demonstrate how legal representation can be used to navigate the work capacity system and assist in reducing administrative costs to the scheme. The examples also illustrate the level of work required to assist an injured worker through the process. They stand as a testament as to why legal representation is necessary in all stages of the work capacity process.

Work Capacity Process

A system of work capacity assessments and work capacity decisions was introduced as a result of the 2012 legislative amendments to the workers compensation scheme. The system did not exist in NSW prior to the amendments. Previously South Australia was the only state or territory to utilise a work capacity system to determine an injured workers level of capacity. The rationale for the introduction of the system was the idea that there needed to be an increase in the return to work rate among injured workers. However, like the South Australian system, work capacity assessments and work capacity decisions are used as a mechanism for pushing people off the workers compensation scheme or pressuring injured workers to remove themselves from the system voluntarily rather than being constantly subject to the whim of the work capacity process.

A work capacity decision is defined by s 43of the 1987 Act as follows:

> *43 Work capacity decisions by insurers*
>
> *1) The following decisions of an insurer (referred to in this Division as work capacity decisions) are final and binding on the parties and not subject to appeal or review except review under section 44 or judicial review by the Supreme Court:*
>
> *a) a decision about a worker's current work capacity,*
>
> *b) a decision about what constitutes suitable employment for a worker,*
>
> *c) a decision about the amount an injured worker is able to earn in suitable*

employment,

d) a decision about the amount of an injured worker's pre-injury average weekly earnings or current weekly earnings,

e) a decision about whether a worker is, as a result of injury, unable without substantial risk of further injury to engage in employment of a certain kind because of the nature of that employment,

f) any other decision of an insurer that affects a worker's entitlement to weekly payments of compensation, including a decision to suspend, discontinue or reduce the amount of the weekly payments of compensation payable to a worker on the basis of any decision referred to in paragraphs (a)–(e).

2) The following decisions are not work capacity decisions:

a) a decision to dispute liability for weekly payments of compensation,

b) a decision that can be the subject of a medical dispute under Part 7 of Chapter 7 of the 1998 Act.

3) The Commission does not have jurisdiction to determine any dispute about a work capacity decision of an insurer and is not to make a decision in respect of a dispute before the Commission that is inconsistent with a work capacity decision of an insurer

The work capacity system fails to function in a rational, efficient or effective manner.

Pre Injury Average Weekly Earnings

It is often overlooked by all stakeholders, but a decision about Pre-injury average weekly earnings is a work capacity decision for the purposes of s 43 of the Act.

The 1987 Act has a total of 7 provisions dedicated to the interpretation of key concepts relating to the calculation of Pre-Injury Average Weekly Earnings (**PIAWE**). PIAWE is defined by s 44C of the 1987 Act as *"the sum of the average of the worker's ordinary earnings during the relevant period" and "any overtime and shift allowance payment that is permitted to be included."* In order to fully understand the implications of the section the injured worker needs to understand the definitions contained in the other 6 sections. Hopefully by this stage an injured worker has enough information to help them understand the concept of PIAWE.

The definitions in Part 3, Division 2, Subdivision 4 of the 1987 Act, are unnecessarily cumbersome and confusing. An injured worker with limited literacy skills will struggle to get through the initial definition of PIAWE let alone the follow-up definitions. These provisions have the effect of putting the concept beyond the reach of the average injured worker and which will often result in an injured worker accepting the decision without question because it is all too hard.

If we combine the definitions in order to properly define PIAWE we end up with the following explanation:

(1) In this Division, ***pre-injury average weekly earnings***, in respect of a 52 week period prior to injury of a period of continuous service with an employer, in relation to a worker means the sum of:

a. The average of the workers rate of pay payable to a worker for, the hours of work agreed or determined in accordance with a fair work instrument between the worker and the employer, of work not including incentive based payments, loading, monetary allowances, piece rates or commissions, overtime or shift allowances, any separately identifiable amount not mentioned, plus amounts payable as piece rates or commissions in respect of that weeks and the monetary value of residential accommodation, use of a motor vehicle, health insurance, education fees during the 52 week period prior to injury, and
b. Any overtime or shift allowance permitted to be included.

Red represents the definition of relevant period in s 44D, blue represents the definition of base rate of pay in s 44G, purple represents the definition of ordinary hours in s44H, green represents the definition of ordinary earnings in s 44E and orange represents the definition of non-pecuniary benefits in s 44F. Each concept comes together to define PIAWE under s 44C. This definition, with its component parts, is meaningless to an injured worker who is struggling to manage life after injury. The definition is meaningless to employee representatives who do not have time to sit down and examine the terrain that is the PIAWE.

It is far too convoluted to work in reality and a simpler definition is necessary. The definition should simply be *"the average of an employee's pre-injury earnings during the 52 week period prior to injury or where an employee has not been employed for 52 weeks, the period of continuous service prior to injury."* The problem lies with trying to carve out different allowances and shift penalties, an exercise that in itself becomes burdensome for all parties within the process.

Determining what is or is not included in the definitions of ordinary earnings and base rate of pay is complex and often involves conflicting arguments between the worker or worker representatives and the insurer.

Decisions regarding PIAWE need legal assistance to navigate and understand the complexity that has been created in this scheme. PIAWE is difficult for insurers, unions and the Authority. It needs the intervention of people who have an ability to construe complex concepts and legislation to try and apply the laws appropriately.

Work Capacity Review and legal costs

One of the main features of the work capacity system is the elongated and complicated review process. Once an insurer has made a work capacity decision the injured worker has a limited avenue in which to seek a review of the decision. The review process is outlined in s 44 of the 1987 Act:

44 Review of work capacity decisions
1) An injured worker may refer a work capacity decision of an insurer for review:
a) by the insurer (an internal review) in accordance with the Workers Compensation Guidelines within 30 days after an application for internal review is made by the worker, or
b) by the Authority (as a merit review of the decision), but not until the dispute has been the subject of internal review by the insurer, or

c) *to the Independent Review Officer (as a review only of the insurer's procedures in making the work capacity decision and not of any judgment or discretion exercised by the insurer in making the decision), but not until the dispute has been the subject of internal review by the insurer and merit review by the Authority.*

2) *An application for review of a work capacity decision must be made in the form approved by the Authority and specify the grounds on which the review is sought. The worker must notify the insurer in a form approved by the Authority of an application made by the worker for review by the Authority or the Independent Review Officer.*
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 of the decision (when the application is for review by the Authority) or the Authority's decision on a review (when the application is for review by the Independent Review Officer),*
   b) *an application for review by the Authority may be made without an internal review by the insurer if the insurer has failed to conduct an internal review and notify the worker of the decision on the internal review within 30 days after the application for internal review is made,*
   c) *the reviewer may decline to review a decision because the application for review is frivolous or vexatious or because the worker has failed to provide information requested by the reviewer,*
   d) *the worker and the insurer must provide such information as the reviewer may reasonably require and request for the purposes of the review,*
   e) *the reviewer is to notify the insurer and the worker of the findings of the review and may make recommendations to the insurer based on those findings (giving reasons for any such recommendation),*
   f) *the Independent Review Officer must also notify the Authority of the findings of a review and the Authority may make recommendations (giving reasons for any such recommendations) to the insurer based on those findings,*
   g) *recommendations made by the Authority are binding on the insurer and must be given effect to by the insurer,*
   h) *recommendations made by the Independent Review Officer are binding on the insurer and the Authority.*
4) *A review of a work capacity decision does not operate to stay the decision or otherwise prevent the taking of action based on the decision.*
5) *The Commission is not to make a decision in proceedings concerning a dispute about weekly payments of compensation payable to a worker while a work capacity decision by an insurer about those weekly payments is the subject of a review under this section.*
6) *A legal practitioner acting for a worker is not entitled to be paid or recover any amount for costs incurred in connection with a review under this section of a work capacity decision of an insurer.*

