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Services Australia

Diagnosis of a medical condition provided by an Assessment Services Psychologist for Disability Support Pension (DSP) 008-03030020

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Background

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This document outlines the circumstances when a customer's eligibility for Disability Support Pension (DSP) can be based on a provisional diagnosis of a psychological/mental health condition by an Assessment Services Psychologist because the customer is unable to be effectively assessed through the usual DSP assessment procedures.

On this Page:

Assessment Services Psychologist

Information can be provided solely by a Specialist Assessment from an Assessment Services Psychologist, and documented in a Job Capacity Assessment (JCA) report.

These circumstances are an exception to the general rules of:

- customers applying for DSP providing medical evidence, as set out in the Medical Evidence Checklist in their claim form or the Medical Evidence Requirements (SA473) form, to support their claim, and
- eligibility for DSP being determined based on medical conditions outlined in the medical evidence they provided with their claim

Customers for whom these procedures may be applied

These exceptional procedures may be applied to assist a small group of vulnerable customers with suspected mental health conditions who:

- are likely to be qualified for DSP or eligible for a significant reduction in their participation requirements, but
- 47E(d)

This includes customers:

- living in remote communities where there is little or no access to health services,

- identified by Service Officers or Employment Services Providers as continually unable to comply with requirements, and demonstrating behaviours consistent with a chronic mental health condition

These procedures do not apply to customers who are willing and able to obtain medical evidence, in accordance with normal procedures.

Health Professional Advisory Unit (HPAU)

The Health Professional Advisory Unit (HPAU) can provide and/or facilitate medical advice and opinion for the purpose of helping to determine a customer's eligibility for DSP. Psychologists conducting these assessments are required to consult with the HPAU before the submission of the Specialist Report and Job Capacity Assessment (JCA) report to make sure that all medical factors are considered. Once medical factors are excluded, the determination of vulnerability sits with the assessor in consultation with their Assistant Director.

Impairment Table changes from 1 April 2023

From 1 April 2023, a new version of Impairment Tables was introduced. The new Tables are used to assess a customer's medical eligibility for all DSP claims lodged on or after this date. See The Impairment Tables.

Related links

The Health Professional Advisory Unit (HPAU)

What is medical evidence for Disability Support Pension (DSP)?

Job Capacity Assessment (JCA) Referral

Process

Medical evidence requirements for DSP

This table describes the process in assessing if a customer is medically eligible for the DSP without providing medical evidence.

Item	Description
1	**Medical evidence requirements for a DSP new claim** + Read more ... There is no variation to the usual eligibility rules for DSP, including the requirement that a medical condition must be diagnosed, reasonably treated and stabilised in order to be assigned an impairment rating (IR), which must be at least 20 points, and for the customer to have a continuing inability to work (CITW). 47E(d) Subject to approval by a Senior Service Officer (SSO) or other senior staff member at SO5 level or above, eligibility for DSP may be determined based on medical conditions diagnosed solely by an Assessor who is a registered Psychologist. In all cases, the diagnosis must be provided as part of a Specialist Assessment, and documented in the customer's JCA report. If a DSP Processing Team staff member (SO5 or above) determines DSP medical eligibility and medical evidence requirements are met based on the submitted JCA report, the customer will be invited to claim DSP.

2	**Requirement for senior staff involvement** + Read more ... A decision to invite a claim for, or grant DSP solely on the basis of a provisional diagnosis provided by an Assessment Services Psychologist must be approved by an SSO or senior staff member at the level of SO5 or above. Social Workers can also identify customers who may meet these criteria. Senior or professional staff should be closely involved in supporting the customer's referral to a JCA making sure all available, relevant evidence has been gathered before the referral and is available to the Assessor. If the customer does not have a nominee, the Service Officer should follow this up as there may be someone able to act on the customer's behalf and be able to access medical information for the customer. As part of the decision making process the Health Professional Advisory Unit (HPAU) must also be engaged to provide and/or facilitate medical advice and opinion for the purpose of helping a decision-maker determine a customer's eligibility for DSP. **Note:** only specific staff can contact the HPAU and then only for specific reasons, depending on the Service Officer's/Specialist's role.
3	**Work item** 47E(d) **- DSP Assessment Services Opinion - Referral** + Read more ... This work item is created when medical evidence is scanned and identified as a Psychologist Report. • Check 47E(d) screen to identify why the request was made • Action the scan and update customer details as per unstructured Medical Documents • select the Transaction ID from 47E(d) screen • Select 47E(d) • Change Status 47E(d)
4	**Granting DSP** + Read more ... Claims for DSP where the medical evidence has been completed by an Assessment Services Psychologist in a Specialist Assessment, are to be assessed by a DSP Processing Team staff member (SO5 or above) due to the sensitivity and complexity. The customer must meet all qualification and payability requirements for DSP. All cases where a customer is granted DSP solely on the basis of a provisional diagnosis provided by an Assessment Services Psychologist, must have a keyword of 47E(d) attached to the 47E(d) **DOC** on the customer's record.
5	**Customer not qualified for DSP** + Read more ... The assessment may indicate the customer does not meet medical qualification therefore they will not be granted DSP. The customer may also not wish to claim DSP. If the customer is receiving a payment, such as JobSeeker Payment (JSP) with mutual obligation requirements, their requirements must be reviewed taking into account the information in the report, particularly where the customer has a partial capacity to work or a temporary reduced work capacity.
6	**Referring the customer for further assistance** + Read more ... The customer must be offered information and assistance to be referred to a Community Health Centre or General Practitioner for a full mental health assessment, and connection to other socially inclusive community services. These referrals should only be made with the customer's consent. Wherever possible, the Assessor should be involved in making these referrals. Social Workers or Senior Service Officers (SSO) must support the Assessor in providing information about these services to the customer and making referrals where required.

References

Policy

Social Security Guide, 1.1.J.10, Job capacity assessment (JCA)

Social Security Guide, 3.6.2.10, Medical & Other Evidence for DSP

Social Security Guide, 1.1.C.330, Continuing inability to work (CITW) (DSP)

Legislation

Links to the Federal Register of Legislation site go to a 'Series' page. Select the 'Latest' version.

