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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.

Introduction and background

1. The applicant injured her lower-back and left-leg as a result of a slip and fall episode during her journey to work on 14 October 2013. After about one month off work, she returned to work on reduced hours (16 hours per week) and by early 2014 had increased to 30 hours per week. In March 2015 her employment was terminated. Currently the applicant remains off work, although she has been certified as fit to work variously between 12, 15 and 16 hours per week. The Insurer accepted liability and made weekly payments for all relevant periods.

2. The applicant seeks procedural review of a Work Capacity Decision made by the Insurer on 20 June 2016. The Decision informed the applicant that her weekly payments of compensation would cease on 27 September 2016 because she does not meet all the requirements of section 38(3). This decision was maintained following internal review. While the decision has identical effect, it is on different grounds. In the original decision the Insurer found that the applicant could work for 16 hours per week, whereas by the time of the internal review she was certified as only capable of 12 hours per week. This is a distinction making no difference to a worker in the "post 130-week" entitlement period, since it is a requirement of section 38(3)(b) that a worker be engaged in employment for "at least 15 hours per week," and this applicant does not currently work at all.

3. The applicant sought Merit Review from the Authority by way of application received 21 September 2016. The Authority delivered its Findings and Recommendations dated 18 October 2016. The Authority

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made findings that the applicant: (i) is able to return to work in suitable employment; (ii) has current work capacity, and (iii) does not satisfy the special requirements in section 38(3) because she does not work up to her current capacity or 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]

4. An application was made to this Office for procedural review received via email on 21 October 2016. I am satisfied that the application was made within time and in the correct form.

Submissions by the applicant

5. 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."*

6. The applicant makes the submission that the Insurer made a "fundamentally flawed" decision in the course of internal review, since it appears that an assumption was made that employment available for 16 hours per week (as found in the original decision) would also be available for 12 hours per week, whereas the evidence available at the time did not actually address this question. Interesting though this submission might otherwise be, it is of academic interest only in the present circumstances, since it cannot assist a worker to be certified as fit for only 12 hours per week when the Act requires the worker to be actually performing work for at least 15 hours per week in order to receive weekly payments of compensation.

7. The remainder of the submissions go to the merits of the decision. Procedural review does not exist for the purpose of re-running merit review. I can only conduct a procedural review of the work capacity decision made by the Insurer.

Submissions by the Insurer

[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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8. The Insurer noted that both the original decision and the internal review decision took account of current medical evidence, with the finding of 16 hours changed to 12 hours in the later decision in accordance with the applicant's certification. The Insurer also noted that, *contra* the submissions by the applicant, a Vocational Assessment report dated 29 February 2016 had referred to employment being available in an identified suitable role for 12 hours per week. They also noted that in the course of Internal Review they referred to Data Entry roles which are available for 12 hours per week. Finally the Insurer noted that the applicant has subsequently upgraded in capacity to 15 hours per week.

Decision

9. The Insurer advised the applicant that the work capacity assessment was completed on 20 June 2016, the same day as the decison.

10. The applicant was advised that she had been found fit to work for 16 hours per week.

11. The applicant was advised that she had received 138 weeks of payments [as at 16 June 2016]. This clearly places the applicant in the period following the second entitlement period, which ends after 130 weeks. The entitlement periods were explained and the effect of section 38 was also set out and explained.

12. The applicant was advised that the due to having whole person impairment assessed at between 11%-20% she would continue to be able to receive medical treatment for a further five years after the cessation of weekly payments. Section 59A(2) and (3) were clearly explained.

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

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

15. Relying on reports from external providers the Insurer found that the applicant could work as a Data Entry Operator, Switchboard Operator or and Administrative Assistant for 16 hours per week.

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16. The merit reviewer also found that the applicant could perform the work outlined in paragraph 15 supra.

17. Due to the subjective nature of the test set out in section 38(3)(c), which is not really a "test" so much as an accretion to the rule in section 38(3)(b), only an Insurer can determine whether or not a worker is complaint with the sub-section. Since compliance with section 38(3)(b) is a pre-condition to a consideration of the matters raised in section 38(3)(c), the question does not arise in this case. For this reason the commentary by the merit reviewer at paragraphs 96-97 might be disregarded.

18. Given that the applicant does not currently work and she is in the post-130 weeks period, it is clear that she does not meet the criteria set out in section 38(3)(c) to qualify for ongoing weekly payments.

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

Finding

20. The Insurer has complied fully with the legislative requirements and with the guidelines and accordingly the application should be dismissed.

RECOMMENDATION

21. The application for procedural review is dismissed.

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Independent Review Officer

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