The section is confusing and convoluted particularly paragraph (3) which is intended to apply to both the Authority and the WIRO but some parts are only applicable to the Authority. The section provides for a three-tier review; internal review; merit review and procedural review. An injured worker must meet all the requirements prior to making a review at the next level.

The complexity and illogical nature of the review system can be demonstrated using the time limits for applications and decisions. An insurer has 30 days to make an internal review decision. Should a decision not be made in that time limit the injured worker is permitted to apply for a merit review.

Contrast this with the merit review. The Authority has 30 days from the day it receives the application to make a merit review decision. However, if the Authority fails to make a decision within 30 days the injured worker has no recourse, they must simply wait for the merit review process.

Legal representation

There is a legislated power imbalance inherent in the work capacity system. Legal representation for an injured worker is all but prohibited during the work capacity review process, while the legislation does little if anything to prohibit an insurer from engaging legal assistance when making and reviewing a work capacity decision. Section 44(6) of the 1987 Act explicitly states:

> 6) *A legal practitioner acting for a worker is not entitled to be paid or recover any amount for costs incurred in connection with a review under this section of a work capacity decision of an insurer.*

A legal practitioner is prohibited from charging an injured worker for assistance with a work capacity decision and WIRO is not permitted to grant an ILARS for assistance with work capacity decisions, while insurer are receiving comprehensive legal advice from their in house lawyers.

Admittedly, Clause 9 in Schedule 8 of the *Workers Compensation Regulation 2010* is intended to restrict the insurer from obtaining legal advice the intended result being quality of access to legal services. While that may be the intention insurers are clearly accessing legal services to make work capacity decisions, make submissions to the merit review service and make submissions to WIRO for procedural review.

This is not unexpected behaviour from the insurers though. During its Statutory review of the Workers Compensation Legislation Amendment Act 2012, the Centre for International Economics found that prior to the 2012 amendments there was an upward trend in insurer legal costs which is believed to be due to the reduction in the claim management capacity of Scheme agents, resulting in an increasing reliance on legal providers.

It is universally accepted by the legal profession, injured workers, and unions, that legal representation is necessary to properly navigate the work capacity process. The system is inherently complex. The principles involved in making a work capacity decision are not entirely logical or rational making it difficult for all parties in the process.

The complexity and expense of the process can be demonstrated by breaking down the work performed by the CFMEU in particular, in assisting injured workers to navigate the work capacity system. The CFMEU has one industrial officer responsible for work capacity reviews. In the initial stages of the work capacity regime, the CFMEU was averaging 4-6 applications a week. This was primarily decisions for existing recipients transitioning to the new system.

Initially the process undertaken by the union attempted to simplify the responses given the limited resources and what was viewed as the inevitability of the outcome. Of these applications lodged only

one was overturned in the early stages of review. This decision showed incredible creativeness and sensibleness from the insurer when reassessing suitable employment options. The vast majority of applications relied on the WIRO procedural review to challenge the decision.

As time progressed, and the merit review service was delaying providing merit review decisions, it quickly became clear that a more detailed and involved response was needed to try and seek justice in the early stages of the review process. This detailed and involved approach requires full attention to all the documentation relied upon by the insurer in making the decision. It involves the applicant, in this case the union, dedicating 10-12 hours per week reviewing the documents, finding flaws or inconsistencies and structuring arguments to address primarily the issue of suitable employment. As the responses became more detailed there appeared to be more success in having the decisions overturned in the initial stages thereby reducing the impact on the individual injured workers.

As time progresses the arguments become more complex and legal, begging for the intervention of the legal profession. There is no logical basis for removing the ability for the legal profession to assist workers in the process.

The Discussion Paper

The Discussion Paper notes that the amending Act provides for three main regulatory controls being:

- Prescription of certain classes of reviews for which legal costs are not payable
- Fixing of maximum legal costs
- Prescription of circumstances in which one party would be required to bear the other party's legal costs.

Section 44BF of the Amending Act states:

44BF Legal costs

1) *A legal practitioner is not entitled to be paid or recover any amount for a legal service provided to a worker or an insurer in connection with a review if:*
    a) *the review is of a prescribed class, or*
    b) *the regulations do not fix any maximum costs for providing the legal service to the worker or insurer in connection with the review.*
2) *Despite section 341 of the 1998 Act, the regulations may provide that, in prescribed circumstances, a party to a review under this Subdivision (other than an internal review) is to bear the other party's costs in connection with the review.*

Prescribed classes

While s 44BF allows for the prescription of particular classes of review, there is no restriction on allowing that prescription to include all avenues of review. There is no logical justification for not allowing paid legal representation at all levels of review.

The table attached at Appendix A, shows that a great deal of time and effort is put into compiling an internal review application. The internal review application is the first time an injured worker is presented with all the evidence in his file and is often several inches thick. It is overwhelming for the injured workers.

The internal review stage allows the legal representative time and opportunity to analyse the documentation, compare the decision to the documentation and compare the decision to the relevant legislation and Guidelines.

Examples D, E, F, J, K and L attached demonstrate that a well argued internal review application can save the scheme administration costs by providing the insurer an opportunity to see the arguments against the decision to determine whether its in the insurers best interests to proceed or whether the decision is likely to fail at a further stage in the process.

The conflict in the review system is the reason why legal costs should not be determined on the outcome of the review. There are many circumstances where the internal review has confirmed the original decision but the merit review service has overturned the original decision.

If such a regulation was to be implemented it would effectively make the review process obsolete. The system would be similar to the system we have now, where we ultimately expect legal representatives to work for free. If success was a precondition of legal expenses then why would a legal representative take on a client where they may be unable to recoup the cost. There is no logical justification for this kind of restriction.

The structure for legal costs must be kept simple and legal representation should be available at all tiers of the review process.

Maximum Costs

The CFMEU is aware that the Australian Lawyers Alliance is in the process of quantifying the time and cost of the different layers of the work capacity review process, which may be helpful in identifying what, constitutes reasonable costs for the process.

Alternatively, the CFMEU also supports fixed fees to keep the process simple, however given that the majority of the work is done in the internal review stage of the process any legal costs structure needs to reflect that effort.