Social Security (Administration) Act 1999, section 12, Deemed claim in certain cases

Training & Support

Add the course number to the Search field in the Learning Portal (LMS) in ESSentials:

- **CLK00465** - Introduction to Job Capacity Assessments

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Cancellation of Disability Support Pension (DSP) 008-03130030

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Background

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This document outlines how to cancel DSP when a customer is no longer qualified or when they request cancellation. The Service Officer must ensure that cancellation is the correct action to take. Take care if a customer with a mental health condition requests cancellation of their payment.

When DSP may be cancelled

- The customer requests to cancel their DSP or submits a claim for another payment.
  Note:
  - This may place vulnerable customers at risk where DSP is cancelled
  - Further actions must occur before cancelling DSP in these circumstances
  - A customer initiated request to cancel DSP is not a decision under social security law. This means that once DSP is cancelled:
    the decision will not be overturned at review, **and**
    DSP cannot be restored on request of the customer
- The customer no longer meets the qualification and/or payability provisions for DSP. Once the record is updated, DSP will auto cancel. For example, a medical service update determines the customer no longer meets DSP impairment criteria
  - DSP does not cancel immediately as a result of a DSP Service Update or Payment Accuracy Reviews if the customer no longer meets impairment and/or CITW requirements
  - It is cancelled after 42 days from the date the advice is sent to the customer
- DSP was suspended for 2 years because the customer was imprisoned or in psychiatric confinement in connection with a criminal charge
- DSP was suspended for 2 years because the customer advised within the notification period a return to work or increase in income which precluded payment, and DSP has not been restored. Note: this is an auto cancellation
- The customer fails to comply with the notification requirement and/or customer obligations
- The customer's partner fails to take action to obtain a comparable foreign payment
- The customer has been advised that another pension or allowance is deemed more appropriate. For example, they reach Age Pension age. If a DSP customer reaches Age Pension age, DSP auto cancels in most cases. Customers in the DSP grandfathered group who elect to transfer to another payment such as Carer Payment will lose their 'Grandfathered Status' if they decide to transfer back to DSP
- The customer dies
- The customer starts work of 30 hours or more per week at award wages and fails to notify within 14 days

When DSP is cancelled with a return to work reason, DSP is deemed suspended. This means payment may be restored if the customer ceases work or reduces hours of work to below 30 hours per week within 2 years.

However, if DSP is cancelled outside the notification period, before the customer notified they had started work of 30 hours a week or more, payment cannot be suspended or deemed to be suspended. It must be cancelled from the day work started.

Effect of PPL/DAP on DSP

For children born or entering care:

- from 1 October 2016, Paid Parental Leave (PPL) and Dad and Partner Pay (DAP) granted to the customer (and/or their partner) are treated as ordinary income for calculating the rate of payment for DSP
- prior to 1 October 2016, PPL and DAP are not treated as assessable income for DSP

PPL and DAP will not reduce DSP to nil rate. The customer would need to have other income for their rate to be reduced to nil and cancel. If DSP cancels due to other income, it may be reinstated depending on the customer's current circumstances.
See Restoration of DSP.

Automatic and manual cancellations

Automatic cancellation will occur following reassessments when no continuing eligibility exists. For example, when a change of income or assets takes a customer over the income or assets threshold. When the income or assets are updated, the system will:

- calculate if the customer has lost eligibility and
- automatically cancel the DSP due to income or assets

Payments may also be automatically cancelled when a customer is no longer eligible. For example, when a customer fails to return correspondence or provide a tax file number. In these cases, the system will set up a manual follow up (MFU) activity for action.

If a vulnerable and at risk customer remains without income support payment for a minimum of six weeks due to an automatic suspension or cancellation, the customer may be eligible for manual intervention. **Note**: customers overseas permanently are not eligible for this initiative. Any MFUs generated for customers in this situation should be cancelled.

Manual cancellation is where a Service Officer makes a decision to cancel a customer's payment based on the applicable social security law and codes this as a direct cancellation.

Automatic cancellation is the preferred method. Manual cancellation of records should only occur when automatic cancellation by coding a change in circumstances is not available.

Related links

Cancellation, suspension and rejection codes for Disability Support Pension (DSP)

Commencing or returning to work or self-employment Disability Support Pension (DSP)

Customer ceases work or reduces hours of employment within the two year suspension period for Disability Support Pension (DSP)

Disability Support Pension (DSP) customer going overseas

Restoration of Disability Support Pension (DSP)

Eligibility for Mobility Allowance (MOB) and rates

Providing services to customers with disabilities

Work Bonus and balance for pensioners of Age Pension age

Transitional rules for pension customers who were on payment at 19 September 2009

Income Test for single pension customers

Income Test for partnered pension customers

Income Test for Disability Support Pension customer who is under 21 years, with no dependent children and with affecting income at 19 September 2009

Income Test for Disability Support Pension customer who is under 21 years, with no children

Disability Support Pension (DSP) letters and advices

Manual intervention for Automatic Suspension and Cancellation of vulnerable and at risk customers

Process

Cancelling DSP

DSP cancellation and follow up action

Cancelling DSP

Table 1

Step	Action
1	**Check that the cancellation action is correct** + Read more ... Customers in the DSP grandfathered group who elect to claim another payment, e.g. Carer Payment, will lose their Grandfathered Status if they decide to reclaim DSP. If a vulnerable and at risk customer remains without income support payment for a minimum of 6 weeks due to an automatic suspension or cancellation, they may be eligible for manual intervention. **Note:** customers who are overseas permanently are not eligible for this initiative. Cancel any MFUs generated for customers in this situation. Is a potentially vulnerable customer (for example, but not limited to, a customer with acquired brain injury, mental health issue, intellectual disability or other conditions that may impact decision making) requesting cancellation of DSP, **or** claimed another payment that will result in cancellation of DSP? • **Yes**, go to Step 2 • **No**, go to Step 3
2	**Discuss the reason with the customer** + Read more ... Providing services to customers with disabilities. Further actions **must occur before** cancelling DSP in these circumstances, including: • Consulting with a team leader **before** making a decision to cancel DSP • If cancelling DSP, consider a further case consultation with a social worker or other specialist (e.g. Community Engagement Officer, Indigenous Service Officer) **Before cancelling DSP**, discuss the reason with the customer or their nominee. Advise the customer or nominee: • If the customer claimed and is granted another income support payment, it will result in the cancellation of DSP.

