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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.**

b. Payments of weekly compensation should be made for all relevant periods when section 44BC(1) applied, being the duration of section 44BB review. The first three weeks of payments should be based on 95% of PIAWE and all subsequent payments based on 80% of PIAWE. The payments should continue until receipt by the applicant of this recommendation.

Introduction and background

1. The applicant sustained a left arm injury, including elbow symptoms, in the course of his employment on 28 January 2016. He has an ongoing certified restriction to lift/carry or push/pull no more than 10 kilograms occasionally, must avoid "vibratory machinery" and avoid gripping with the left hand.

2. The Insurer accepted liability and made payments for 10 weeks.

3. The applicant seeks procedural review of a work capacity decision made by the Insurer on 21 July 2016. The applicant was advised that his payments would cease forthwith, since he had current work capacity and an ability to earn an amount equal to or greater than his PIAWE. The insurer concedes that the applicant has an inability to perform his pre-injury work. Relevantly, the applicant was within the first entitlement period.

4. The applicant sought internal review on 15 August 2016 and by a decision dated 21 September 2016 the insurer upheld the original decision.

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5. An application for merit review was received by the Authority on 18 October 2016 and findings and recommendations were issued on 17 November 2016. The Authority found that the applicant: (i) has the capacity to undertake 38 hours of employment per week, with a 10 kilogram occasional lifting, pulling and pushing capacity; (ii) is able to return to work in suitable employment as a Sales Representative; and (iii) has current work capacity as defined in section 32A.

6. The merit reviewer went on to make a recommendation that the Insurer calculate the applicant's weekly payments in accordance with the above findings. This is an oddity, since at paragraph 70 the reviewer also noted that the Insurer had correctly calculated the entitlement to compensation in the work capacity decision itself. The relevant figures are as follows:

   $1,035.25 x 95% = $983.53.

   $983.54 - $1,176.66 = **$0.00**.

7. By the time the claim reached the merit review stage, the applicant would have been in the second entitlement period, so the correct figures should be:

   $1,035.25 x 80% = $828.20

   $828.20 - $1,176.66 = **$0.00**.

8. The applicant sought procedural review by application received by this Office on 13 December 2016. I find that the application was made within time on in the correct form.

9. 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

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10. 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.*"

11. The applicant makes two submissions:

- Decision made too early as I was and still am receiving ongoing treatment and possible further surgery on my injured arm; and

- I don't believe internal review was properly conducted. Refer to highlighted paragraph stating I submitted request outside the 30 day limit so original decision stands, NOT TRUE – I have documented evidence to prove this was not the case.

12. There is no temporal bar on Insurers making work capacity decisions while workers are still symptomatic and requiring treatment. An assessment and/or decision may be made "at any time" under the Guidelines. It is likely that the applicant is saying no more than that he has yet to reach Maximum Medical Improvement (MMI) in his elbow and left arm generally and so it is therefore premature to make a decision. He certainly has a point if the decision is about the level of Whole Person Impairment (WPI), but such a decision cannot be a "work capacity decision" because it involves a medical dispute (see s. 319 of the 1998 Act and s. 43(2)(b) of the 1987 Act) which must be determined by an Approved Medical Specialist (see section 65(3) of the 1987 Act).

13. The insurer made the following cryptic statement in a letter to the applicant dated 25 October 2016 (that is, nearly five weeks after the internal review decision was made, and after the applicant had already applied for merit review):

> [The Insurer] acknowledges your request for a review of your recent Work Capacity Decision. As your request on 17/10/2016 was not within the 30 days of being notified of the Work Capacity Decision, your weekly benefits will cease in accordance with the previous decision dated 21 July 2016.

14. While it is likely that this is a garbled attempt at saying that the stay under section 44BC(2) can only apply if application is made within 30 days of receipt of the previous decision, it is based on the false premise

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that the applicant had not applied within the relevant time. All the evidence is to the contrary – (a) it is clear that the applicant sought internal review on 15 August 2016, being less than 30 days following receipt of a decision dated 21 July 2016, and (b) his application for merit review was received on 18 October 2016, which is also less than 30 days from the date he would have received the internal review decision dated 21 September 2016.

15. It follows that, while nothing in paragraphs 12-13 *supra* invalidates the work capacity decision, the Insurer must abide by the "stay" provision in section 44BC(1). For the benefit of the applicant I reproduce section 44BC(1) thus:

> 44BC(1) *A review of a work capacity decision in respect of a worker operates to stay the decision that is the subject of the review and prevents the taking of action by an insurer based on the decision while the decision is stayed*.

The applicant would therefore be entitled to 95% of his PIAWE for the first three weeks during which the section 44BB process was underway, and thereafter to 80% of his PIAWE until the receipt of the procedural review outcome. This is because he would have moved from the first entitlement period of 13 weeks into the second entitlement period during the course of section 44BB review. The purpose of section 44BC(1) is to preserve the rights the worker would have had if the work capacity decision had not been made.

Submissions by the Insurer

16. The Insurer made no submissions beyond setting out a chronology of events and making the bald statement that:

- [The Insurer] contend[s] that the work capacity decision and internal review are procedurally correct and made in accordance with the legislation.

The Decision

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17. 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 28 June 2016 that an assessment leading to a decision was underway. This was confirmed in a letter of the same date. The applicant was invited to submit any new evidence which might be thought relevant in accordance with the Fair Notice provision in Guideline 5.2.

18. In the notice dated 21 July 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 36, and 59A(1)-(3). The Insurer advised that the applicant's entitlement to pre-approved medical and related expenses will continue for two years beyond 21 July 2016.

19. The various reports relied upon in making the decision were set out, followed by an explanation of section 43(1)(a), (b), (c) and (d).

20. The definitions of "current work capacity" and "suitable employment" were fully set out.

21. The method for calculating ongoing entitlements was correctly and fully explained.

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

23. The various entitlement periods were set out, with a clear explanation of why the applicant was then within the first entitlement period.

24. Suitable employment was identified, including Sales Representative, Supply and Distribution Manager and Customer Service Manager. All identified suitable employment was certified as suitable by the applicant's own Nominated Treating Doctor. The merit review service agreed with the assessment of the insurer.

25. The applicant acknowledges that he requires further treatment on his left arm and it follows that he cannot be assessed as having WPI of greater than 10% or 20% or 30% for the purposes of either (i) section 59A or (ii)

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the recognition of any status he might have as a high needs or highest needs worker.

26. The error made by the insurer in explaining the applicability of the stay in a letter dated 25 October 2016 post-dated both the work capacity decision and the internal review decision and therefore cannot be regarded as a procedural error in the decision-making process.

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

Finding

28. The work capacity decision was validly made.

RECOMMENDATION

29. The application is dismissed.

30. Payments of weekly compensation should be made for all relevant periods when section 44BC(1) applied, being the duration of section 44BB review. The first three weeks of payments should be based on 95% of PIAWE and all subsequent payments based on 80% of PIAWE. The payments should continue until receipt by the applicant of this recommendation.

Wayne Cooper
Delegate of the Workers Compensation
Independent Review Officer
16 January 2017