Requirement to bear the other parties cost

The injured worker should not be required to bear the other party's costs. The injured worker is the most vulnerable party in the system and is at the behest of the insurance company. Every element of the work capacity process is designed to punish the injured worker for factors beyond their control. A

requirement that they be forced to pay the insurers costs in the event that the review is not successful would deter injured workers from accessing the review process.

Agents

The CFMEU has been very active in the work capacity process since the introduction of the system in 2012, along with several other unions. Any legal costs regulation should reflect that these matters may be dealt with by persons outside the legal profession. In that regard, any regulation should not be confined to lawyers, as with the ILARS scheme. The proposed regulatory changes must acknowledge and reward agents for the time and effort spent assisting injured workers with their applications for review.

Conclusion

Any legal costs regulation must be simple, concise and easy to navigate. The regulation should not seek to exclude certain classes of review and should be available to all injured workers at all stages of the review. The regulation should not act as a deterrent to the injured worker by punishing an injured worker in circumstances where a review is unsuccessful.

EXAMPLE A

The following example highlights the additional complications, which may arise from an application for internal or merit review. This example required knowledge of the intricacies of the different Guidelines and how the injured worker could use the Guidelines to ensure either the insurer or the Authority made a decision. The union was instrumental in advising the Authority of its obligations under the Guidelines.

Fair Notice phone call	Worker notified that due to changes to the workers compensation laws the injured worker was going to lose his weekly benefits.
Notice of an impending work capacity decision	Information from the phone call was reiterated in the fair notice letter
Notice of work capacity decision	The letter notes that after considering all the relevant information the injured worker has capacity to work full hours per week as an: 1. Inquiry clerk 2. General clerk 3. Supply clerk The letter addresses 17 different documents implying the documents assisted the insurer to reach the decision that the injured worker is no longer entitled to weekly benefits.
Application for internal review	The injured worker seeks the assistance of the union. He has not been provided the medical evidence so the union contacts the insurer to get copies of the documents. This process takes approximately 1.5-2 weeks. Upon receipt of the documents the union spends considerable time reading through the documents and comparing the conclusions to those contained within the decision. The process involves identifying any flaws or inconsistencies in the information obtained. The next step is to confirm whether the options highlighted as suitable employment are consistent with the findings of the medical reports and the definition contained in s 32A of the 1987 Act. This requires a great deal of analytical assessment. The above process is undertaken to assess likelihood of success. The union assists with the completion of the form and it is then sent to the insurer for review.
Application for merit review	The insurer is required to make an internal review decision within 30 days of receiving the application. The union and the injured worker had not heard from the insurer within the required time frame. The injured worker was awaiting the decision from the insurer and was unaware that the 30 days had lapsed since the internal review decision was due to be made. The union identified a clause in the relevant Guidelines, which allowed the merit review service to conduct a merit review if an internal review decision

	had not been reached in the required time period. The union also identified that the merit review had the discretion to accept a merit review decision that is lodged outside the time limit. The union helped the injured worker complete an application for merit review and attached a cover letter highlighting clauses 7.6 and 9.12 of the *Guidelines for work capacity decision Internal Reviews by insurers and Merit Reviews by the WorkCover Authority* in support of the argument to conduct a merit review.
	Following the application for merit review the union received correspondence from the insurer alleging that the date and time on the fax transmission were incorrect.
Letter from WorkCover	WorkCover responded to the application for merit review claiming that there was no jurisdiction by virtue of s 44(3)(b) of the Act because the matter had not been subject to an internal review decision, a remark which was inconsistent with the legislation and the Guidelines.
Letter from CFMEU	The union wrote to WorkCover and explained the meaning of s 44(3)(b) noting that the *"section explicitly allows an injured worker to apply for a review by the Authority in circumstances where an insurer has failed to notify the worker of the decision on internal review within 30 days."* The union reiterated that WorkCover had jurisdiction to conduct the merit review and explained that WorkCover was only permitted to refuse to conduct a review in limited circumstances and this application did not fit into those circumstances.
Letter from WorkCover	WorkCover responded confirming their acceptance of the points raised in the CFMEU correspondence and indicated that it would be carrying out a merit review of the decision.
Internal Review Decision 27 Sept	The insurer subsequently made an internal review decision ultimately decided that the insurer had failed to identify suitable employment options for the injured worker and the injured worker would receive the transitional rate moving forward as he was an existing recipient.
Letter from CFMEU	The CFMEU wrote to WorkCover and advised that the insurer had made a favourable internal review decision and the injured worker will be discontinuing the application
Letter from WorkCover	Confirming that the application had been withdrawn and the merit review will not proceed

EXAMPLE B

The following example highlights the difficulties faced by an injured worker who has limited English skills and relies on professionals to explain the complexity of work capacity decisions in a manner in which the injured worker can understand. Those inured workers with limited English will find it difficult if not impossible to make legal arguments such as the statutory meaning of "current capacity."

It is also an example of how agents or lawyers can assist in identifying whether a claim has prospects of success thereby reducing disputation and administration costs.

Fair Notice phone call	Worker notified that due to changes to the workers compensation laws the injured worker was going to lose his weekly benefits.
Notice of an impending work capacity decision	Information from the phone call was reiterated in the fair notice letter
Notice of work capacity decision	The letter states that the injured worker is no longer entitled to weekly benefits under s 38 of the Workers Compensation Act 1987. The decision is 11 pages in length and identifies each sub paragraph of s 43 of the Act extracting large pieces of information from a medical report that the insurer relied upon. The insurer decides that the injured worker has capacity to work as: 1. Light delivery driver 2. Light courier 3. Light packer The insurer extracts s 38(3) and confirms that the injured worker does not meet the special requirements contained in that section. The decision was accompanied by 7 medical reports with the insurer relying heavily on one report in particular. English is not the injured worker's primary language and the injured worker was overwhelmed by the large pieces of extracted information in the decision.
Consultation with the CFMEU	The injured worker presented at his union office confused about the documents and what they meant. The injured worker was not aware that his weekly benefits were going to cease and he did not know why the decision had been made. This was the injured workers second work capacity decision. The union representative spent a couple of hours explaining the 11 page document and that the injured worker could seek a review of the decision if he wanted but the union could not promise that the new decision would be favourable.
Application for internal review	The next step was to confirm whether the options highlighted as suitable employment were consistent with the findings of the medical reports and the definition contained in s 32A of the 1987 Act. The process required a great deal of analytical assessment. The above process is undertaken to assess likelihood of success.