	• DSP cannot be restored once cancelled. A new claim and current medical evidence **must be lodged** to re-test eligibility for DSP Cancellation at the customer's request is not a decision under Social Security Law, therefore, once DSP is cancelled: • **the decision will not be overturned on review** • **DSP cannot be restored on request of the customer** Has the customer provided a valid reason for cancelling payment? • **Yes**, see Step 1 in Table 2 • **No**, go to Step 3
3	**Does the customer want to continue with their cancellation request or claim for another income support payment?** + Read more ... • **Yes**, see Step 1 in Table 2 • **No**, record decision on a **DOC**. If a claim for another income support payment was lodged, the claim will need to be withdrawn. See Withdrawal of claims.

DSP cancellation and follow up action

Table 2

Step	Action
1	**Cancellation reason** + Read more ... • If the customer has advised they have **started or returned to work**, see Commencing or returning to work or self-employment DSP. Procedure ends here • If the cancellation is the result of **updating the customer's circumstances** (e.g. increased income/assets above the thresholds, change in relationship status or death of the customer or partner, go to Step 2 • If the result of a Service Update or Payment Accuracy Reviews is that the customer is no longer medically qualified for DSP, go to Step 3 • If the customer requests to cancel the payment, go to Step 6 • For all **other** cancellations, go to Step 4
2	**Record the updated information** + Read more ... If the customer is to be cancelled due to a change in circumstances, the new circumstances must be recorded as this may affect the customer's eligibility for other payments for example Mobility Allowance (MOB). If the DSP customer is receiving the higher rate of MOB and is cancelled due to **increased hours**, they may continue to receive MOB at the higher rate. For more information, see Eligibility for Mobility Allowance (MOB) and rates. When a customer with employment income is: • **under Age Pension age**, Working Credit may enable the customer to keep some of their income support payment while they are working • **over Age Pension age** and getting a pension (excluding Parenting Payment Single), they may be eligible for the Work Bonus. **Note:** the Work Bonus is not used in the customer's transitional rules calculation, but partners may still benefit by the reduction in total income When a customer's income **reduces their fortnightly rate to nil** and some is employment income, if the customer notified:

	• **within 14 days**, they may be eligible to have their payment suspended instead of cancelled. See Commencing or returning to work or self-employment DSP • **outside 14 days**, payment may remain current at nil rate for up to six fortnights if still eligible for DSP DSP will auto cancel when recording the change of circumstances. The 47E(d) screen shows this. • An automatic advice should generate. Check this in the 47E(d) field help on the 47E(d) screen, or see if a Manual Follow-up (MFU) creates on the 47E(d) screen the next day • Check if the customer's partner is receiving a payment, and if it should be cancelled. If it should cancel but has not auto cancelled, , cancel their payment using the appropriate 47E(d) • Record details on a **DOC** Go to Step 7.
3	**Record decision not to continue DSP** + Read more ... Record a **DOC** that the customer is not qualified to continue receiving DSP as a result of the service update. The DSP cancellation is not to take effect until **42 days after** sending the advice to the customer. Create a 47E(d) Activity on the 47E(d) screen to submit the cancellation activity with the correct date.
4	**Is the customer partnered and/or a care receiver?** + Read more ... • If the customer is a **care receiver** (and carer on Carer Payment), go to Step 5 • If the customer is **partnered** (but not a care receiver), check if their partner gets a payment which needs to be cancelled. If so, refer to the relevant procedure in Cancellation of payments. Go to Step 6 • If **not** partnered or a care receiver, go to Step 7
5	**DSP customer is a care receiver** + Read more ... When a care receiver's payment is cancelled, an Income & Asset Review 47E(d) is created on the 47E(d) screen on their record. When the IAR review is due, the system issues a Carer Payment - Income and assets details of the person being cared for (16 years and over) (SA304(A)) form if the carer receiver is getting an income support payment from Services Australia or the Department of Veterans' Affairs (DVA). If the care receiver's DSP is suspended and is likely to remain suspended for a long time (e.g. Suspended RTW), issue the SA304(A) form manually to the care receiver. If the care receiver has a partner or carer receiving CP, the eligibility to remain on CP depends on the level of continuing care. The Carers Processing Service Team should investigate this. Use **Fast Note** – 47E(d) 47E(d) Include relevant information in the **Fast Note** text. Advise that the care receiver's DSP has been suspended or cancelled. CP qualification will only continue if • the care receiver still requires a qualifying level of personal care and/or supervision, and • the carer still provides the equivalent of a working day of personal care over the 24 hour period
6	**Customer requests to cancel the payment** + Read more ... Before cancelling a payment, take care to check if the customer has lost eligibility for that payment. If a customer with mental health issues, impaired cognitive capacity, or other impairment or vulnerability requests cancellation, consult with a team leader. If cancelling the payment will place the customer at risk, consider a case consultation and referral to a social worker, or other specialist officer before cancelling. Cancellation at the customer's request:

	• **cannot be formally reviewed** as the decision has not been made under any provision of the Social Security Act 1991. So if a customer requests cancellation and later wants to change the request, it cannot be legally reviewed • **cannot be restored** because the decision has not been made under the Social Security Act 1991 Record on a **DOC**: • any discussions with the customer about their reasons for cancelling payment • advice or action taken to ensure the customer is not placed at risk If there is **no indication** that the customer is vulnerable and may be further disadvantaged by cancellation: • Go the 47E(d screen • Code 47E(d) in the 47E(d) : field • Code 47E(d) in the 47E(d) : field • Code the relevant cancellation/rejection reason code in the 47E(d) : field. Use 47E(d) for the relevant code • Code date of effect in 47E(d) : field. For a voluntary surrender/cancel of DSP, encourage the customer to give the reason and relevant date (e.g. returned to work, increase in income, re-partnered.) so that a proper date of effect of cancellation can be determined. If they do not give any details of why they want DSP cancelled, code date paid to (DPT) + 1 • Record details in a **DOC** • Finalise activity via 47E(d) screen • Advise the customer of the outcome and advise there are no review and appeal rights • Check the MFU activity on 47E(d)screen the following day to see if the manual letter needs to be sent. If so, use 47E(d) or 47E(d)
7	**Check that the customer and/or partner have not been overpaid** + Read more ... Go to the 47E(d) screen and check for a 47E(d) debt activity.

