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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 is dismissed.**

Introduction and background

1. The applicant suffered a slip and fall injury in the course of her employment as a Store Manager on 14 May 2009. She returned to work, but was eventually terminated in January 2012. With the exception of a subsequent period of employment, now ended, she continued to receive weekly payments of compensation until the Insurer made a work capacity decision on 31 May 2016 and advised the applicant that her weekly payments would cease on 9 September 2016.

2. The applicant sought internal review and the insurer upheld the original decision.

3. An application for merit review was received by the Authority on 5 September 2016 and the Authority issued findings and recommendations on 29 September 2016. The Authority found that the applicant: (i) has current work capacity; (ii) has a present inability to perform her pre-injury work; (iii) is able to return to work is suitable employment as an "Appointment Setter"; (iv) is in the post second entitlement period (after 130 weeks of payments); and (v) does not meet the special circumstances set out in section 38(3) to justify ongoing weekly payments.

4. Having made such findings the Authority did not make a recommendation to the Insurer.

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5. The applicant sought procedural review of the Insurer's work capacity decision by application received by this Office on 27 October 2016.

6. 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 Guidelines are dated 8 October 2013.

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 submissions made by the applicant were in these terms:

   - I believe the decision by the Insurer to cease my weekly comp payments is incorrect.
   - I believe this decision was made without the Insurer being in possession of all relevant material.

9. The correctness of the decision is a matter for the Authority to deal with in the course of merit review. This Office cannot revisit issues already decided by the proper person. No attempt was made by the applicant to identify or refer this Office to the "relevant material" allegedly not considered by the insurer.

10. It is possible that when using the expression "relevant material" the applicant is making oblique reference to subsequent medical evidence from her Nominated Treating Doctor [NTD]. If so, it makes no impact on the procedural validity of the original decision, which such evidence pre-dates. At the time of the Insurer's decision, the NTD certified the applicant as capable of working for 18 hours per week in suitable employment. At the same time the Insurer had a report from an Independent Medical Expert stating that the applicant could work fulltime in her pre-injury employment "without restriction of activity or hours." Despite this, the Insurer accepted the opinion of the applicant's own doctor.

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Submissions by the Insurer

11. The Insurer provided a comprehensive history of the decision-making process. In relation to the application for procedural review the insurer said that the submissions made by the applicant have been addressed in the course of merit review. Perhaps surprisingly they tacked the following sentence on to the end of their submissions:

    - [The Insurer] notes [the applicant's] comments and notes that a new work capacity decision has been made taking into account the new evidence.

12. Because this Office has no power to review a decision which has not gone through the section 44BB process, including merit review, the current review concerns only the decision made on 31 May 2016. I can have no regard to any subsequent decision by the Insurer.

The Decision

13. Guideline 5.2 requires the insurer to give the worker fair notice of at least two weeks duration that an adverse work capacity decision may be forthcoming. The applicant was told by telephone on 21 March 2016 that an assessment leading to a decision was underway. This was confirmed in a letter of the same date.

14. In the notice dated 31 May 2016, the Insurer set out the relevant legislative provisions with an explanation of how they affected the decision-making process. The applicant was taken through sections 38, 54(2)(a), 60, and 59A(1)-(3). The various reports relied upon in making the decision were then set out, followed by an explanation of section 43(1)(a), (b) and (c). The definitions of "current work capacity" and "suitable employment" were fully set out. The method for calculating ongoing entitlements was correctly and fully explained.

15. The calculation of the applicant's ability to earn was done according to the procedures set out in the legislation.

16. The various entitlement periods were set out, with a clear explanation of why the applicant is now within the period following the "second entitlement period," which ends at 130 weeks.

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17. Proper notice was given under section 54(2)(a).

18. I can identify no errors of a procedural nature in this work capacity decision.

Finding

19. The work capacity decision was validly made.

RECOMMENDATION

20. The application is dismissed.

Wayne Cooper
Delegate of the Workers Compensation
Independent Review Officer
29 November 2016