WorkCover independent review office

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

SUMMARY:

a. The work capacity decision of the insurer dated 31 October 2013 is set aside.

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

c. The payments are to be back-dated to 31 January 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 31 October 2013. This decision terminated the worker's weekly benefits effective from 31 January 2014. An internal review was conducted on 19 December 2013. This review confirmed the original decision. The applicant sought merit review. Following receipt of the Merit Review Service (MRS) recommendation dated 13 August 2014 2014, the applicant made an application to this office dated 18 August 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 ankle in the course of his employment as a security guard on 24 October 2013. He twisted his ankle whilst chasing a patron at the bar where he was working. The applicant is currently working 20 hours per week for a different employer as a security guard and concierge.

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 four submissions alleging procedural defects in the insurer's decision. He submitted that the insurer had thrice failed to reference the relevant legislation. The applicant also submitted that the insurer had failed to advise the impact of the decision on his entitlement to medical and treatment expenses.

Submissions by the Insurer

9. The Insurer made no submissions.

CONSIDERATION

10. 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]

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

12. *Guideline* 5.3.2 requires the insurer to *"reference the relevant legislation".* The work capacity decision heading is as follows:

[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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"*Notification under section 54 of the Workers' Compensation Act 1987 to cease payment of workers compensation due to a work capacity decision*."

13. The applicant submits the work capacity decision is defective because the reference in the heading was "section 54" rather than "section 54(2)(a)." Since Section 54(2)(a) is contained within Section 54, I do not consider the wording of the heading breaches the *Guideline*.

14. The applicant submits the insurer did not make reference to Section 54(2)(a) of the 1987 Act nor Section 76(1)(a) of the *Interpretation Act* when explaining the three month notice period for terminating weekly payments.

15. The decision states correctly that notice of 3 months is required prior to reducing benefits as a result of a work capacity decision. The decision refers to Section 54 of the 1987 Act in that part. I do not consider its failure to reference a specific part of Section 54 to be a breach of the *Guideline*.

16. *Guideline* 6 states that for delivery of documents service is taken to have been received "in *the case of a postal address, on a day 4 days after the document is posted."* Section 76(1)(b) of the *Interpretation Act* 1987 states that service by post is "*taken to have been effected on the fourth* ***working*** *day after the letter was posted". Guideline* 6 is no doubt well meaning, but it is in conflict with Section 76(1)(b) of the *Interpretation Act* 1987.

17. The insurer's decision is dated 31 October 2013. The decision terminated the worker's weekly payments effective 31 January 2014, three months after the date of the decision. There is no reference to Section 76(1)(b) of the *Interpretation Act*. Further, the insurer failed to take into account any time it would take for the worker to receive the decision. This means the worker would have received less than three months' notice. This constitutes a breach of the *Guideline*[3].

18. The applicant submits the decision made "no reference to the entitlement period for medical expenses". *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 decision made

[3] The insurer did make reference to additional four days' notice in the internal review but erroneously concluded there was "no requirement for further notice."

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no reference at all to the applicant's entitlement to medical expenses. 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. The insurer attempted to remedy this in its internal review. This attempt to remedy cannot succeed. The only remedy is to issue a fresh decision[4].

19. 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.

20. The 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.

21. *Guideline* 5.3.2 requires the insurer to "*explain the relevant entitlement periods*". The decision does not fully explain how compensation is claimed after the second entitlement period[5]. 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.

FINDING

22. 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.

RECOMMENDATION

[4] See Guideline 7.8 of the *Guidelines for Work Capacity Decision Internal Reviews by Insurers and Merit Reviews by the Authority*
[5] Another issue the insurer belatedly attempted to remedy in its internal review.

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

24. I recommend that the Insurer pay the applicant the weekly benefit to which he was entitled prior to 31 January 2014 until such time as he is properly transitioned.

25. The applicant is not required to produce work capacity certificates for the period from 31 January 2014 to date by virtue of the operation of section 44B(2) of the 1987 Act.

26. These recommendations are binding on the insurer: see section 44(3)(h) of the 1987 Act.

Jeffrey Gabriel
Delegate of the WorkCover Independent Review Officer
30 September 2014