References

Policy

Guide to Social Security Law, 3.6.1.100, continuation Variation or Termination of DSP - 30 Hour Rule

Legislation

Links to the Federal Register of Legislation site go to a 'Series' page. Select the 'Latest' version.

DSP qualifications

Social Security Act 1991, section 94, continuing inability to work

Manual cancellations

Social Security (Administration) Act 1999

- section 80, Cancellation or suspension determination
- section 81, Cancellation or suspension for non-compliance with certain notices

Automatic cancellations

Social Security (Administration) Act 1999

- section 93, customer complying with subsection 68(2) notice
- section 94, customer not complying with subsection 68(2) notice
- section 95, failure to provide statement under subsection 68(2)

Training & Support

Add the course number to the **Search** field in the Learning Portal (LMS) in ESSentials:

- **CLK01111** - Suspensions, cancellations & restoration

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Reviews and appeals for Disability Support Pension (DSP) rejection or cancellation decisions 008-03190000

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Background

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This document explains details on how to manage reviews and appeals of decisions for a DSP customer.

Rejected DSP claim / cancelled DSP

When a customer's claim for DSP is rejected or their DSP is cancelled, they have the right to have the decision reviewed. There are several levels of review and appeal both internal and external to Services Australia.

Note: if the DSP claim has been rejected for reasons 47E(d) or 47E(d) and the customer has provided the required information within 13 weeks of the rejection, the claim can be reopened without the need for a SME quality check/explanation of decision or formal review.

Internal:

- before 15 May 2021, a quality check by a Subject Matter Expert (SME)
- from 15 May 2021, an explanation of the decision by a SME, or
- formal review of the decision by an Authorised Review Officer (ARO)

External:

- Administrative Appeals Tribunal (AAT) first review
- AAT second review
- Federal Court, on a point of law only
- High Court, with leave of the Court

An internal review of decision must be completed before initiating an external review.

Further assessments via the Medical Assessment Team (MAT), Job Capacity Assessment (JCA) or Disability Medical Assessment (DMA) may be requested as appropriate during the process.

Quality check of DSP medical decision requested before 15 May 2021

If required, the Medical Assessment Team (MAT) will refer customers for an Appeal JCA after a SME request to reassess medical evidence.

The 47E(d) Fast Note was amended to include additional information required for MAT to refer the customer for an Appeal JCA.

For DSP SMEs, where a DSP claim has been rejected and the customer has requested a review of decision before 15 May 2021:

- SME will refer to ARO if the DSP claim was rejected on the basis of a DMA recommendation
- SME will refer to MAT where further medical evidence was provided
- MAT will refer to JCA (if required) for DSP Review of Decision

Explanation of DSP medical decisions requested from 15 May 2021

From 15 May 2021, a new internal review process applies to both DSP new claims and medical reviews where a customer requests an explanation of a decision to reject or cancel DSP due to medical eligibility.

Customers can either:

- request an explanation of a decision which will be provided by a SME, or
- apply for a formal review of a decision which will be undertaken by an ARO

Although DSP claims are processed in 47E(d) , action all SME explanation processes in 47E(d) .

Payment pending review (PPR)

From 15 May 2021, **only** consider PPR for customers who have applied for a formal review of the decision to cancel their DSP. See Payment Pending Review (PPR) of decision to cancel DSP due to medical eligibility.

Implementing review of decision outcomes

Service Officers or SMEs must follow the appropriate procedures to finalise and implement review of decision outcomes for:

- ARO decisions
- AAT decisions

Job Capacity Assessment (JCA) requests for AAT, Federal Court or High Court

All new assessments required for the:

- AAT first review, will be made by an ARO
- AAT second review, Federal Court or High Court, will be referred directly to Assessment Services from the Litigation and Information Release Branch. These referrals will be managed by the Assessment Services National Administration Team (ASNAT) Support Team

Impairment Table changes from 1 April 2023

From 1 April 2023, a new version of Impairment Tables was introduced. The new Tables are used to assess a customer's medical eligibility for all DSP claims lodged on or after this date. See The Impairment Tables.

The Resources page contains:

- suggested 47E(d) text
- links to the Assessment Services Branch homepage, and
- contact details for Assessment Services

Related links

Request for an explanation or application for a formal review (CLK)

Reviews by an Authorised Review Officer (ARO)

Process

This page contains details about when and how a Job Capacity Assessment (JCA) referral is made when required as part of the review/appeal process.

On this page:

Customer contact about a rejected or cancelled DSP claim

Table 1: For non-disability processing and disability trained staff.

Step	Action
1	**Determine DSP rejection/cancellation reason** + Read more ... When a customer's claim for DSP is rejected or their DSP is cancelled, they have the right to have the decision reviewed. It is important the decision is discussed with the customer, at first point of contact. If the customer has lodged new information but not requested an explanation or applied for a formal review, the Service Officer (SO) is to consider the new information and:

	• if the original decision can be reassessed and the outcome will be fully favourable, undertake a reassessment • if the new information will not change the original decision, or if the decision can be reassessed but the outcome will not be fully favourable, make genuine attempts to contact the customer to discuss the new information and provide review and appeal options If the customer requests an explanation, applies for a review or provides more information regarding a decision, the action required depends on the reason for the rejection/cancellation. For DSP claims rejected for: • reason 47E(d) or 47E(d) (insufficient medical evidence), go to Step 2 • reason 47E(d), go to Step 3 • reason 47E(d) go to Step 4 • medical reason, such as 47E(d) (excluding reason 47E(d) - insufficient medical evidence), go to Step 5 • all other DSP rejection and cancellation reasons, go to Step 6 **Disability SME only** To action a: • SME quality check/explanation for a non-medical decision, see Table 2 • SME quality check requested before 15 May 2021, see Step 1 in Table 3, or • SME explanation of decision requested from 15 May 2021, see Step 1 in Table 4

2	**DSP claim rejected for reason** 47E(d) **or** 47E(d) **(Insufficient medical evidence)** + Read more ...
	
