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 3 December 2013 is set aside.

b. The applicant is to be reinstated to his weekly payments at the rate applicable immediately prior to 11 March 2014.

c. The payments are to be back-dated to 11 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 3 December 2013. This decision reduced the worker's weekly benefits from $452.60 to $166.75 effective 11 March 2014. An internal review was conducted on 14 January 2014, which confirmed the original decision. The applicant sought merit review. Following receipt of the Merit Review Service (MRS) recommendation dated 31 July 2014, the applicant made an application to this office dated 21 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 back in the course of his employment on 5 May 2005. He ceased working for the employer and according to the MRS recommendation obtained alternative employment as a paralegal, where he has been working since November 2010.

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.

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).

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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 pursuant to Section 54(2)(a) of the 1987 Act.

Submissions by the applicant

8. The applicant submitted the insurer did not consider evidence provided by the worker, specifically the report of Dr Ahmed. The other submissions related to the merits of the insurer's decision.

9. A procedural review may not consider matters of merit nor review the decision of the MRS. 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

10. The Insurer submitted that the worker's submission on procedural grounds had already been addressed by the internal review, where it was reported that they were never provided with the report of Dr Ahmed.

CONSIDERATION

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 "outline the evidence considered in making the decision, noting the author, the date and any key information. All evidence considered should be referred to, regardless of whether or not it supports the decision." The applicant submitted the report of Dr Ahmed dated 18 October 2013 had not been considered.

[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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This report is not listed in the decision as a document "reviewed and considered" by the insurer. The insurer submits they were not provided with the report. The applicant has not demonstrated evidence to the contrary and I find no reason to dispute the insurer's position. An insurer does not breach the *Guideline* when it fails to consider a report it was never provided with. Therefore, I reject the applicant's submission.

13. *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.

14. *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." At page two of the decision, the insurer advised the applicant 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 misrepresents 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, as opposed to a maximum payment period. Therefore, the insurer has not properly stated the impact of the decision on the worker's entitlement to weekly payments.

15. *Guideline* 5.3.2 requires the insurer to "explain the relevant entitlement periods". The decision states that the applicant has received 432.8 weeks of weekly compensation and explained Section 38 of the 1987 Act. The insurer did not explain the operation of Section 39 of the 1987 Act (Cessation of weekly payments after 5 years) and the relevant transitional provision in Clause 4 of Schedule 8 of the Regulation, which states that when applying Section 39 "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

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16. I find that the Insurer has failed to follow the procedures as set out in the legislation and the WorkCover Guidelines. Therefore the work capacity decision is invalid.

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 11 March 2014 until such time as he is properly transitioned.

19. The applicant is not required to produce work capacity certificates for the period from 11 March 2014 to date by virtue of the operation of section 44B(2) of the 1987 Act.

20. 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
2 October 2014