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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.

SUMMARY:

a. **The work capacity decision of the insurer dated 23 December 2013 is set aside.**

b. **The applicant is to be reinstated to his weekly payments at the rate applicable immediately prior to 31 March 2014.**

c. **The payments are to be back-dated to 31 March 2014.**

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 23 December 2013. This decision terminated the worker's weekly benefits effective from 31 March 2014. An internal review was conducted on 14 February 2014 and confirmed the original decision. The applicant sought merit review. Following receipt of the Merit Review Service (MRS) recommendation dated 28 May 2014, the applicant made an application to this office dated 1 July 2014.

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

3. The applicant injured his cervical spine in the course of his employment on 18 August 2009. After an unsuccessful attempt at pre-injury duties, he secured alternative employment and has been in receipt of weekly payments from the insurer.

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

6. The relevant version of the *Guidelines* came into effect on 11 October 2013. That publication stated that the *Guidelines* provide instructions and guidance to Insurers regarding the appropriate and consistent application of work capacity assessments and decisions.

7. Once the Insurer has conducted an assessment then the Insurer is required to make a work capacity decision[1]. Where that decision involves a reduction or cessation 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

8. The applicant made brief submissions which related to the merits of the insurer's decision. 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*[2]

Submissions by the Insurer

9. The Insurer made no submissions.

CONSIDERATION

10. Clause 5.3.2 of the *Guidelines* set out the twelve requirements of a written advice of a work capacity decision and its outcome.

11. *Guideline* 5.3.2 requires the insurer to *"reference the relevant legislation".* The insurer's decision does not state that the assessment was required pursuant to *Clause 8* of *Part 19H* of *Schedule 6* to the 1987 Act. This constitutes a breach of the Guideline.

[1] Schedule 8, Clause 22 of the *Workers Compensation Regulation* 2010
[2] See *Workers Compensation Act* 1987 section 44(1)(c)..

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12. *Guideline* 5.3.2 requires the insurer to "*explain the relevant entitlement periods*". The decision states that the applicant has received "*in excess of 130 weeks of weekly compensation to date*". The Insurer has attached an extract of Section 38 of the 1987 Act. It has not fully explained how compensation is claimed after the second entitlement period. Further, it did not explain with the cessation of weekly payments after 5 years in Section 39 of the 1987 Act that pursuant to clause 4 of Schedule 8 of the Regulation "no regard is to be had to any weekly payment of compensation paid or payable to the worker before 1 January 2013". Without that explanation the applicant could be left under the impression that his entitlement to weekly payments would be affected by the fact he received weekly payments prior to 1 January 2013.

13. *Guideline* 5.3.2 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." The insurer's advised the worker that the work capacity decision "*does not immediately affect your entitlements to medical and related treatment expenses*". At best, that phrase only explains the short term impact on the worker's entitlement to medical expenses. It does not completely state the impact of the decision on the worker's entitlements. The insurer did not explain Section 59A(2) of the 1987 Act, which 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. Advising the decision "*does not immediately affect your entitlements to medical and related treatment expenses*" fails to disclose the effect of section 59A(2) on such entitlements beyond 31 March 2015.

14. 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.

15. Guideline 5.3.2 requires the insurer to "*advise the date of the work capacity assessment*". The decision does not state that a work capacity assessment was ever made by the insurer. This is problematic for two reasons. First, *Clause 22* of *Schedule 8* of the 2010 Regulation states that the weekly payment amendments apply to the worker "*on the expiration of a period of 3 months after an insurer makes a work*

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capacity decision arising from the first work capacity assessment". It is not clear whether the decision arises from an assessment. Secondly, 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"[3]. If the date of the assessment is omitted, it is unclear to the applicant whether or not the decision was made "as soon as practicable after the first work capacity assessment."

FINDING

16. 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

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

18. I recommend that the Insurer pay the applicant the weekly benefit to which he was entitled prior to 31 March 2014 until such time as he is properly transitioned. Those payments should continue from 31 March 2014 being the date on which they ceased.

19. 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.

Jeffrey Gabriel
Delegate of the WorkCover Independent Review Officer
28 August 2014

[3] Clause 23 of Schedule 8 of the Regulation