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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 injury in circumstances set out in WIRO recommendation 17815 (#178 of 2015), which do not require repeating here. The applicant is an "existing recipient" for all relevant purposes.

2. The applicant now seeks procedural review of a work capacity decision made by the Insurer on 6 July 2016. The decision informed the applicant that his weekly payments of compensation would cease on 12 October 2015. This decision was made on the basis that his ability to earn in suitable employment is assessed at an amount which exceeds the transitional rate payable to an existing recipient. Under the formula in section 38(7) there can be no ongoing entitlement.

3. The evidence for this assessment is reasonably strong, it being the actual amount the self-insured employer continues to pay him in his current job, a job in which he has worked continuously for in excess of ten years. Since this weekly amount exceeds the transitional rate by more than $100 per week, any basis for argument might be accurately described as remote.

4. The applicant sought internal review and by letter dated 21 September 2016 was advised that the original decision to cease weekly payments was affirmed.

5. The applicant then applied to the Authority for Merit Review, received on 19 October 2016 and they delivered findings and recommendations dated 11 November 2016. The Authority made findings that the

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applicant: (i) is able to, and has, returned to work in suitable employment; (ii) has current work capacity; (iii) is able to earn $1,120.59 per week in suitable employment; (iv) has a statutory PIAWE equal to the transitional rate of $1,014.40 per week; and (v) has an ongoing entitlement of $0.00 by virtue of section 38(7).

6. An application for procedural review was received in this Office on 9 December 2016. I am satisfied that the application was made within time and in the correct form.

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

Submissions by the applicant

8. 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."*

9. The applicant made several submissions (8), which are accurately reproduced below in the submissions from the Insurer. It is convenient to display the two sets of submissions together, with the latter answering the former.

Submissions by the Insurer

10. The Insurer faithfully reproduced the applicant's 8 numbered submissions and replied beneath each, separately. I have **highlighted** the submissions by the applicant. The bullet-points are the replies by the Insurer.

    1. **Please review the work capacity decision form, as I question the relevance of information and or lack of information used.**

        - You will note that many of [the applicant's] initial concerns were regarding the PIAWE/transitional amount, lack of consideration of lost overtime, lack of consideration of lost job mobility, etc. These issues were discussed with [the applicant] and the requirements and effects of the

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legislation explained. However, [the applicant] was hesitant to accept our explanation of these issues and in this regard we draw attention to [the applicant's] requests for Internal and Merit reviews and the wordings thereof (continued reference to irrelevant issues and our explanation of their central relevance).

2. WorkCover medical certificates do not mention all permanent restrictions.

- This is a surprising submission by [the applicant]. All previous discussions had affirmed his continued ability to function in the suitable employment without hindrance. Since the 2005 settlement of his permanent impairment, no medical evidence has been submitted to indicate other injuries or permanent impairment(s). Eight years of medical monitoring up to May 2013 did not reveal any such impairments. Despite repeated request for [the applicant] to produce all relevant medical evidence, he has not previously mentioned or produced such evidence. Our records continue to show that he has not sought approval for medical treatment since May 2013.

- In brief, [the applicant] has never provided any detail of such an impairment, he has never previously complained of such an impairment and he has never provided any medical evidence even indicating the existence of such an impairment. On the contrary, as conceded by him in the documentation (and to the two Merit reviewers), he continues to functionally perform his suitable employment and they are well within his limits/restrictions.

3. I have not received a certificate of capacity.

- [The applicant] was temporarily placed in his suitable role in 2006 and permanently redeployed in January 2007. The workplace assessments, return to work plans and doctors' sign off have all been served. The previous WorkCover Medical Certificates have also been served. The pay records have been served.

- It is not contested by [the applicant] that he is capable of performing his suitable employment and that he has done so for 10 years. He confirmed this to the self-insurer and to

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the two Merit reviewers. Therefore, I do not see the procedural relevance of this.

4. **I have never been offered a vocational/earnings assessment.**

    - The assessment of suitable employment has already been reviewed by Merit Review Service, twice. [The applicant] conceded that the current employment is indeed suitable.

    - [The applicant's] assessment relies on the suitable employment for the last 10 years and his current weekly earnings in that role (which document was served and Reviewed).

