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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 work capacity decision of the insurer dated 25 September 2017 is set aside.
b. The insurer should make a new work capacity decision in accordance with the findings of the merit review service.
c. The insurer should correctly explain the operation of section 59A in the course of any new work capacity decision.

Introduction and background

1. The applicant suffered injury to the cervical spine in the course of her employment as a Sales Representative. The agreed date of injury is nominated as 23 February 2015. The insurer accepted liability and made weekly payments for all relevant periods.

2. The employer made the applicant's position redundant on 15 July 2015. The applicant subsequently found alternative employment and currently works for 20 hours per week, as certified by her Nominated Treating Doctor (NTD).

3. The applicant seeks procedural review of a Work Capacity Decision made by the insurer on 25 September 2017. The insurer informed the applicant that her weekly payments would reduce from $1,520.00 to $551.20, effective 31 December 2017. The insurer accepted that the applicant can only work 20 hours per week and advised that payments would continue under section 38(7). For current purposes it might suffice to say that section 59A(2) was correctly explained, if not applied.

4. An Internal Review Decision dated 07 November 2017 confirmed the original Work Capacity Decision. There were, however, two variations to the decision: first, "Software Salesperson" was deleted from the list of occupations said to constitute "suitable employment;" and, secondly,

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sections 59A(2) and (3) were both incorrectly explained and erroneously applied. At paragraph 2 and again at paragraph 128 the insurer advised the applicant that:

> "… compensation will not be payable for any treatment, service or assistance given or provided after 31 December 2019 provided that [the applicant] does not satisfy section 59A(3)."

It would, of course, be impossible for the applicant to satisfy or comply with section 59A(3), since that section only applies to workers who have had their weekly compensation payments terminated, which is not the case here. Sectiona 59A(2) and (3) have no relevance when weekly payments are continuing.

5. The applicant sought Merit Review from the Authority by way of application received on 05 December 2017. The Authority delivered its Findings and Recommendations dated 24 January 2017. The Authority made findings that the applicant: (i) is able to return to work in suitable employment; (ii) has the ability to work as a "Sales Manager"; and (iii) has the ability to earn $728.80 per week in suitable employment.

6. The merit reviewer made no recommendation. This had the effect of leaving the internal review decision as the only decision on foot.

7. An application to this office for procedural review was received on 20 February 2018. 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 relevant *Guidelines*.

Submissions by the applicant

9. Section 44(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 submits that she was never physically examined in the course of a functional or vocational capacity assessment. Neither the

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insurer nor the merit reviewer took this "into consideration" when assessing the applicant's work capacity.

11. The submission by the applicant is odd, since there is no dispute that she was physically examined by her own NTD and several specialists, all of whom provided reports to the insurer. The implied suggestion that a non-doctor might perform a physical examination the results of which could be relied upon to inform a functional or vocational capacity assessment is misguided. It is clear from the Certificates of Capacity issued by the NTD that the applicant is capable of working for 20 hours per week in her current role, which is not disputed by the insurer.

Submissions by the Insurer

12. The Insurer responded thus:

- The Insurer acknowledges [the applicant's] submissions and submits that the Insurer has adhered to the guidelines and legislation.

- In relation to [the applicant's] grounds for review - the Insurer submits that although [the applicant] did not attend an updated functional and vocational assessment, her functional capacity was certified by Dr A and through her abilities in her current role. Dr A was provided with a full list of the functional requirements of the identified roles and signed that [the applicant] was capable of performing the duties outlined.

- Additionally, [the applicant] had previously attended a Vocational Assessment in 2015 where a full history of her employment and transferable skills were obtained.

Decision

13. The applicant was given fair notice prior to the decision being made and was given more than the required notice under section 54(2)(a).

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14. The explanation of section 38(3) and 38(7) in the work capacity decision and in the internal review decision by the Insurer was adequate in all respects. The applicant was not misled or any way misinformed.

15. The same cannot be said for the explanation of section 59A. The applicant was left with the impression that she had no entitlement to ongoing pre-approved hospital, medical and related treatment expenses after two years from 31 December 2017. This was a clear error, since the section only applies to a worker who has received weekly payments once those payments cease. In this case the payments were not due to cease, they were due to reduce only.

16. The Guidelines and legislation were otherwise fully complied with and there were no other procedural errors in the decision-making process. However, the guidelines which came into effect on 1 August 2016 clearly prohibit the insurer from misleading a worker in any material respect which might affect their rights. If the applicant had never challenged this decision she might never have realised that her right to ongoing pre-approved medical treatment would continue past 31 December 2019. It is a simple case of the applicant being misled in a material respect. On that basis the work capacity decision is procedurally unsound since it breaches the relevant Guidelines.

Finding

17. The Insurer has breached the Guidelines by misleading the applicant and the work capacity decision must be set aside.

RECOMMENDATION

18. The work capacity decision of the insurer dated 25 September 2017 is set aside.

19. The insurer should make a new work capacity decision in accordance with the findings of the merit review service.

20. The insurer should correctly explain the operation of section 59A in the course of any new work capacity decision.

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20 March 2018