	The union identified that the medical reports relied upon were over 12 months old. Relying on s44A, the requirement that it be an assessment of the injured workers current work capacity and the general rules of statutory interpretation, the union argued that the decision was invalid because it relied on stale reports. The union assists with the completion of the form and it is then sent to the insurer for review. In the application the union notified the insurer that the injured worker was entitled to a stay of the work capacity decision given that the injured worker was an existing recipient relying on Schedule 8, Part 2 Clause 30 of the Workers Compensation Regulation 2010.
Notification of internal review decision	The decision mentions a number of legislative provisions and notes that it *relies upon the decision, process and documentation previously made and provided to you in accordance with Sections 43 and 44 of the Workers Compensation Act 1987*, without explaining to the injured worker what that means. The decision is set out in much the same manner as the original decision although it does not extract whole sections of one of the reports. The decision is 7 pages long but makes substantially the same arguments as the original decisions. The decision again references s 38(3) of the Act without thorough explanation. The decision then notes that it has considered the application but didn't address the arguments raised.
	Following the internal review decision the union spent a significant period of time explaining to the injured worker the consequences of the internal review decision and explaining that the next step in the process is a merit review application, but again no guarantees could be made. The injured worker agreed to go ahead with the application.
Application for merit review	Having compiled all the relevant arguments in the internal review stage there was less work to be done for merit review. The union helped the injured worker complete the application form and send sent the application to WorkCover and the insurer.
Merit Review decision	The merit review decision is much easier to comprehend than the internal review decision. The decision notes the submissions made by the injured worker and by the insurer before addressing the merit of the claim. The merit review decision is 9 pages long. The decision extracts the relevant sections of the legislation including s 32A and 38(3) as well as Division 2, Part 19H, Schedule 6 of the 1987 Act. The final decision is that the injured worker does not meet the special requirements of s 38(3) and is therefore not entitled to ongoing weekly benefits.
	Following receipt of the merit review decision, the union ran a 'procedure checklist' to ascertain whether the original decision was consistent with the Guidelines and to identify whether there were any procedural irregularities on which the injured worker could rely prior to conducting a conference with the injured worker.

	The union was unable to identify any irregularities which may give rise to a further review
Conference with injured worker	Given the injured workers language barriers the union organized a conference to explain the merit review decision and available options. The union explained that the merit review had agreed with the insurer and the merit review had decided that he would not receive weekly benefits once the notice period expired. The union also explained the process for medical expenses and explained that the next step in the process was a procedural review. The union explained that a procedural review does not look at whether the insurer made the correct decision but rather whether they did everything they were supposed to when they made the decision. The union explained that a procedural review was unlikely to be successful.
Second Conference with injured worker	The injured worker requested a second conference so the union could again explain what had happened to his claim. The union explained the changes to the legislation and the fact that the insurer was required to make a work capacity decision. The union explained that unfortunately for the injured worker the insurer did everything required when it made the decision and even though the union may not agree with the decision the insurer was entitled to make that decision. The union again went through the medical evidence that the insurer had relied on to try and explain how the insurer had reached the decision to discontinue benefits.

EXAMPLE C

This following example demonstrates that additional research outside of the decision and medical documentation may be necessary. The example also highlights the necessity of understanding the nuances of the particular legislation such as the postage rule a fact that a layperson may not recognise as a procedural error.

Fair Notice phone call	Worker notified that due to changes to the workers compensation laws the injured worker was going to lose his weekly benefits.
Notice of an impending work capacity decision	Information from the phone call was reiterated in the fair notice letter
Notice of a work capacity decision	The decision is only 2 pages in length due to being in the initial stages of the transition process The decision states that *"GIO has determined that your weekly benefits should cease, under section 38 and section 43 (a) (a) (b) (c) (d) (e) (f) of the 2012 Workers Compensation Legislative Amendments."* This is not explained to the injured worker in the decision and the injured worker is unaware of why his benefits will be discontinued.
Application for internal review	The injured worker attempted the internal review on his own without assistance from the union.
Internal review decision	As with the original decision the internal review decision names the relevant sections without explaining their meaning. The internal review decision also relies on additional documentation in reaching its decision. The insurer decides that the injured worker is capable of working 20 hours per week as a Train Controller.
Consultation with injured worker	The injured worker seeks the assistance of the union in applying for a merit review. The injured worker had previously spoken to Sydney Trains and had an email saying the Train Controller role did not exist and the injured worker was not qualified for any role that may be considered similar to that of a train controller. The union investigator the role of a school crossing guard and discovered that the Roads and Maritime Authority is the only employer of this role and they offer maximum 10 hours per week. The union used the information acquired to argue that neither role was suitable employment
	There was further communication with WorkCover who requested additional information which was provided via email
Merit review decision	The decision canvassed all the reports available and ultimately found that the injured worker had capacity to return to his role as a safety officer despite the fact it did *"not have a large amount of information regarding the pre-injury role."* The decision did note that the role of Train Controller was not suitable employment.

	Following receipt of the merit review decision, the union ran a 'procedure checklist' to ascertain whether the original decision was consistent with the Guidelines and to identify whether there were any procedural irregularities on which the injured worker could rely prior to conducting a conference with the injured worker. The union identified a number of procedural errors and communicated this to the injured worker who instructed the union to proceed with a procedural review.
Application for Procedural Review	The union assisted the injured worker in completing the application. The arguments consisted of three pages addressing the insurers failure to adhere to the relevant guidelines, The union also argued that the insurer had contravened s 54 of the 1987 Act due to its failure to allow for postage.
WIRO Decision	In its decision WIRO identified the irregularities and the failure of the insurer to adhere to the postage rule and declared the original decision invalid.

EXAMPLE D

This example illustrates the time and effort it takes to put together an application for internal review to ensure all areas are covered and addressed. It also demonstrates that other sections of the legislation may be helpful in compiling a persuasive argument.

Fair Notice phone call	Worker notified that due to changes to the workers compensation laws the injured worker was going to lose his weekly benefits.
Notice of an impending work capacity decision	Information from the phone call was reiterated in the fair notice letter
Notice of a work capacity decision	The injured worker seeks the assistance of the union. He has not been provided the medical evidence so the union contacts the insurer to get copies of the documents. This process takes approximately 1.5-2 weeks The decision encompasses 7 pages and spends a large proportion of space discussing the evidence and the notice requirements. This is the injured workers second work capacity decision and the insurer makes the same decision finding that the injured worker has capacity to work as a: 1. Inquiry clerk 2. General clerk 3. Supply Clerk The insurer notes that in accordance with s 38(3) the injured worker is no longer entitled to benefits. In reaching its decision the insurer relied upon 16 documents.
Application for internal review	The union assisted the injured worker to complete the application for internal review. In accordance with the union's approach at the time, an initial procedural checklist was done and procedural irregularities were identified. The union analysed the decision and the additional documentation relied upon. The union argued that the insurer had failed to take into account the nature of the injured workers incapacity using the definition of incapacity from s 4 of the 1998 Act. The union relied on comments in some of the reports provided from the insurer to show that the injured worker had a broader incapacity, which was a relevant consideration under s 32A. The union criticized the insurer's failure to retrain or rehabilitate the injured worker adequately. The union then moved to examining the different roles chosen as suitable employment noting the evidence regarding the injured workers skills, qualifications and physical restrictions. The application finished with identifying the procedural irregularities and noting that the insurer continued to rely on the transition provisions despite

	the injured worker being previously transitioned. The additional arguments were 9 pages in length
	Prior to making an internal review decision the union was notified that the injured worker had suffered a stroke. On that basis the insurer withdrew the work capacity decision

EXAMPLE F

This example demonstrates that other relevant considerations may exist which can form the basis of an argument regarding capacity. An injured worker is not likely to connect visa restrictions to his work capacity decision, which is where the use of an agent or legal professional can be useful.

