Level 4, 1 Oxford Street, Darlinghurst NSW 2010
T: 13 9476
contact@wiro.nsw.gov.au
www.wiro.nsw.gov.au

# 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 suffered injury to his lumbar spine, left leg and left shoulder in the course of his employment as a Delivery Driver on 13 January 1999. More correctly, the injury to the left leg was to the "left leg at or above the knee" as that injury was described legislatively at the date of injury. The need for such close parsing of the injury arises because there were also symptoms in the left ankle, but as a result of legislative amendment in 1994 compensation payable for the injury "at or above the knee" is said to "include" compensation for injury below the knee. A similar qualification might be appropriate for the left shoulder injury, since there were also wrist symptoms.

2. The applicant's employment continued for 8 years, but on 25 January 2007 his employment ceased and he has not worked in paid employment since that date. The insurer accepted liability for all relevant periods. The applicant was therefore an existing recipient of weekly payments immediately prior to 1 October 2012.

3. The applicant now seeks procedural review of a Work Capacity Decision made by the Insurer on 28 September 2016. The Decision informed the applicant that his weekly payments of compensation would cease, effective from 6 January 2017. For the sake of clarity the Insurer specified that the last day of payment would be for 5 January 2017, with nil thereafter.

4. The Insurer determined that the applicant had the ability to work for 25 hours per week. Since the applicant had received more than 130 weeks of payments and did not currently work, he did not comply with the requirements of section 38(3)(b) (those requirements being that he work for at least 15 hours per week and earn at least $183 per week) and as a result his payments could not continue.

5. The applicant sought internal review and the Internal Review Decision was dated 16 November 2016. The Internal Review Decision confirmed the original Work Capacity Decision.

6. The applicant sought Merit Review from the Authority on 9 December 2016. A complication at the time was that he had yet to receive the outcome from internal review. The Internal Review decision was resent and the applicant received it on 22 December 2016. A new application was then made to the Authority on 4 January 2017. The Authority delivered its Findings and Recommendations dated 20 January 2017. The Authority made findings that the applicant: (i) has a present inability to perform his pre-injury employment; (ii) is able to return to work in suitable employment; (iii) has current work capacity; and (iv) does not satisfy the special requirements under section 38(3) for the continuation of weekly payments.

7. The applicant made an application to this office for procedural review received on 17 February 2017. I am satisfied that the application has been made within time and in the proper form.

8. Section 44A of the 1987 Act provides that a work capacity assessment must be conducted in accordance with the Guidelines. The relevant Guidelines came into effect on 1 August 2016.

**Submissions by the applicant**

9. 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."*

10. The applicant made the general submission that the Insurer made the work capacity decision "without an assessment of percentage whole person

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impairment (WPI).” Restated later, the applicant says that “[t]he work capacity decision from the Insurer assumes that I did not qualify [as a worker with ‘high needs’], without there being a recent report on this issue.”

11. The submission by the worker is misconceived, since it assumes an obligation on the part of the Insurer to prove his case, whereas the onus lies the other way around. In addition, it assumes that the Insurer is unable to make a work capacity decision unless there is supporting evidence that the applicant does not have high needs.

12. This argument was settled by the Supreme Court decision of *Hallman v The National Mutual Life Association of Australia Ltd* [2017] NSWSC 151, in which Wilson, J made the following remarks in a case dealing with the former wording of the Act which required a 30% threshold for a determination that a worker was “seriously injured”:

> 40. The plaintiff asserts that, to make a determination that a worker is not a seriously injured worker, the insurer must be positively satisfied that the worker’s whole person impairment is not more than 30%. This, however, inverts the language of the provision. What is required is a state of satisfaction that the degree of permanent impairment is likely to be more than 30%.
>
> 41. The insurer is entitled, and in specific instances required, to conduct a work capacity assessment unless “satisfied” that the level of impairment “is likely to be more than 30%.”
>
> ……………………………
>
> 43. It is not necessary for the decision maker to reach a state of satisfaction about the worker’s level of impairment as a prerequisite to the conduct of a work capacity assessment.

13. It is beyond dispute that the upshot of her Honour’s commentary is a requirement in the legislation for the worker to prove to the satisfaction of the insurer that he/she is a worker with high needs. If there is no such proof, it is up to the worker to seek and obtain evidence to convince the Insurer.

14. In this case the applicant has previously settled claims for lump sum compensation under section 66. Most recently he had a Medical Assessment Certificate issued by an Approved Medical Specialist in November 2009. Because his date of injury was before 1 January 2002, his injuries have never been subject to a formal assessment of WPI. Due to his status as an existing recipient of weekly benefits immediately

prior to 1 October 2012, the applicant may benefit from a recent amendment to the *Workers Compensation Regulation* 2016, which inserted Clause 28D in Part 2A of Schedule 8:

> 28D Further permanent impairment assessments
>
> (1) This clause applies to an injured worker if the degree of permanent impairment resulting from the worker's injury is or has been assessed for the purposes of the Workers Compensation Acts.
>
> (2) Section 322A of the 1998 Act does not operate to prevent a further assessment being made of the degree of permanent impairment resulting from the worker's injury for the purposes of Part 3 of the 1987 Act.
>
> (3) However, only one further assessment may be made of the degree of permanent impairment resulting from the worker's injury.

15. It follows that there may be no impediment to this applicant seeking a further Medical Assessment Certificate with a view to being assessed for the purpose of determining whether or not he meets the "high needs" threshold. He should take his own independent legal advice on this question.

**Submissions by the Insurer**

16. The Insurer made no submissions.

**Decision**

17. The insurer advised that the work capacity assessment was completed on 28 September 2016 and that as a result the decision had been made to discontinue payments in accordance with section 38(3).

18. Notice was properly given under section 54(2)(a), with an added four days as required by section 76(1)(b) of the *Interpretation Act* 1987.

19. The applicant was taken through section 43(1)(a),(b) and (f).

20. Section 59A(2) and (3) were clearly explained. The applicant was advised that his entitlement to pre-approved medical expenses could continue for two years after the cessation weekly payments due to his not having greater than 10% whole person impairment [WPI].

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21. The concept of "current work capacity" as defined in section 32A was fully explained. It was explained that the applicant's own nominated treating doctor certified him fit for work for 25 hours per week with modified duties.

22. It was noted that the applicant had received weekly payments for 921 weeks and that he is in the period following the second entitlement period which expires after 130 weeks. Therefore section 38(3) was fully set out and discussed at length.

23. The evidence relied upon by the insurer was set out, totalling 18 documents, including the most up-to-date Certificate of Capacity provided by the applicant. The three types of identified employment were: Sales Representative, Customer Service Officer and Shelf Filler. The merit reviewer came to the same conclusion as the Insurer about the suitability of the identified employment.

24. A great deal of attention was paid to explaining how the identified suitable employment was appropriate for the applicant.

25. I can identify no procedural errors made by the Insurer on this occasion.

**Finding**

26. The work capacity decision dated 28 September 2016 was validly made.

**RECOMMENDATION**

27. The application for procedural review is dismissed.

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Wayne Cooper
Delegate of the Workers Compensation
Independent Review Officer
20 March 2017