	Non-disability processing staff
	
	Claim can be re-opened where:
	
	• DSP claim has been rejected for reason 47E(d) or 47E(d), and
	• customer has provided the required information within 13 weeks of the rejection
	
	A SME quality check/explanation of decision or formal review is not required in this instance, see Request to reassess a rejected claim.
	
	Possible terminal illness
	
	Create a Fast Note for the Disability processing team if the:
	
	• claim was rejected 47E(d) within the last 13 weeks, and
	• customer has lodged either:
	  ○ a Verification of terminal illness form (**SA495**), or
	  ○ other medical evidence indicating a possible terminal illness
	
	Use Fast Note - 47E(d) Add notes to indicate the customer has supplied evidence of terminal illness.
	
	The **Fast Note** work item presents as the highest work priority for the Disability processing team. See Prioritising Disability Support Pension (DSP) claims for terminally ill customers.
	
	Disability processing staff
	
	When allocated a 47E(d) **Fast Note** or **Priority**-47E(d) **Fast Note**, see Streaming a new claim for Disability Support Pension (DSP) to 47E(d) and progress DSP claim.
	
	Procedure ends here.

3	**DSP claim rejected for reason** 47E(d) + Read more ...

	If the DSP claim was rejected for reason 47E(d) (failed to attend/participate in a Disability Medical Assessment), reopen and reassess the DSP claim. A SME quality check/explanation or formal review is not required if the customer: • contacts within 13 weeks of the rejection, and • indicates their intention to attend a Disability Medical Assessment (DMA) See Disability Medical Assessment (DMA) appointment outcome for action required. Procedure ends here.
4	**DSP claim rejected for reason** 47E(d) + Read more ... DSP claim is rejected for 47E(d) (failed to attend medical examination - JCA). If the customer fails to attend a Job Capacity Assessment, and it could not be completed as a file or phone assessment, or the customer would not participate in the assessment, the JCA referral is finalised as 47E(d) (Unable to complete) and claim rejected. DSP Claim can be reopened and reassessed if the customer: • contacts within 13 weeks of the rejection, and • indicates their intention to attend/participate in the JCA 47E(d) the claim and progress the claim, see Streaming a new claim for Disability Support Pension (DSP). Procedure ends here.
5	**DSP claim rejected for a medical reason** 47E(d) **or any other medical reason), excluding reason** 47E(d) **- insufficient medical evidence** + Read more ... If the customer does not understand or agree with the decision as to why their claim was rejected for the medical reasons above, including where the customer has provided, or will provide, further medical evidence for consideration, explain their options to request: • an explanation • a formal review For action required, see Reviews and appeals. Procedure ends here.
6	**All other DSP rejections or cancellations** + Read more ... If the customer does not understand, or agree with a decision, explain their options to request an explanation of the decision or a formal review. For action required, see Reviews and appeals. Procedure ends here.

SME quality checks/explanations for DSP claims rejected for non-medical reasons

Table 2: For appropriately trained staff only.

Step	Action
1	**SME quality check/explanation registered for rejection reason** 47E(d) **or** 47E(d) + Read more ... Reopen the DSP claim, without the need for SME quality check/explanation or formal review, if a SME quality check has been registered for rejection reason: • 47E(d) or 47E(d) and the customer has supplied all the required information within 13 weeks of the rejection • 47E(d) and the customer has contacted within 13 weeks of rejection indicating their intention to attend DMA

	• 47E(d) and the customer has contacted within 13 weeks of rejection indicating their intention to attend/participate in JCA
	
	The SME **must** make genuine attempts to contact the customer to tell them a SME quality check/explanation is **not required** and the DSP claim can be reopened.
	
	If the customer requests to **withdraw** the quality check/explanation:
	
	• action the withdrawal using the 47E(d) script
	• 47E(d) DSP claim and progress accordingly in 47E(d)
	• annotate 47E(d) Notes to advise claim has been reopened
	
	If the customer **cannot be contacted**:
	
	• 47E(d) claim and progress accordingly in 47E(d)
	• annotate the **DSP Appeal** 47E(d) Notes to advise claim has been reopened
	• hold the **DSP Appeal/** 47E(d) for 7 days
	• DSP claim and DSP Appeal held under Hold to User
	• when the **DSP Appeal/** 47E(d) becomes due, make genuine attempts to contact the customer to discuss withdrawing the quality check/explanation:
	  ○ if the customer agrees to withdraw the quality check/explanation, action the withdrawal using the 47E(d) script
	  ○ if contact is unsuccessful, hold **DSP Appeal** 47E(d) for a further 7 days
	
	Continue to make contact attempts to discuss the quality check/explanation until the DSP claim is finalised.
	
	Record all attempts to contact the customer about the quality check/explanation in the **DSP Appeal** 47E(d) [47] and **DSP Progress** 47E(d) /Notes.
	
	If customer contact is unsuccessful, finalise the quality check/explanation when the claim is finalised.
	
	Procedure ends here.