It also demonstrates that at times there may be a necessity to conduct research outside of the legislation and guidelines to assist an injured worker.

Fair Notice phone call	Worker notified that due to changes to the workers compensation laws the injured worker was going to lose his weekly benefits.
Notice of an impending work capacity decision	Information from the phone call was reiterated in the fair notice letter
	Notice was extended twice via telephone and was not followed up with a letter confirming that the insurer required additional time to make the decision
Notice of a work capacity decision	During the notice period the injured worker continued to provide pay slips and medical certificates in accordance with his obligation. The insurer relies upon 8 documents in making its decision commenting briefly on each document. The insurer notes that there is a new entitlement regime and the injured worker is to be assessed under s 37 but doesn't explain the entitlement structure. The insurer decides that the injured worker has capacity to work full time as a sound technician with an earning capacity of $1036.00 per week, which exceeded the amount he was eligible to earn from the insurer.
Application for internal review	The injured worker sought helps from the union not know what to do with this information. The injured worker advised that he was injured whilst employed on a student visa. The union researched the requirements of the injured workers particular visa and discovered that he was only permitted to work 20 hours per week. The union helped the injured worker complete the application and attached the visa information to the application.
Internal Review Decision	The insurer chose not to conduct an internal review decision on the basis it was withdrawing the original decision to get further clarification regarding the injured workers visa status

EXAMPLE G

This example highlights the necessity of good legal advice in the internal review stage of the process. Identifying the procedural errors in early stages allows the insurer to make a decision to withdraw the application on their own accord where errors have been identified.

Fair Notice phone call	The insurer did not make a fair notice phone call relying on a phone call from the previous work capacity decision that had been withdrawn.
Notice of an impending work capacity decision	The insurer did not send a fair notice letter relying on the fair notice letter from the previous work capacity decision that had been withdrawn.
Notice of work capacity decision	The decision explains that the transition rate will apply without providing an explanation as to why. The decision purports to reduce the injured workers weekly benefit without referring to legislation or medical evidence.
Application for internal review	The injured worker again sought the assistance of the union. The union argued that the decision was invalid because: 1. The insurer failed to make a fair notice phone call 2. The insurer failed to send a fair notice letter 3. The insurer failed to comply with the relevant guidelines 4. The insurer failed to provide the correct period of notice. The union also relied on the visa requirements and provided the same information to the insurer.
Internal review decision	The case manager decided to withdraw the application on the basis that the insurer had failed to give appropriate notice.

EXAMPLE H

This example illustrates the need to ensure that insurers address all relevant information. It's important to use the Guidelines to support and justify the position taken, a skill the average worker is unlikely to possess.

Fair Notice phone call	Worker notified that due to changes to the workers compensation laws the injured worker was going to lose his weekly benefits.
Notice of an impending work capacity decision	Information from the phone call was reiterated in the fair notice letter. 8 Additional documents were also provided
Notice of work capacity decision	The decision outlines each of the work capacity decisions that have been made in accordance with s 43 of the Act. The decision addressed each of the documents that had previously been provided. The decision also explains the different entitlement periods and the effect of s 54 of the Act. The insurer makes the decision that the injured worker has capacity to work full time as a: 1. Sound Technician 2. Deliver driver 3. Sales representative The decision argues that the injured workers visa restrictions are not related to his work capacity to work and therefore are irrelevant.
Application for internal review	The injured worker again sought the assistance of the union. The union's response was 8 pages long and relied on the argument that suitable employment had not been identified. This argument was based on the fact that not enough information had been provided regarding the physical demands of the role and therefore an assessment as to whether the injured worker was physically capable to perform the roles was likely to be inaccurate. The argument regarding the visa restrictions was raised again. The argument relied on s 32A not being an exhaustive list of factors to be considered and the fact that the Guidelines required the insurer to evaluate all available and relevant material and relevant considerations and make a decision that was tailored to the work capacity of the injured worker. The union then raised a list of procedural irregularities with the decision.
Internal review decision	The internal review decision found that the injured worker was capable of working 32 hours a week and because he was not working the injured worker did not meet the requirements for s 38(3) of the Act. The insurer rejected the arguments regarding the failure to identify the physical demands of the roles.

	The insurer argued that it was not required to consider whether a person had a legal right to work in Australia and therefore the visa restrictions did not have bearing on whether the injured worker had capacity to work.
Application for merit review	The union assisted the injured working in filing an application for merit review. Since the arguments had been compiled during the internal review stage there was little more to do for this stage beyond filling out the correct form.
Merit Review decision	The merit review service weighed the medical evidence and agreed that the injured worker had capacity to work 32 hours per week. The merit review service declined to comment on the visa restrictions factor when making its decision. The merit review service ultimately found that the injured worker did not meet the requirements of s 38(3) of the Act and was no longer entitled to weekly benefits.
	The union held a conference with the injured worker to explain the situation and the prospects of success regarding the possibility of a procedural review. The union advised that there may be an argument about relevant considerations but some of the other issues were trivial although could be sufficient given previous decisions. The injured worker advised he wanted to go ahead with the next part of the review anyway
Application for Procedural review	The union assisted the injured worker with the application for procedural review. The union focused on the insurer's failure to take into account relevant material, the visa restrictions. The arguments then turned to failure to comply with the relevant guidelines.
WIRO decision	The decision notes that the legal disability as a result of the visa lost its relevance when the injured worker was not actually working. WIRO also decided that the procedural errors were not sufficient to invalidate the original decision.
	The union sent an email to the director of the Work Capacity Review team noting that the application had identified procedural errors and asking for him to look into the issue.

EXAMPLE I

This example illustrates the need to test whether decisions made by the insurer are rational and logical. In this example the insurer had exceeded what was rational by identifying that the injured worker was capable of working in excess of 60 hours a week and had capacity to work with a particular company, decisions which are inconsistent with the legislation and clearly not the outcome parliament intended.

Fair Notice phone call	Worker notified that due to changes to the workers compensation laws the injured worker was going to lose his weekly benefits.
Notice of an impending work capacity decision	Information from the phone call was reiterated in the fair notice letter. 3 Additional documents were also provided. Unlike other decisions the fair notice letter identified the likely calculation of weekly benefits.
	The injured worker sought the assistance of the union. He didn't understand how or why the insurer was cutting his benefits and wanted some advice as to whether it was legal. The union advised the injured worker of the purpose of the work capacity decision and what options might be available. The injured worker was told to contact the union once a decision had been made.
Notice of a work capacity decision	The decision explained s 43 and he different work capacity decisions that had been made. The insurer decided that the injured worker had capacity to work 60 hours per week as a: 1. Earthmoving machinery operator 2. Truck/car/tow truck/van driver The insurer calculated the injured workers weekly benefit as $78.17 per week.
Conference with injured worker	The union explained to the injured worker that there was a risk with applying for a review because the merit review service could decide to reduce the weekly benefit further but the union was happy to assist on his instruction. The injured worker agreed to apply for the merit review.
Application for merit review	The union assisted the injured worker with completing the application for merit review. The union argued that the insurer had failed to take into account the nature of the injured workers capacity and in particular his physical restrictions. The union also argued that the insurer had exceeded its power by deciding that the injured worker had capacity to work excessive hours noting that section 62 of the *Fair Work Act 2009* stated the maximum number of hours for a full time employee are 38 hours. The argument was that the insurer was requiring the injured worker to find employment that provided non-stop overtime. The union also argued that the insurer had exceeded its power by identifying suitable employment with a particular company, which was inconsistent

