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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.

b. Such weekly payments as the applicant is receiving by virtue of the stay under section 44BC(1) are to continue until receipt of this decision.

Introduction and background

1. On or about 20 October 2009 the applicant sustained injury to her neck in the course of her employment. Some eight months later in June 2010 she also reported lower back pain. At the time she was employed fulltime and as a result of her injuries she has changed jobs and now works between 15 and 25 hours per week for a different employer. Having been in receipt of weekly payments for partial incapacity immediately prior to 1 October 2012 the applicant is both an "existing recipient" and an "existing claimant" for all relevant purposes.

2. The applicant seeks procedural review of a work capacity decision made by the Insurer on 6 May 2016. The decision informed the applicant that her weekly payments of compensation would cease on 12 August 2016. The Insurer also took the opportunity to "decide" that it did not regard the applicant as a worker with "high needs."[1]

[1] The "high needs" element is not a "work capacity decision" within section 43(1). It is therefore not reviewable under section 44BB. Further, the issue of whether or not a worker has high needs is not a matter for the exercise of discretion, or even a "decision" as generally understood. While an insurer might be "satisfied" that a worker "is likely" to suffer more than 20% WPI in circumstances where there is no Medical Assessment Certificate because an Approved Medical Specialist (AMS) will not certify that a worker has reached maximum medical improvement, there is no warrant in the legislation for an insurer to determine that a worker is ***not*** a worker with high needs. Only an AMS has the power to make that determination (see section 65(3)). This prohibition against insurers purporting to make "high needs" decisions

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3. The applicant sought internal review and the Internal Review Decision, dated 24 June 2016, also resulted in a notice of termination of payments, however it did not merely maintain the earlier decision. Whereas the first decision was based on an application of the formula in section 38(7) which resulted in an "entitlement" of Nil per week, the internal reviewer was not satisfied that the applicant was working to maximum potential and decided that section 38(3)(c) was the appropriate section to invoke for the termination of payments. One benefit to the applicant was that the Insurer extended the notice period under section 54(2)(a) to expire on 30 September 2016.

4. The applicant applied to the Authority for Merit Review, received on 27 July 2016 and they delivered findings and recommendations dated 23 August 2016. The Authority made finding consistent with both decisions of the insurer, namely (i) that the applicant could work for 38 hours per week in suitable employment (rather than the 15 hours certified by her nominated treating doctor or the 25 hours she had actually been working prior to the first decision), and (ii) that the applicant does not satisfy the special provisions under Section 38(3)(c) of the *Workers Compensation Act* 1987 (1987 Act). For extra certainty the merit reviewer also purported to "find" that the applicant does not satisfy the definition of "a worker with high needs" in accordance with section 32A.[2]

5. The applicant then made an application to this Office, received on 27 September 2016. I am satisfied that the applicant has made the application for procedural review in the proper form and within time. It follows that the statutory stay of the original work capacity decision will be in place until receipt by the parties of this recommendation.

6. Section 44A of the 1987 Act provides that a work capacity assessment must be conducted in accordance with the *Work Capacity Guidelines* (Guidelines).

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applies *a fortiori* to the merit review service of the Authority. Neither the Insurer nor the Authority has any more power to "decide" that a worker does or does not have "high needs" in the absence of a MAC issued by an AMS than they have power to "decide" that a worker has received more than 130 weeks of payments in the absence of the worker having done so. Both are a question of fact, not discretion.

[2] See note 1 *supra*.

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Submissions by the applicant

7. 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."*

8. The applicant makes the following submissions:

   - The work capacity decision:
     - Fails to state when the assessment of the applicant's work capacity commenced and ended;
     - Provides the applicant with confusing information about the way entitlements have been calculated. In paragraph 4 Section 37(2) was quoted however at paragraph 7.2 it appears that the calculations were made in accordance with section 38; and
     - It is unclear whether the insurer asserts that [the applicant] falls within the second or after the second entitlement period.

9. Contrary to the first submission, the Insurer wrote to the applicant on 15 April 2016 confirming earlier telephone advice that they were in the process of conducting an assessment leading to a work capacity decision. The assessment was completed on 6 May 2016, as advised in paragraph 1 of the decision notice.

10. The applicant was advised in the course of the first decision that she had received payments for 317 weeks and in the internal review decision she was advised that she had received payments for 357 weeks. While both figures cannot be true, what cannot be in dispute is that the applicant has received far in excess of 130 weekly payments and is therefore in the period described as "after the second entitlement period."

11. It is true that section 37(2) is incorrectly referenced in paragraph 4. That is the only reference to the incorrect section and nothing seems to turn on it, since the ultimate decision was based on section 38, which was thoroughly set out and explained in great detail in both the original decision and the internal review. It is unlikely the applicant was in any real doubt about the bases on which the two decisions were made.

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Submissions by the Insurer

12. The Insurer has not made any submissions in response to this application.

The Decision

13. The relevant Guidelines are dated 4 October 2013 and came into effect on 11 October 2013.

14. Guideline 5.3.2 requires the Insurer to advise the applicant of the date of the work capacity assessment. The Insurer informed the applicant that a work capacity assessment was completed on 6 May 2016. She was advised of the work capacity decision by letter of the same date.

15. The same Guideline requires the Insurer to advise the date when the work capacity decision will take effect and state the impact the decision has on the worker in terms of her entitlement to weekly payments and medical and related treatment expenses.

16. In the work capacity decision letter to the applicant the Insurer advised that payments would cease on 12 August 2016. The notice period is correct.

17. The Insurer has referenced and explained Section 59A(2) and (3) of the 1987 Act. The Insurer has provided an adequate explanation of the legislation which was in place at the time the decision was made.

18. The Insurer is also required to inform the applicant of the relevant entitlement periods. The Insurer advised the applicant that she has received 317 weeks of compensation payments and her ongoing entitlements are subject to the special requirements contained in Section 38(3) of the 1987 Act.

19. The Insurer also informed the applicant that as she was in receipt of weekly payments immediately before 1 October 2012 she was considered to be an *existing recipient* and her pre-injury average weekly earnings were subject to the transitional provisions of Clause 8 Division 2 Pat 19H of Schedule 6 of the 1987 Act.

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20. It was noted by the Insurer that the applicant had returned to work for 25 hours per week in suitable duties and was earning $577.85 per week.

21. It was also noted that an independent doctor had assessed the applicant as capable of working for 38 hours per week. The insurer preferred the opinion of the independent doctor to the opinion of the applicant's doctor. This is within the discretion of the insurer and cannot be subject to procedural review.

22. The Insurer advised the applicant that she had complied with the special requirements set out in Section 38(3)(b) & (c) and as a result her ongoing entitlements were subject to Section 38(7). The Insurer explained the algorithm used to calculate the applicant's ongoing entitlement to weekly compensation. The calculation resulted in the applicant being entitled to compensation of $nil per week.

23. All of the above was correctly done in full compliance with the legislation and the Guidelines.

24. The internal reviewer came to the same conclusion on different grounds, but did so equally in compliance with the legislation and the Guidelines.

25. The decision of the insurer dated 6 May 2016 has displayed a careful consideration of the requirements of the Guidelines and legislation.

Finding

26. There are no procedural errors identifiable in the decision. The Insurer has complied with the Guidelines and relevant legislation.

RECOMMENDATION

27. The application for procedural review is dismissed.

28. Such weekly payments as the applicant is receiving by virtue of the stay under section 44BC(1) are to continue until receipt of this decision.

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Wayne Cooper
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Independent Review Officer
27 October 2015