WorkCover independent review office

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

RECOMMENDATION FOLLOWING AN APPLICATION FOR REVIEW OF THE INSURER'S WORK CAPACITY DECISION PURSUANT TO SECTION 44(1)(c) OF THE *WORKERS COMPENSATION ACT* 1987*.*

SUMMARY:

a. The work capacity decision of the insurer dated 24 July 2013 is set aside.

b. The applicant is to be reinstated to his weekly payments at the rate applicable immediately prior to 1 November 2013.

c. The payments are to be back-dated to 1 November 2013.

d. The payments are to continue until such time as a further work capacity decision is made and comes into effect.

Introduction and Background

1. The applicant seeks procedural review of a work capacity decision made by the insurer dated 24 July 2013. This decision terminated the worker's weekly benefit effective from 1 November 2013. An internal review was conducted on 18 October 2013 and confirmed the original decision. The applicant sought merit review. Following receipt of the Merit Review Service (MRS) recommendation dated 18 June 2014, the applicant made an application to this office dated 26 June 2014.

2. I am satisfied that the applicant has made the application for review in the proper form and within time.

3. The applicant was injured on 7 April 1997. He was loading and unloading fruit and vegetables in the course of his employment as a store-person when he injured his lower back.

4. The applicant re-trained as a social worker and obtained a job with NSW Health. He continues to be employed by NSW Health although he is not currently working.

5. The applicant was in receipt of weekly payments immediately before 1 October 2012. Accordingly *Clause 8* of *Part 19H* of *Schedule 6* to the *Workers Compensation Act* 1987 (1987 Act) required the Insurer to conduct a work capacity assessment.

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6. *Section 44A* of the 1987 Act provides that a work capacity assessment must be conducted in accordance with the *WorkCover Work Capacity Guidelines* (Guidelines).

7. The relevant version of the *Guidelines* is the one dated 27 September 2012, which came into effect on 1 January 2013. Those *Guidelines* provide instructions and guidance to Insurers regarding the appropriate and consistent application of work capacity assessments and decisions.

8. Once the Insurer has conducted an assessment then the Insurer is required to make a work capacity decision. Where that decision involves a reduction in the weekly benefits payable to the injured worker then the Insurer is required to give proper notice to the worker (section 54(2)(a) of the 1987 Act).

Submissions by the applicant

9. The applicant made brief submissions which related to the merits of the insurer's decision as well as the extended period of time taken by the MRS to make its recommendation. A procedural review may not consider matters of merit by virtue of the specific wording in section 44(1)(c) which circumscribes procedural review as follows:

> *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*[1]

Submissions by the Insurer

10. The Insurer made no submissions.

CONSIDERATION

11. The decision states that a work capacity assessment was undertaken but not when it took place. The Insurer is required to make a *"work capacity decision in respect of an existing recipient of weekly payments as soon as practicable after the first work capacity assessment of the worker is conducted"*[2]. If the date of the assessment is omitted, it is

[1] See *Workers Compensation Act* 1987 section 44(1)(c)..
[2] Schedule 8, Clause 23 of the *Workers Compensation Regulation* 2010

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unclear to the applicant whether or not the decision was made "*as soon as practicable after the first work capacity assessment."*

12. *Guideline* 5.4.2 sets out the requirements of a written Work Capacity Decision Notice. Among the requirements listed, the insurer must "reference the relevant legislation."

13. The decision does not state that the assessment is required pursuant to *Clause 8 of Part 19H of Schedule 6* to the 1987 Act. As such the legislation has not been properly referenced as *Guideline* 5.4.2 requires.

14. *Guideline* 5.4.2 requires the Insurer "to 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." Section 59A(2) of the 1987 Act states that treatment expenses and related expenses are no longer payable 12 months after a worker ceases to be entitled to weekly payments of compensation. The decision states that "any entitlement you may have to payment of pre-approved reasonable and necessary medical and other expenses, until 1 November 2014, will not be affected." This phrasing does not disclose the effect of section 59A(2) on such entitlements beyond 1 November 2014.

15. Further, section 59A(3) of the 1987 Act states that the applicant may, after the entitlement to compensation for medical expenses ends, become eligible for further payments for medical expenses if the applicant becomes entitled to compensation for weekly benefits at some stage in the future and for such time as those weekly payments continue. This was not disclosed by the Insurer, which constitutes a further breach of the Guidelines.

16. Another defect arises at page 3 of the decision. There, the worker was advised that his entitlement to weekly payments at the current rate "must cease within 3 months of this decision – please refer to: section 43(1)(f) and 54(2)(a)" of the 1987 Act. This explanation is a complete misrepresentation of the purpose and effect of section 54 of the 1987 Act. The section provides workers with a period of time in which to adjust to the upcoming changes in weekly benefits. It is both misleading and incorrect to say section 54 mandates when "payments must cease." The section should be explained as creating a period of time during which payments *must not* cease. It is a minimum notice period, not a maximum payment period. Therefore, the insurer has not properly stated the impact of the decision on the worker's entitlement to weekly payments.

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FINDING

17. I find that the Insurer has failed to follow the procedures as set out in the WorkCover Guidelines which is required by section 44A of the 1987 Act. The Insurer has also failed to follow the 1987 Act and the *Workers Compensation Regulation* 2010 (the Regulation).

RECOMMENDATION

18. I recommend that the Insurer conduct a new work capacity assessment in accordance with the WorkCover Guidelines and make a new work capacity decision.

19. I recommend that the Insurer pay the applicant the weekly benefit to which he was entitled prior to 1 November 2013 until such time as he is properly transitioned. Those payments should continue from 1 November 2013 being the date on which they ceased.

20. These recommendations are binding on the insurer: see section 44(3)(h) of the 1987 Act. Since the applicant was not in receipt of weekly payments as at the date of this recommendation, clause 21 of schedule 8 to the *Regulation* cannot apply.

Wayne Cooper
Delegate of the WorkCover Independent Review Officer
19 August 2014