5. **I have never had a function assessment. The work capacity makes no mention about physical demands of job.**

    - That assessment took place at the time of redeployment and was served and twice Reviewed. Moreover, as previously noted, [the applicant] concedes that the employment is suitable and that he is able to perform the role without significant of further injury. I submit there is no relevance to this objection and that no evidence has been submitted by [the applicant] in this regard, to make the need for further assessment relevant.

6. **No return to work plan or updates.**

    - The signed Return to work plans were served. The treating doctor issued a Final medical certificate and yet continued to monitor [the applicant's] progress until 2013, when [the applicant] himself ceased attending for reviews.
    - [The applicant] has not submitted any material that would indicate the need for a review of those plans and on the contrary, affirms the suitability of the work and his continued ability to perform it.

7. **No injury management program.**

    - After many years of monitoring, injury management ceased. So in many ways, my answer is as in 6 above.

8. **In summary, I believe that the report does not contain enough information about the role for the insurer (named), to determine whether it is consistent with my restrictions**

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identified on my certificate of capacity, which I currently do not have.

- I respectfully disagree and submit there is no procedural error or deficiency highlighted here by [the applicant]. Moreover, he has not presented any evidence of such an error or in support of such an error.

11. One surprising element of all the above is the peculiar perspective of the applicant, who is apparently unaware that the onus lies with him to produce certificates of capacity, not the insurer. If submissions #2 and/or #3 had any relevance at all, the fault would lie with the applicant and his doctor. I accept the explanations of the Insurer in relation to the alleged paucity of "return to work" and "injury management" plans, since the applicant has clearly been able to work in his current job for over a decade. Exactly how the existence of a current set of "plans" or "programs" would result in a better outcome for the worker is not known.

12. The submissions of the applicant tend towards the merits of the case and the conduct of his claim by the Insurer generally, rather than to the procedures adopted by the insurer in making the work capacity decision. To that extent they are irrelevant for present purposes.

The Decision

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

14. Guideline 5.2 requires an Insurer to give "fair notice" of at least two weeks to a worker that an adverse work capacity decision might be imminent. The Insurer wrote to the applicant on 8 June 2016 foreshadowing a future a decision and soliciting any information from the applicant which he might wish to have considered in the decision-making process. This complies with the Guidelines.

15. The applicant was told that an assessment of his claim was completed on 5 July 2016 and a decision was made on 6 July 2016.

16. Guideline 5.3.2 requires the Insurer to advise the applicant of the date that the decision takes effect. In accordance with Section 54(2)(a) of the 1987 Act the Insurer must provide the applicant with 3 months notice

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when the decision results in reduction or termination of the applicant's weekly payments. The effect of Section 76(1)(b) of the Interpretation Act 1987 allows for an additional four business days to be added to the notice period. These notice period requirements are correctly stated by insurer.

17. In accordance with Guideline 5.3.2 the Insurer has informed the applicant that he has received 244 weeks of compensation payments. As a result his ongoing entitlements are subject to Section 38 of the 1987 Act. Since he currently works for more than 15 hours per week and earns well in excess of $1,000 per week, he easily meets the "special requirements" within section 38(3)(b). However, when the formula in section 38(7) is applied, the applicant exceeds his PIAWE (the statutory "transitional rate") and has no eligibility for continuing payments.

18. The applicant was taken through section 43(1) by the Insurer on page 2 of the decision. The findings and outcomes of the decision were also set out on that page. This complies with Guideline 5.3.2.

19. Under a series of headings, the Insurer set out and had explained to the applicant al of the following:

- Legislative amendments
- Existing recipient
- Existing claim
- Transitional amount
- Reasons for this decision
- Current work capacity
- Current return to work status
- Relevant medical information
- PIAWE
- Impact of this decision
- Entitlement period
- Special requirements for continuation of payments after 130 weeks
- Notice period
- Medical and related expenses (section 59A(1)-(3))
- Evidence considered in making the decision

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- The review process

20. The decision was very thorough and comprehensive, perhaps at least in part, in reaction to an earlier decision being overturned by this Office for procedural error. There were no such errors on this occasion.

Finding

21. The work capacity decision of the Insurer dated 6 July 2016 complies with the legislation and the Guidelines and was validly made.

RECOMMENDATION

22. The application is dismissed.

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Wayne Cooper
Delegate of the Workers Compensation
Independent Review Officer
21 December 2016