2	**SME quality check/explanation registered for rejection reason** 47E(d) **(excess income and assets) or** 47E(d) **(compensation income too high)** + Read more ... Where a SME quality check/explanation has been registered for rejection reason: • 47E(d) (excess income and/or assets), or • 47E(d) (compensation income too high) and the SME determines: • the rejection was correct and non-medical eligibility is not met, go to Step 3 • non-medical eligibility is met, and the customer requires a medical assessment (referral to JCA), reopen the DSP claim and refer to JCA The SME **must** make genuine attempts to contact the customer to tell them a SME quality check/explanation is **not required** and the DSP claim can be reopened. If the customer requests to **withdraw** the quality check/explanation: • action the withdrawal using the 47E(d) script • 47E(d) DSP claim and progress accordingly in 47E(d) • annotate **DSP** 47E(d) to advise claim has been reopened If the customer **cannot be contacted**: • 47E(d) claim and progress accordingly in 47E(d) • annotate the **DSP Appeal/** 47E(d) and **DSP** 47E(d) /Notes to advise claim has been reopened • hold the **DSP Appea** 47E(d) for 7 days

	• DSP claim and DSP Appeal held under Hold to User • when the **DSP Appea** 47E(d) becomes due, make genuine attempts to contact the customer to discuss withdrawing the quality check/explanation: ○ if the customer agrees to withdraw the quality check/explanation, action the withdrawal using the 47E(d) script ○ if contact is unsuccessful, hold **DSP Appeal** 47E(d) for a further 7 days Continue to make contact attempts to discuss the quality check/explanation until the DSP claim is finalised. Record all attempts to contact the customer about the quality check/explanation in the **DSP Appeal** 47E(d) 47E(d) nd **DSP** 47E(d) Notes. If customer contact is unsuccessful, finalise the quality check/explanation when the claim is finalised. Procedure ends here.
3	**All other non-medical decisions** + Read more ... For all other non-medical rejection reasons, the SME must follow the process in SME explanations, ARO referrals and implementing ARO decisions. Procedure ends here.

SME quality checks of DSP medical decisions for reviews requested before 15 May 2021

Table 3: For appropriately trained staff only.

Step	Action
1	**DSP claim rejected on basis of MAT/JCA Recommendation - SME referral to MAT** + Read more ... If a customer has requested a SME quality check **after** a DSP Claim has been rejected on the basis of MAT or JCA and: • no new evidence has been supplied, go to SME explanations, ARO referrals and implementing ARO decisions • new medical evidence has been provided, or a SME identifies an error in the original decision recommendation, the case must be returned to MAT, use Fast Note 47E(d) 47E(d) DSP SME **must**: • complete all the required information in the **Fast Note** • record notes in the **DSP** 47E(d) and clearly outline the reason for return to MAT. For example, new medical evidence lodged or details of the error identified in original decision • place the **DSP** 47E(d) on Hold to User for 7 days MAT Assessor: • considers existing medical evidence in the context of the appeal request, and • completes a new recommendation to support the review of decision and uploads this 47E(d) 47E(d) **Note**: where new medical information is not relevant to the original decision under consideration (that is, DSP claim date and 13 weeks thereafter), however the Assessor indicates the evidence may require further assessment, the Assessor will recommend the decision is unchanged and add notes to the SA479/MAT Recommendation. The SME is to discuss a possible reclaim with the customer. If an appeal JCA referral is required: • complete the **JCA ref required post MAT** 47E(d) **Fast Note** • select referral reason 47E(d) in **Fast Note** • annotate the **DSP** 47E(d) with the text 47E(d) ', and

	• place the appeal on hold for 28 days MAT Assessors who are not trained in the JCA referral process must take the **DSP** 47E(d) off hold so it allocates back to a SME to complete the JCA referral. Where a JCA referral is not required, return the work item to the DSP SME by taking the **DSP** 47E(d) off hold. A **new** MAT recommendation **must** be completed in all scenarios where **new medical evidence is submitted** as part of the request for a review of a decision, even if this evidence does not change the outcome of the recommendation. In scenarios where the customer has appealed a rejection as a result of an assessment of their DSP claim, and a different rejection reason applies on the basis of a new assessment, **do not** 47E(d) **and reject the claim**. Issue the customer with a Q351 letter advising of the outcome of the quality check, select 47E(d) Incorrect decision at 47E(d) of the Q351 letter and include the new rejection reason in the free text area. In any scenario where the customer cannot be contacted to advise of the outcome of the quality check: • finalise the quality check • issue the customer with a Q351 letter to notify the customer of the outcome and their further review rights. See SME explanations, ARO referrals and implementing ARO decisions

2	**SME action post MAT Reassessment** + Read more ...
	
	The SME is to review the MAT outcome. If a quality issue is identified, the SME is to refer back to the MAT via the **DSP** 47E(d) **Fast Note** and select relevant option.
	
	If the MAT decision:
	
	• is **unchanged and the rejection supported**, contact the customer and finalise appeal as outlined in SME explanations, ARO referrals and implementing ARO decisions. Where the MAT determines the decision is unchanged because the new medical information is outside the DSP claim period, however may require further assessment, discuss reclaiming DSP
	• **recommends manifest medical eligibility**:
	  ○ MAT will assess Continuing Inability to Work (CITW) where manifest medical eligibility is met. If CITW assessment is required but has not been assessed, use 47E(d) **Fast Note** 47E(d) 47E(d) to request CITW assessment
	  ○ hold **DSP** 47E(d) for 7 days under Hold to User
	  ○ once CITW has been assessed, see Residence Assessment for customers claiming Disability Support Pension
	  ○ finalise claim as outlined in Granting Disability Support Pension (DSP) (manifest) or Rejecting a new claim for Disability Support Pension (DSP) including manifest rejections
	  ○ contact customer and finalise appeal as outlined in SME explanations, ARO referrals and implementing ARO decisions
	• **recommends JCA Referral**:
	  ○ MAT will refer to JCA in most instances and place the **DSP** 47E(d) on hold for 28 days
	  ○ if JCA Referral has not been actioned by MAT, create a **JCA Referral** 47E(d) using referral reason 47E(d)
	  ○ annotate the **DSP** 47E(d) to advise JCA Referral has been actioned, and
	  ○ Hold to User for 28 days

3	**SME action post JCA Assessment** + Read more ...
	