	with the intention of the legislation. The union also noted procedural irregularities.
Internal Review Decision	The internal review decision is a new work capacity decision thereby taking the place of the original decision. The internal reviewer did not accept the arguments regarding the insurer exceeding its power but found that there was no evidence to show that the injured worker possessed the appropriate qualification to be a truck driver. This decision reduced the injured workers capacity to earn from $1300 per week to $1016.44 per week. This led to a decision that the injured worker was entitled to weekly benefits of $361.73 per week
Conference with injured worker	The union advised the injured worker that the internal review had resulted in an increase in his weekly benefits. The union also advised the risks of taking the matter further with a chance that the merit review service would not agree and could reduce the weekly benefit. The injured worker ultimately decided not to proceed with the merit review.

EXAMPLE J

This example highlights the difficulties faced by injured workers from non-English speaking backgrounds. Injured workers rely on their solicitors to assist them in all matters of a serious matter, as did this injured worker. This injured worker assumed that his solicitor would be able to help. This highlights the importance injured workers place on their solicitors to explain the insurer's actions.

It also demonstrates that there are times when reviews require additional arguments and lobbying on behalf of the injured worker to ensure some semblance of justice.

Fair Notice phone call	Worker notified that due to changes to the workers compensation laws the injured worker was going to lose his weekly benefits.
Notice of an impending work capacity decision	Information from the phone call was reiterated in the fair notice letter
Notice of work capacity decision	The insurer notified the injured worker that a review had been conducted and that his benefits would be discontinued. The injured worker comes from a non-English speaking background and was confused as to the paperwork.
	The injured worker took the papers to his solicitor for her to review unaware that the lawyer was basically precluded from assisting with the application. The injured worker then on leave under the impression that the solicitor would deal with the paperwork. On his return he received a letter from the lawyer suggesting he speak to the union.
Application for Internal Review	The union assisted the injured worker to complete the application form and drafted a cover letter explaining the delay in applying and requesting the insurer still complete the internal review.
Internal Review Decision	The decision highlights the different elements of s 43 of the Act and addressed the documentation. The decision notes that the injured worker has capacity to work as a courier and relies on s 38(3) to discontinue the injured workers weekly benefits
Application for merit review	The union assisted the injured worker to complete the merit review application. The union argued that the original decision did not comply with the Guidelines
	Due to the time taken to undertake the merit review, the injured worker and insurer were required to provide the merit review service with up to date information to assist in the making of the decision.
Merit Review Decision	The merit review service found that the insurer had not provided enough information regarding the duties/tasks of identified job options or information regarding the physical demands of the roles. On that basis the merit review service was unable to identify suitable employment options based on the lack of information. That resulted in an ongoing entitlement to weekly benefits for the injured worker.

EXAMPLE K

This example demonstrates the necessity to undertake further research to arguing whether there are actual suitable employment options. The insurer had taken the word of the Merit Review Service from a previous decision, whereas the research undertaken by the union showed that safety officer was clearly not a viable option.

It also illustrates the benefit of making all arguments, merit and procedural in the initial application allowing the insurer to decide to withdraw the work capacity decision without the necessity to go all the way to WIRO.

Fair Notice phone call	Worker notified that due to changes to the workers compensation laws the injured worker was going to lose his weekly benefits.
Notice of an impending work capacity decision	Information from the phone call was reiterated in the fair notice letter
Notice of work capacity decision	The decision is poorly set out and difficult to read. The decision attached 11 documents to support its decision. The decision identifies and addresses each of the documents it intends to rely and decides that the injured worker has capacity to work as: 1. Handyman/maintenance worker 2. Sales assistant 3. Parking officer 4. Safety officer The decision regarding safety officer relies on a previous merit review decision and the insurer does not attempt to provide additional information to support this conclusion
Application for internal review	The union assisted the injured worker with completing the application form. The union response is 9 pages in length. The union argued that the insurer failed to take into account the nature of the injured workers incapacity, specifically his cardiac disease relying on the definition of incapacity from section 4 of the 1998 Act. The union notes that the insurer has failed to address a report by Dr Chamberlain, as it did not support their final decision. It was particular relevant to identifying the injured workers physical restrictions. The union then addressed the suitable employment options noting the lack of information regarding the physical tasks required for each role. As to the safety officer role, the union was able to locate a job description for the role and spoke to a safety officer who provided invaluable advice. The safety officer identified that the injured workers restrictions would prevent the injured worker from completing the tasks required of a safety officer. The union then identified all the procedural irregularities with the original decision.
Phone call from the insurer	The insurer telephoned the union acknowledging the procedural errors in the notice. The insurer confirmed that the decision was being withdrawn.

EXAMPLE L

This example highlights the importance of knowing the injured workers limitations, particularly with language and using the definition of suitable employment appropriately. In accordance with s 32A, the insurer was required to have regard to language barriers.

It also illustrates the necessity to do a thorough read through of all the material provided by the insurer. The throw away comments in the rehabilitation reports were the key to arguing that language was going to be a significant barrier.

Fair Notice phone call	Worker notified that due to changes to the workers compensation laws the injured worker was going to lose his weekly benefits.
Notice of an impending work capacity decision	Information from the phone call was reiterated in the fair notice letter
Notice of a work capacity decision	The decision relies on 9 documents to support its findings briefly addressing each in turn. The documents were provided with the decision. The insurer in its 7 page decision finds that the injured worker has capacity to work full time as: 1. Delivery driver 2. Sales assistant 3. Assembler The decision also notes that the content was explained to the member with the assistance of a Croatian interpreter but makes no further reference to possible language barrier.
	The injured workers wife contacts the union for assistance noting her husband's difficulties with English and the necessity for her to relay the information.
Application for internal review	The union assists the injured worker with completing the application form. The union goes through the process of dissecting the medical information and checking the documents against the decision. The union also considers all the monthly rehabilitation reports. The union argues that the insurer has failed to identify suitable employment options for the injured worker. The union notes that the insurer has failed to consider the progress report from a work trial undertaken by the injured worker where the employer explained language was a barrier to further employment. The union argues that s 32A requires the insurer to consider language when identifying suitable employment options and that language was definitely a factor for this injured worker. The union also argued that the reality of a particular role was more important than a theoretical assessment. The insurer assumed that the injured worker would have scope to negotiate the physical demands of a particular role, which the union noted was a fallacy. The union also identified a series of procedural errors with the decision

Internal Review decision	The internal review decision agreed that limited English skills were a significant barrier to employment for the injured worker. The internal review decision also agreed that there was insufficient information to support a finding that assembler was a suitable employment option. The internal reviewer observes, *"until such time as English Language skills are assessed and/or he completes his English Language course, I am unable to determine that there are options that would constitute suitable employment."*

EXAMPLE M

This example again highlights the need to read all the material thoroughly, take an analytical approach to the work capacity decision and making all arguments, merit and procedural, in the initial stage of the review process.

