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 44BB(1)(c) OF THE *WORKERS COMPENSATION ACT* 1987*.*

SUMMARY:

a. The application for procedural review is dismissed.

Introduction and background

1. The applicant seeks procedural review of a Work Capacity Decision made by the Insurer on 5 May 2016. The Decision informed the applicant that his weekly payments of compensation would cease on 14 August 2016. This decision was maintained following internal review.

2. The applicant sought Merit Review from the Authority by way of application received 27 June 2016. The Authority delivered its Findings and Recommendations dated 1 August 2016. The Authority made findings the applicant has is able to return to work in suitable employment, has current work capacity, and does not satisfy the special requirements in section 38(3)(2) because he does not work for at least 15 hours per week. Despite making these findings, the merit reviewer saw no reason to make a recommendation of any kind, thus rendering the status of the document issued "non-binding."[1]

3. An application was made to this Office for procedural review dated 7 September 2016 and was received via email on 8 September 2016. This presents a problem for the applicant, since the date of the application is some 37 days following the issuing of the merit review, and it was received after the passage of 38 days. Even allowing four days for receipt of that document, I cannot be satisfied that the application has been made within time.

[1] Section 44BB(3)(g) says that recommendations are binding on the Insurer, whereas there is no similar statement in section 44BB(3)(e) and (f) concerning the findings on which recommendations are based.

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4. It follows that the application must be dismissed.

5. In the event that I am wrong on this question, I will go through the steps of review to show the outcome which might have been reached in the course of a procedural review.

Submissions by the applicant

6. Section 44BB (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."*

7. The applicant makes the following submission:

"I am not of the opinion that every step was taken to have my case check out and i was never checked out after my 2014 operation to which I am over the 20% scale. I have had 4 back operation plus I believe that my back is still unstable and if I go to a job which have to sit and not do what I was trained to do over my many years in the computer industry to which I worked hard to do many different types of work. The report that was done by [name supplied] by [name supplied] I believe was done on the Sydney Market not Newcastle and I cannot find any work to fit my small type as on the report and companies don't want a person that can only work for 16 hours a week. As I have finished Workcover now and I still have a few years more working years but I still have pain while doing house work and work around the yard. The insurance companies info has many errors, one I know is the company I was working for was [W],[G] not [name supplied] plus other errors over the time I have been on Worker comp."

Submissions by the Insurer

8. The Insurer provided a useful summary of the history of the claim and sought to rebut the submissions on the merits.

9. Neither the applicant nor the insurer made submissions relevant to procedural review.

Decision

10. The Insurer advised the applicant that a work capacity assessment was completed on 27 April 2016.

11. The applicant was found fit to work for 16 hours per week. This accords with the certification from the applicant's own Nominated Treating Doctor

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[NTD]. The Insurer had a report from an IME saying that the applicant could perform 20 hours work per week, but that was disregarded in light of the opinion of the NTD.

12. The applicant was advised that he had received 420 weeks of payments, taking him past the second entitlement period. The entitlement periods were explained and the effect of section 38 was also set out and explained.

13. The applicant was advised that due to having more than 10% whole person impairment (but not more than 20%) he would continue to be able to receive medical treatment for a further five years after the cessation of his weekly payments. Section 59A(2) and (3) were clearly explained.

14. The medical evidence relied upon in the decision-making process was current and included work capacity certificates from the NTD.

15. The relevant notice period in section 54(2)(a) was given.

16. There appear to be no procedural errors committed by the Insurer in this case.

Finding

17. The Act requires a worker to apply for procedural review within 30 days of receipt of the merit review outcome. In the present case this clearly did not occur. In any event, the Insurer seems to have complied fully with the legislative requirements and with the guidelines and accordingly the application should be dismissed.

RECOMMENDATION

18. The application for procedural review is dismissed.

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Wayne Cooper
Delegate of the Workers Compensation
Independent Review Officer
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