	If the JCA decision:
	
	• **supports rejection**:
	  ○ SME to action (accept) JCA as outlined in Checking and actioning a Job Capacity Assessment (JCA) report
	  ○ contact customer and finalise appeal as outlined in SME explanations, ARO referrals and implementing ARO decisions
	• **supports manifest grant**:
	  ○ assess DSP claim per normal process
	  ○ make sure non-medical eligibility is assessed. See Granting Disability Support Pension (DSP) (manifest)

	○ contact customer and finalise appeal as outlined in SME explanations, ARO referrals and implementing ARO decisions • **supports DSP eligibility (not manifest)**: ○ the auto DMA Referral should occur ○ if the Auto DMA Referral is not successful, action DMA referral for reason DMA Appeal as outlined in Disability Medical Assessment referrals ○ annotate **DSP** 47E(d) to advise DMA referral has been made ○ Hold to User for 28 days ○ when DMA has been submitted, go to Table 4 in Assessing eligibility for Disability Support pension (DSP) after a Disability Medical Assessment (DMA), to finalise claim ○ contact customer and finalise appeal as outlined in SME explanations, ARO referrals and implementing ARO decisions
4	**DSP claim rejected on the basis of a DMA recommendation - referral to ARO** + Read more ... Where the customer's DSP claim was originally rejected on the basis of a DMA recommendation, DSP SMEs must refer the case for a formal review by an ARO. This includes situations where additional medical evidence has been provided. SME action required: • run 47E(d) script • at Step 4 47E(d) • at Step 5 47E(d) • at Step 6 47E(d) • at Step 7 47E(d) 47E(d) • select '**No**' to the question 'Is the customer satisfied with the outcome of the quality check?' • annotate the **DSP** 47E(d) to indicate the customer was not actually contacted and why the matter was referred to an ARO
5	**Implementing ARO/AAT decisions for DSP medical decisions** + Read more ... When the ARO or AAT make a decision regarding DSP medical eligibility that requires implementation by a SME, the instructions are recorded on a **DOC** and allocated to a SME. When implementing ARO/AAT decisions, the SME must: • review the decision and update the customer's record as per the instructions provided • check if updates are required to the Medical Conditions Details 47E(d) and Work Capacity Details 47E(d) screens • if the DSP claim was originally rejected on the basis of a MAT Recommendation, there will be no corresponding JCA line present on the 47E(d) screen and a **Manual JCA** activity may be required • refer to Service Support Officer (SSO) via 47E(d) overrides or Manual JCA coding is required. Details of the updates required must include: ○ ARO/AAT decision, medical conditions, impairment ratings, work capacity, POS (if applicable), and relevant DSP decision date • annotate the 47E(d) **DOC** to advise referral to SSO has been made • Hold to User for 28 days **Note**: **do not** 47E(d) **a DSP** 47E(d) **activity** while awaiting updates to be made. **SSO will review the ARO/AAT decision** and action as follows: • complete 47E(d) , see Overriding Medical Conditions and Work Capacity recommendations in a Job Capacity Assessment (JCA) report, or • refer to Level 2 Policy Helpdesk to request Manual JCA coding 47E(d) coding. 47E(d) coding is required when there is no existing ESAt/JCA entry on 47E(d) for the Event Date of the DSP claim because the medical outcome was determined by a MAT Recommendation or a Current & Valid ESAt/JCA, from an earlier date • Level 2 will update 47E(d) and 47E(d) screen details as required, document the record and finalise the Level 2 Enquiry

	• SSO will finalise 47E(d) database entry to advise SME that 47E(d) overrides or Manual JCA updates have been finalised
	
	The SME will:
	
	• action claim per normal process, including assessment of non-medical eligibility and run the 47E(d) 47E(d) script in 47E(d) to update 47E(d) system
	• if the claim is not ready to be finalised for a non-medical reason, **do not** 47E(d) **the claim**. Annotate the 47E(d) 47E(d) **DOC** and hold for relevant period with outstanding detail. For example, Request for Information required
	• once the non-medical eligibility has been assessed:
	  ○ 47E(d) and finalise the claim, and
	  ○ run the 47E(d) script

6	**DMA Error** 47E(d) + Read more ... **ARO decisions:** ARO decisions to grant DSP must be supported by a DMA assessment (unless customer is manifestly medically eligible). If decision has been made by ARO and: • no DMA is present, SME must contact the ARO, refer to process in SME Explanations, ARO referrals and implementing ARO decisions • DMA is present: • 47E(d) the claim in 47E(d) • Make sure non-medical eligibility has been established • Finalise claim as outlined in 47E(d) Table 4 of Assessing eligibility for Disability Support Pension (DSP) after Disability Medical Assessment (DMA) • Run the 47E(d) script • DMA report has been accepted and the 47E(d) error is present: • Check the DMA Report has been accepted and outcome appears on 47E(d) screen from the correct 47E(d) Date • If DMA has been accepted and the error is still present, refer to process 47E(d) of Assessing eligibility for Disability Support Pension (DSP) after Disability medical Assessment (DMA) **AAT decisions** DMA Error 47E(d) will be present where AAT make a decision to grant DSP but no DMA exists. When implementing an AAT decision and an 47E(d) error is present: • 47E(d) DSP new claim activity in 47E(d) and make sure claim is fully coded and **ready to be finalised** • apply all updates within the claim via 47E(d) • go to the 47E(d) creen to make sure there are no other errors presenting on 47E(d) • if 47E(d) overrides or Manual JCA coding is required, this must be completed via the 47E(d) web form as a separate request **before** running the **Fast Note** • use Fast Note - 47E(d) 47E(d) • annotate the 47E(d) **DOC** to advise of the referral to SSO for finalisation due to 47E(d) and place the DSP new claim activity on hold for 5 working days **Service Support Officer (SSO)**: • finalise the claim, and • record the appeal outcome via the 47E(d) script • refer to Table 4, Step 12 to determine if a post appeal ESAt is required If the SSO identifies any errors or outstanding information/assessments required before DSP claim can be finalised, SSO will:

	• annotate the 47E(d) • send feedback to SME via Staff Feedback Tool, and • refer back to SME via email to their Team Leader for follow up action

SME explanations of DSP medical decisions requested on or after 15 May 2021

Table 4: For appropriately trained staff only.