Fair Notice phone call	Worker notified that due to changes to the workers compensation laws the injured worker was going to lose his weekly benefits.
Notice of an impending work capacity decision	Information from the phone call was reiterated in the fair notice letter
Notice of a work capacity decision	This is the second decision in relation to this injured worker following a previous internal review decision that found the injured worker had no work capacity. The decision relies on 9 documents to support its findings briefly addressing each in turn. The documents were provided with the decision. The insurer in its 7 page decision finds that the injured worker has capacity to work full time as: 1. Delivery driver 2. Sales assistant 3. Car detailer The decision also notes that the content was explained to the member with the assistance of a Croatian interpreter but makes no further reference to possible language barrier. The decision does not mention whether an English language assessment has been completed a factor which was significant in the last attempt to make a work capacity decision
Application for internal review	Again all communication was through the injured worker's wife who relayed this to her husband in Croatian. The union's additional arguments totaled 11 pages. The union relied on the documentation provided to argue that the injured workers skills, education and experience provided barriers for suitable employment noting concerns raised in a vocational assessment which stated that the member had been assessed as having *"poor English reading and writing skills and very limited computer skills including a very slow typing speed."* The union noted that the insurer had asked for the nominated treating doctor's approval of the suitable employment options, however the doctor had not examined the injured worker for 18 months and was thus unaware of his current capacity. The union also noted the insurer's acceptance that the injured worker would easily be able to negotiate the physical demands of his chosen role despite the reality of a competitive job market and the injured workers language difficulties. The union also identified that the rehabilitation provider had expressed concern about the physical demands of a car detailer role and the necessity

	for the role to be part time not full time. The union again raised the English language difficulties. The union's final argument was that the injured worker had recently commenced employment and was working in excess of 15 hours per week meaning he had an entitlement to weekly benefits in accordance with s 38(3) of the Act. The union also argued procedural irregularities
Internal Review Decision	The internal review decision agreed that the original decision did not comply with the Guidelines and the original decision was withdrawn on that basis.

EXAMPLE N

This example demonstrates that the injured worker can be a valuable resource for determining the legitimacy of any documents relied up by the insurer to make a decision.

Fair Notice phone call	Worker notified that due to changes to the workers compensation laws the injured worker was going to lose his weekly benefits.
Notice of an impending work capacity decision	Information from the phone call was reiterated in the fair notice letter
Notice of a work capacity decision	The decision is three pages in length and does not address the documentation on which it relies. The insurer has decided that the injured workers has capacity to work full time earning $1485 per week as: 1. Sales Rep 2. Foreman 3. Admin assistant The decision does not address the requirements of s 38(3) nor does it explain why this decision was made and how it was reached.
Consultation with injured worker	The injured worker spends most of the conference explaining all the inaccuracies in the vocational report, which appears to form the basis of the decision. The union also explains the notice period requirements
Application for internal review	The union assists the injured worker to complete the application form. The union addresses the decisions failure to adhere to the Guidelines. The union makes submissions regarding s 54 and the requirement for notice. Much of the application addresses the vocational assessment report and its inaccuracies concluding that the report cannot be trusted and should have been disregarded prior to making the original decision.
Internal Review Decision	The internal review decision continues to rely on the flawed vocational assessment and does not address the inaccuracies identified by the union. The internal review decision states that the injured worker has capacity to earn in excess of the transitional rate and therefore the injured worker has no entitled to weekly benefits.
Application for merit review	The union assisted the injured working in filing an application for merit review. Since the arguments had been compiled during the internal review stage there was little more to do for this stage beyond filling out the correct form.
Merit Review Decision	The merit review service noted that many of the documents provided by the insurer are useful to understand the history of the claim but are not relevant to the injured workers current capacity.

	The merit review service considered that the injured worker had capacity to work as a plasterer due to the fact that the injured worker was performing that role in a restricted manner. The merit review service applied the transitional rate and the amount the injured workers is capable of earning exceeds to the transition rate meaning the injured worker has no entitlement to weekly benefits
Application for procedural review	The union assisted the injured worker complete the procedural review form. Prior to compiling the arguments the unions ran a second 'procedural checklist' to identify the irregularities which were outlined in the application. The union also addressed s 54 considerations and argued that the insurer had taken into account irrelevant documentation i.e. the flawed vocational assessment
WIRO Decision	The decision identified that the original decision was inconsistent with the guidelines and therefore invalid. The decision also referenced then recent amendments to the legislation allowing for a stay of the decision for existing recipients.

EXAMPLE O

This example illustrates the difficulties in determining whether a decision is a work capacity decision or a liability decision and when a work capacity decision ceases to have effect.

In this example there was a complex argument about the different sections of the legislation, which affected whether granted was funded. Due to the prohibition against paying for legal representation for a work capacity decision, the arguments had to take place on two separate fronts.

Given the complexity and the connection between the two interpretations it would have been more costs effective to allow legal representation on both fronts.

Fair Notice phone call	Worker notified that due to changes to the workers compensation laws the injured worker was going to lose his weekly benefits.
Notice of an impending work capacity decision	Information from the phone call was reiterated in the fair notice letter
Notice of work capacity decision	The insurer conducted an assessment and found that the injured worker had no current work capacity. The insurer also determined that the injured worker was entitled to the transitional rate being an existing recipient
Conference with injured worker	The injured worker was unsure about the meaning of the documentation and why he was going to be receiving less money. The union explained that due to changes in the legislation the insurer was required to make a decision and because he was receiving benefits when the laws changed the insurer was required to apply the transitional rate. The union explained that that was the maximum the injured worker could seek to achieve under the new legislation
Section 74 notice	The injured worker then received a notice purporting to deny liability. The notice also contained a finding as to whether the injured worker had capacity to work, which according to s 43 was a work capacity decision. The union referred the injured worker to solicitors for assistance who applied for an ILARS grant to dispute the liability decision. Partial funding was granted.
Application for internal review	The union assisted the injured worker with an application for internal review on the basis of the decisions regarding his capacity. The union argued that the decision was a work capacity decision disguised as a liability decision relying on s 43 of the Act. The union highlighted the insurers failure to adhere to the guidelines in making its decision The union also notices the failure to comply with the s 54 notice requirements
Internal review decision	The insurer denied that they had made a work capacity decision and would not be conducting an internal review.

