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 26 November 2013 is set aside.**

b. **The applicant is to be reinstated to his weekly payments at the rate applicable immediately prior to 6 March 2014.**

c. **The payments are to be back-dated to 6 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 26 November 2013. This decision terminated the worker's weekly benefits effective from 6 March 2014. An internal review was conducted on 21 January 2014, which confirmed the original decision. The applicant sought merit review. Following receipt of the Merit Review Service (MRS) recommendation dated 14 August 2014, the applicant made an application to this office dated 1 September 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 lower back in the course of employment as a cleaner on 29 July 1996. He ceased working for the employer. According to the MRS, he obtained post injury employment as a waterside worker which ceased early in 2014. The applicant is currently working in his own business providing handyman and lawn mowing services.

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. 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 initial 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 made brief submissions which related to the merits of the insurer's decision and alleged inaccuracies in the MRS recommendation. A procedural review may not consider matters of merit nor review the decision of the MRS. Section 44(1)(c) 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 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 three of the decision, the insurer advised the applicant that his entitlement to weekly payments "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. While the insurer correctly explained Section 54(2)(a) in its internal review, an internal review does not replace the original work capacity decision. Thus the incurable defect remains. Therefore, the insurer has not properly stated the impact of the decision on the worker's entitlement to weekly payments[3].

13. In relation to the applicant's entitlement to medical expenses, the insurer advised the applicant that his entitlement to medical and treatment expenses "will cease on 6 March 2015." Whilst this is true it does not completely state the impact of the decision on the worker's entitlements. The insurer did not explain Section 59A(3) of the 1987 Act, which 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[4]. This was not disclosed by the Insurer, which constitutes another breach of the *Guideline*.

14. *Guideline* 5.3.2 requires the insurer to "explain the relevant entitlement periods". The decision states that the applicant has received 894.4 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

[3] Clause 7.8 of the *WorkCover Guidelines for Work Capacity Decision Internal Reviews by Insurers and Merit Reviews by the Authority*.
[4] This was another issue the insurer correctly explained, albeit too late, in the internal review.

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affected by the fact he received weekly payments prior to 1 January 2013.

FINDING

15. 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

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

17. I recommend that the Insurer pay the applicant the weekly benefit to which he was entitled prior to 6 March 2014 until such time as she is properly transitioned. Those payments should continue from 6 March 2014 being the date on which they ceased.

18. The applicant is not required to produce work capacity certificates for the period from 6 March 2014 to date by virtue of the operation of section 44B(2) of the 1987 Act.

19. 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
10 October 2014