WiRO
WorkCover independent review office

Level 4, 1 Oxford Street, 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 June 2014 is set aside.**

b. **The applicant is to be reinstated to his weekly payments at the rate applicable as at 30 September 2014.**

c. **The payments are to be back-dated to 30 September 2014.**

d. **Such 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 on 24 June 2014. The decision advised the applicant that his weekly payments of compensation would cease on 30 September 2014. The applicant sought internal review and the Internal Review Decision was dated 11 September 2014. He then sought Merit Review on or about 25 September 2014 and the Authority issued the Merit Review recommendation on 23 October 2014. The applicant made application to this office on 17 November 2014.

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

3. On 13 December 2012 the applicant suffered injury to his left shoulder in the course of his employment as a machine operator. At the time the work capacity decision was made the applicant was not working.

4. Section 44A of the 1987 Act provides that a work capacity assessment must be conducted in accordance with the *WorkCover Work Capacity Guidelines* (Guidelines). The relevant version of the Guidelines came into effect on 11 October 2013.

Submissions by the applicant

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5. Section 44(1)(c) of the 1987 Act states that this review is "*only of the insurer's procedures in making the work capacity decision and not of any judgment or discretion exercised by the insurer."* The applicant has made submissions which are not relevant to procedural review.

Submissions by the Insurer

6. The Insurer has not provided submissions in response to the application.

The Decision

7. Guideline 5.3.2 requires the insurer to reference the relevant legislation, state the decision and give brief reasons for making the decision, outline the evidence considered in making the decision noting the author, the date and any key information. Further, the insurer is to clearly explain the line of reasoning for the decision and state the impact of the decision on the applicant in terms of his entitlement to weekly payments, entitlement to medical and related treatment expenses and return to work obligations.

8. The insurer has informed the applicant that it has assessed him to have a capacity to earn on average $829.00 per week in suitable employment. Suitable employment has been determined to be hardware sales/customer service assistant.

9. The insurer advised the applicant that as he has received 82 weeks of weekly compensation his entitlements would be assessed under Section 37 of the 1987 Act. The applicant had been assessed as having an earning capacity and had not returned to suitable employment therefore his benefits would be calculated using the following method as described in Section 37(3):

> *"(average weekly earnings x 80%) – deemed Earning*
> *=($771x.80) - $829.00*
> *=$616.80 - $829.00*
> *= -$212.20 (hence nil WB entitlements)"*

10. The insurer has failed to explain *"average weekly earnings*" and why the figure of $771 has been used. The insurer has failed to refer to the relevant legislation (Sections 44C, 44D and 44E of the 1987 Act) and

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has not explained if the figure used was the applicant's pre-injury average weekly earnings and if so, it failed to provide particulars of the period of earnings used and the pre-injury hours worked by the applicant.

11. At page 2 of the decision in the paragraph titled *"Outcome"* the applicant is advised of the following:

> *"You will be entitled to weekly payments of compensation at the rate of $829.00* ***during the second entitlement period*** *pursuant to Section 37(3) of the 1987 Act.*
>
> *Your weekly payments of compensation will* ***cease*** *effective from 30 September 2014."*

12. These statements are confusing to the applicant. If the applicant were to receive weekly payments at the above rate ***during the second entitlement period*** then he would be receiving payments for a further 48 weeks, assuming that "during the second entitlement period" is understood to mean "for the duration of the second entitlement period." The second statement above advises the applicant that his payments will cease prior to that time. Earlier in the decision the applicant had already been informed that his weekly payments will be reduced to nil.

13. The insurer has failed to explain and reference the legislation in respect of the pre-injury average weekly earnings and has not *clearly* explained the effect of the work capacity decision. The insurer has failed to comply with the Guideline and this breach is sufficient to set aside the decision.

14. At page 7 of the decision the insurer has advised the applicant:

> *"Section 59A(2) of the 1987 Act states that you are entitled to claim treatment and service costs for up to 12 months after weekly payments have ceased. In order for [named insurer] to consider requests for reasonably necessary treatment and services during the period of 12 months after weekly payments have ceased, please continue to submit a current WorkCover certificates of capacity, which confirms your recommended treatment plan. Please note that should you become re-entitled to weekly payments of compensation after first having ceased to be entitled, under Section 59A(3) of the 1987 Act you should once again be entitled to reasonably necessary treatment and service costs during the period that weekly payments are payable."*

15. Section 59 A of the 1987 Act states:

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59A Limit on payment of compensation

(1) Compensation is not payable to an injured worker under this Division in respect of any treatment, service or assistance given or provided more than 12 months after a claim for compensation in respect of the injury was first made, unless weekly payments of compensation are or have been paid or payable to the worker.

(2) If weekly payments of compensation are or have been paid or payable to the worker, compensation is not payable under this Division in respect of any treatment, service or assistance given or provided more than 12 months after the worker ceased to be entitled to weekly payments of compensation.

(3) If a worker becomes entitled to weekly payments of compensation after ceasing to be entitled to compensation under this Division, the worker is once again entitled to compensation under this Division but only in respect of any treatment, service or assistance given or provided during a period in respect of which weekly payments are payable to the worker.

16. In a recent decision of the *Workers Compensation Commission*[1] the phrase *'12 months after the worker ceased to be entitled to weekly payments of compensation'* is interpreted in accordance with *Section 38(1)* in that the worker's entitlement to weekly compensation ceases at the end of the second entitlement period (130 weeks) unless the worker has a further entitlement under the exception in *Section 38(3).* This exception is not relevant to this case.

17. In this particular case the applicant has been in receipt of weekly payments of compensation for 82 weeks. Therefore, he has not exhausted his entitlement to weekly payments of compensation under Section 38(1). Until the worker does exhaust his entitlement to weekly payment of compensation Section 59A does not apply.

18. The insurer's explanation of Section 59A is incorrect. A more appropriate way for the insurer to have explained the impact the decision has upon the applicant's medical and treatment expenses would have been to inform him that his medical and treatment expenses cease 12 months after the cessation of his *"entitlement"* to weekly payments, rather than *"12 months after weekly payments have ceased."*

[1] *Christopher Vella v Penrith City Council* [2014] NSWWCC 363; see para 48-96

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19. This incorrect explanation by the Insurer is sufficient for the decision to be set aside.

FINDING

20. Under the legislation the Insurer can make an assessment of the applicant's work capacity and then a decision about that work capacity, but they must comply with the legislation, the Regulation and the Guidelines in order to produce a procedurally correct result. In the current instance there have been breaches of the Guidelines which are to be treated as delegated legislation. Accordingly the work capacity decision must be found to be invalid.

RECOMMENDATION

21. The work capacity decision of the Insurer dated 24 June 2014 is set aside.

22. The applicant is to be reinstated to his weekly payments at the rate applicable at 30 September 2014.

23. The payments are to be back-dated to 30 September 2014.

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

Tracey Emanuel
Delegate of the WorkCover Independent Review Officer
19 December 2014