	The union sought advice from the WIRO
Application for merit review	The union continued with the merit review application. Since much of the work had been done in the merit review stage the process was fairly simple. The union attached a cover letter outlining the conflict, noting the union's assessment that the insurer had made a work capacity decision and requesting a merit review of the decision.
	The Merit Review Service sought additional information from the insurer who advised they had refused to conduct an internal review relying on it being a decline of liability
Merit review Decision	The merit review service discussed whether there was jurisdiction to determine the matter in light of the differing views of the parties. The merit review service determined that it had jurisdiction to conduct a merit review for the period preceding the decline of liability. The merit review service decided that the injured worker had no work capacity for the period which was the subject of the review and the insurer was required to calculate what the injured worker should have been paid for that period and the injured worker was back paid for that period.
	The solicitors were then granted full funding for the purpose of disputing the entirety of the s 74 notice.

EXAMPLE P

This example is typical of a PIAWE decision. Whilst a PIAWE decision is a work capacity decision by virtues of s 43 of the Act, it is not held to the same standard as a regular work capacity decision.

The examples also highlights the fact that the injured worker has two options for a review and should be receiving proper advice as to the advantages of each option. The fact that two options exist is also something that a legal representative may need to remind the insurer.

Fair Notice phone call	There was no fair notice phone call for this decision
Notice of an impending work capacity decision	There was no notice of an impending work capacity decision
Notice of a work capacity decision	The decision is a PIAWE decision, which outlines the injured workers pre-injury average weekly earnings as determined by the insurer and the employer. The decision provides fact sheets but does not explain how the decision was made
Consultation with worker	The union explained to the worker that the decision is a work capacity decision and that we could pursue the regular avenues for review. The union also explains that there is a second avenue, which allows for the injured worker to get back pay if the decision increases benefits. The union also explains that there is a risk going forward that the insurer may reduce the weekly benefits as a result of the review. The injured worker opts for the second option. The union asks the injured worker to provide pay slips so that the union can calculate the injured workers PIAWE
Application to recalculate pre-injury average weekly earnings	The union assists the injured worker to complete the application. The union relies on s 42 of the Act and argues that certain allowances should be included in the calculation of PIAWE based on the union's interpretation of the legislation. The union addresses past decisions on the issue of productivity allowance and fares allowance. This particular application also argues that the relevant period means full weeks not partial weeks and only full weeks should be considered when calculating PIAWE. The union provides spreadsheets to show how the unions figure was reached

Internal Review Decision	The internal review decision notes section 44C to 44I without explaining what they are or how they operate. The internal review team discovered that overtime had not been included in the calculation of PIAWE but it would not include productivity or travel allowance. The decision resulted in a significant increase in the injured workers PIAWE.
Email to insurer	The union wrote to the insurer reminding the insurer that the injured worker had applied for an internal review under s 42 of the Act. The union argued that unlike an internal review under s 44, there was no restriction on the injured worker receiving back pay as a result of an increase in wages under a s 42 review. The insurer agreed to back pay for the period preceding the internal review decision

Appendix A

Description of Work Done	Time taken
Telephone call from injured worker advising they are going to cut off or reduce wages	5 mins
Advising has received a letter (NOI) that intended to make a WCD around [date]	5 mins
Asks worker to bring in all payslips, doctors certificates, work trial information, anything that might address the "further information" request.	5 mins
Sends to insurer any relevant material in response	15mins
Received call from injured worker advising a WCD has been done advises to bring WCD and all documents as soon as received	5 mins
Briefly meets with injured worker and asks them to sign Authority for Release of information directed to insurer. Reads WCD.	5-15mins
Sends Authority to Access All information to I and requests all material relied upon.	
explains the WCD, all documents, advises on the process of review and of dispute resolution and obtains the history from the worker of injury and employment and matters relevant to the WCD.	
Goes through the IR form with the worker and make sure the worker signs the form before the worker leaves conference. If the worker is from an NESB, the worker generally provides his or her own person to interpret. This can make the conference and explanation quite difficult and lengthy. The bundle of documents can be between 5 to 10cm thick and it is too difficult to review those documents in the presence of the worker.	1 hr + Depending on NESB and interpreter or other issues
Reviews all documents relied upon by insurer	
In absence of worker: Reads WCD & determine issues Complete the internal review form	½-1hr
Begins to work up the arguments and catalogues and additional material relied upon by the worker that the worker has made available themselves.	
Examine the WCD against 'procedural compliance checklist' and accumulate arguments. Checks procedural compliance (against checklist prepared from Guidelines and legislation) and notes nay procedural compliance issues (28-30 matters to consider for procedural compliance)	1/3-1/2 hour
Examine the WCD thoroughly and tease out salient points • Capacity determination • Suitable employment determination	1hr

• Earnings	
Examine the WCD to tease out the flaws on the merits and list for consideration during detailed examination of documents	½-1hr
Review the documents to see what information can be used in favour of the worker and accumulate notes and list references	3-5 hours minimum depending on volume of documents
Match material to rely upon to issues eg suitable employment criteria (age, education, skills, training, language). Look critically at s 32A(a) and (b).- Work up arguments and prepare annexure to IR form.	
Confer with worker in documents and discuss information that the worker can respond to. This can be done face-to-face (if an interpreter is required for example) or by telephone	1/2hr- 1 hr depending on NESB
Compile the addendum to the internal review form: • Address the PROCEDURAL defects • Address the MERITS ARGUMENT • Attach any additional documents Type and settle (average 7-12 pages)	2-3 hours minimum
Check final document	15mins- ½ hr
Send IR form to insurer	
Reads NIRD	½ hour
Explains NIRD to worker (note if interpreter takes longer)	½ hour
Potential outcomes: 1. "withdraw WCD" "issue new WCD (in time)" "confirm part or all of original WCD" If NIRD favourable to worker, advise worker that insurer has made a new WCD.	(> if NESB)
Prepare MR form	½ hour max (assuming IR is conducted as explained above)
Have worker sign M are form (by post) or by attendance	15mins
Prepare addendum to MR form by way of arguments. Usually they are the same arguments used in the IR except that you seek "Merit Review" and not "Internal Review".	½ hour
Lodge MR form	
Provide copy of MR form to insurer and WIRO and worker	
Letter requesting that worker provides up-to-date work capacity certificates for wage slips relevant to the issues	5mins
Conveys information required by MRS and asks that material be provided as soon as possible	2mins
Provides material as requested	2 mins
Reads MR Decision	30mins

Considers outcome and availability of WIRO review and judicial review explaining to the worker the purpose, potential outcomes, potential for adverse cost orders and time delay	15 mins
Explains MR Decision to worker and advises as to outcome—findings and recommendations. Take instructions if appropriate on Procedural review to WIRO	1hr-1 ½ hrs (depending on NESB)
Redo the procedural checklist on the original WCD (because WIRO can only procedurally review original decision) Check the arguments already provided in the IR. Make amendments to the arguments as necessary	1-2 hrs
Complete the WIRO Review Form. This form is different to the other 2 forms and requires different information	½ hr- 1 hr
Get worker in to sign the form. Explain that this is only a procedural review and can only get an outcome that ensures the decision was made in a proper way.	½ hr
Lodge form	
WIRO sends WIRO decision	
Read WIRO decision	
Explain WIRO decision to worker. If decision favours worker the original WCD is invalidated and backpay is payable.	
If WIRO review does not favour the worker the lawyer must explain to the worker.	1-2 hours (depending on NESB)