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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 seeks procedural review of a Work Capacity Decision made by the Insurer on 2 September 2016. This decision was made after a sequence of events set out in WIRO recommendation 7116 (# 71 of 2016), which require no repetition.

2. The applicant was advised that her weekly payments would cease on 9 December 2016 as a result of having a current ability to earn $919.16 per week, in circumstances where she was entitled to compensation assessed under the formula in section 37(3) by virtue of having received 54 weeks of payments and not having returned to work for 15 hours per week. 80% of the applicant's PIAWE of $982.00 = $785.60. Given that this is $133.56 less than her current ability to earn, her entitlement is calculated to be zero.

3. The applicant sought internal review, which reached the same conclusion.

4. The applicant then sought Merit Review from the Authority by way of application received 4 December 2016. The Authority delivered its Findings and Recommendations dated 13 January 2016. The Authority made findings that the applicant: (i) is able to return to work in suitable employment as an Administration Assistant; (ii) has current work capacity; and (iii) is able to earn $860.03 per week in such suitable employment. Despite making a different finding to the Insurer in relation to the amount the applicant is able to earn, the difference is inconsequential because in both cases the formula in section 37(3) results in no entitlement to weekly payments for the applicant. Oddly, the

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Merit Reviewer saw no need to make a "recommendation" to the Insurer concerning the amount the applicant is able to earn, despite coming to a slightly different decision.

5. The applicant then applied to this office for procedural review by way of application dated 16 January 2017. I am satisfied that the application has been made within time and in the proper form.

Submissions of the parties

6. The applicant made extensive submissions, which prompted unusually lengthy submissions in reply from the Insurer. I do not propose to address them other than in summary form.

Applicant's Submissions

7. The applicant makes a series of submissions about the conduct of the insurer which have nothing to do with the decision-making process. For instance, something is sought to be made of the Insurer making an appointment for the applicant to see an injury management consultant [IMC] within two days of seeking an opinion from the applicant's own nominated treating doctor [NTD]. The report of the IMC was shown to the NTD, who concurred with the conclusions in the report about the applicant's suitability for certain types of work, as well as agreeing with the account of the conversation between himself and the IMC. Thus, it may be a rare instance of a worker complaining that an Insurer had too much information prior to making a decision.

8. The applicant avers that the Insurer failed to fully explain the effect of the stay in section 44C. Quoting verbatim:

> "*It only states that if the request for a review of a Work Capacity Decision is made within 30 days a stay applies. That does not fully explain all provisions relating to a stay, specially with the lodgement of the application for Merit Review and also the lodgement of an Application for Procedural Review with WIRO and how the stay fully applies.*"

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Of course the applicant knows all this because she has previously gone through the entire section 44B review process and had the stay explained to her at that time. The insurer is under no obligation to tell the applicant things they know that she already knows. Further, it is obvious from the words quoted above that the applicant needs no more explanation, since her own words show that she is familiar with all the ramifications of the stay provisions, despite the alleged shortcomings of the insurer's explanation.

9. The applicant makes extensive submissions about the reports of a vocational assessor, which submissions are undermined in total by the concurrence with the reports by the applicant's NTD. Even if every word of complaint were to be accepted, the simple fact is that the applicant's doctor agrees that she can do the very work identified by the vocational assessor. The applicant makes no similar complaint about her NTD.

10. The applicant alleges that the Insurer has not complied with "Guideline 5.3.2." This is an error, since the decision was made on 2 September 2016 and the version of the Guidelines containing guideline 5.3.2 was repealed on and from 1 August 2016.

11. The applicant also seeks to take issue with the Merit Review. This Office has no power to review findings and recommendations issued by the Authority, therefore all such submissions are irrelevant.

12. Finally the applicant regards it as unfair that she cannot have recourse to legal advice, which she cannot afford to pay for. This submission has no relevance for present purposes.

13. The applicant further submissions, largely doing no more than seeking to underline what had been previously put. Accordingly they have the same problems as those described *supra*.

Insurer's submissions

14. The Insurer responded to the submissions by the applicant and made no further substantive submissions. I accept the submissions of the Insurer, where relevant.

The Decision

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15. The Insurer gave the applicant fair notice of the assessment and decision making process on 7 July 2016, more than 6 weeks before the decision was made.

16. The applicant was advised that the assessment process commenced on 7 July 2016 and ceased on 2 September 2016.

17. The Insurer took the applicant through sections 43(1)(a), (b), (c), (d) and (f).

18. Reasons for the decision were given, including an explanation of the vocational assessment reports and medical evidence.

19. The process of obtaining medical evidence was set out, including an explanation of the relationship between the NTD and the IMC. The Insurer clearly explained that the NTD was asked for a response to the IMC report, and that the response was provided to the Insurer on 13 May 2016. The response of the NTD was to the effect that the applicant could perform the three roles identified by the vocational assessor and the IMC.

20. The Insurer advised that they considered evidence provided by the applicant herself on 28 July 2016 (in the fair notice period) including medical evidence from the NTD and a report from a psychologist. The medical evidence used by the Insurer in the decision-making process was certainly current.

21. The Insurer explained the various entitlement periods and noted that the applicant had received 54.8 weeks of payments, placing her in the second entitlement period, which is covered by section 37. The relevant provisions were set out and explained.

22. Section 59A was explained in full and the applicant was advised that she would be entitled to pre-approved medical expenses until 9 December 2018, on the basis that there is no current Medical Assessment Certificate issued by an Approved Medical Specialist with an assessment in excess of 10% whole person impairment.

23. The period of notice given conforms with section 54(2)(a).

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Finding

24. There are no procedural errors and the decision was validly made.

RECOMMENDATION

25. The application is dismissed.

Wayne Cooper
Delegate of the Workers Compensation
Independent Review Officer
21 February 2017