Step	Action

1	**DSP claim rejected and no new medical evidence lodged** + Read more ...
	
	If the customer has requested an explanation of the decision after the DSP claim has been **rejected** and **no new medical evidence** has been supplied, the **SME** must:
	
	• check the record to get a clear understanding of why the decision was made
	• check for any errors or information that was not considered in the original decision:
	  ○ if an error regarding medical eligibility (for example, incorrect version of the Impairment Tables has been applied) or information that was not considered is identified, go to Step 2
	  ○ if no errors in the original decision are identified or no information is provided, make genuine attempts to contact the customer to provide an explanation of the decision
	
	If customer contact is successful:
	
	• explain the reason for the decision
	• where the rejected DSP claim was lodged before 1 April 2023, tell the customer the Impairment Tables used to assess medical eligibility for DSP have changed from 1 April 2023. Direct the customer to the Services Australia website for more details
	• explain their review and appeal rights including:
	  ○ they can apply for a formal review at any time
	  ○ it is important to apply for a formal review within 13 weeks of being notified about the decision. If their application is made more than 13 weeks after being notified of the decision and the decision can be changed, they may only receive their entitlement from the date they applied for the formal review
	  ○ ask the customer if they would like to provide any additional medical evidence to be considered
	
	If the customer does not want to supply additional medical information:
	
	• 47E(d) script and finalise the request for an explanation with the outcome 47E(d) **(Decision not changed)**
	• if the customer wants to apply for a formal review of the decision, in the script, key today's date as the date the customer applied for a formal review on the 47E(d) screen. See 47E(d) 47E(d) script
	• procedure ends here
	
	If the customer indicates they would like to supply additional medical information for the SME explanation:
	
	• tell the customer to supply information within 7 days. Explain that if information is not provided, the explanation will be finalised and no further action will be taken
	• update the 47E(d) **DOC** and hold for 7 days
	• apply Hold to User
	
	After 7 day hold period, if information has:
	
	• been supplied, go to Step 2
	• not been supplied, use the 47E(d) script to finalise the request for an explanation
	• procedure ends here
	
	If customer contact attempt is unsuccessful:

	• use the 47E(d) script to finalise the request for an explanation with the outcome 47E(d) **(Decision not changed)** • the script creates a 47E(d) to be sent to the customer inviting them to contact • **DOC** the record with the information required to explain the decision to the customer if they contact • procedure ends here
2	**Customer lodges new medical information or medical error identified** + Read more ... Determine the basis for the medical rejection (for example, MAT, JCA, DMA) where: • the customer has requested a SME explanation after their DSP claim has been rejected and has supplied new medical evidence, or • an error regarding medical eligibility/evidence has been identified If the DSP claim was rejected on the basis of: • MAT or JCA recommendation, go to Step 3 • DMA recommendation, go to Step 7
3	**DSP claim rejected on the basis of MAT or JCA recommendation** + Read more ... The SME must: • create an open work item using the Fast Note - 47E(d) 47E(d) • annotate 47E(d) clearly advising that additional medical evidence has been provided or an error regarding medical eligibility/evidence has been identified and referred to MAT for consideration and hold for 7 days • apply Hold to User The MAT Assessor will: • consider existing or new medical evidence in the context of the appeal request, and • complete a new recommendation to support the review of decision and upload this to 47E(d) (47E(d) or **SA479**) **Note**: where new medical information is not relevant to the decision under consideration (that is, DSP claim date and 13 weeks thereafter), however the Assessor indicates the evidence may require further assessment. The Assessor will recommend the decision is unchanged and, add notes to the SA479/MAT Recommendation. The SME is to discuss a possible reclaim with customer. For decisions, with a date of effect before 1 April 2023, tell customer about the new Impairment Tables from 1 April 2023 and direct them to the Services Australia website. Once the MAT assessment has been completed, the SME is to review the MAT outcome, if a quality issue is identified, the SME is to refer back to the MAT via 47E(d) **Fast Note** and select relevant option. Where MAT recommends: • the decision is unchanged or varied, go to Step 4 • manifest medical eligibility, go to Step 5 • JCA referral, go to Step 6
4	**MAT recommends no change or variation to DSP rejection** + Read more ... If the decision is unchanged or varied, the SME must: • **not** 47E(d) and reject a claim decision, even if the rejection reason has changed. For example, 47E(d) 47E(d) • make genuine attempts to contact the customer to provide an explanation

	If customer contact is **successful**:
	
	• explain the reason for the decision, including any changes in medical eligibility
	• if the MAT determine the decision is unchanged because the new medical information is outside the DSP claim period, however may require further assessment, discuss reclaiming DSP
	• where the rejected DSP claim was lodged before 1 April 2023, tell the customer the Impairment Tables used to assess medical eligibility for DSP have changed from 1 April 2023. Direct the customer to the Services Australia website, for more details
	• explain their review and appeal rights, including:
	  ○ they can apply for a formal review at any time
	  ○ it is important to apply for a formal review within 13 weeks of being notified about the decision. If their application is made more than 13 weeks after being notified of the decision and the decision can be changed, they may only receive their entitlement from the date they applied for the formal review
	• clearly **DOC** the discussion with the customer, including if they were satisfied with the explanation
	• use the 47E(d) script and finalise the request for an explanation with the outcome 47E(d) **(Decision not changed)**
	• if the customer wants to apply for a formal review of the decision, in the script, at **Finalise Explanation and/or Refer to ARO (if appropriate)** > '**Has the customer applied for a formal review by an ARO?**' > select **Yes**. See Using the 47E(d) script
	• procedure ends here
	
	If customer contact attempt is **unsuccessful**:
	
	• use the 47E(d) script and finalise the request for an explanation with the outcome 47E(d) **(Decision not changed)**
	• 47E(d) inviting them to contact to discuss the decision
	• clearly **DOC** the record advising contact unsuccessful and include the information required to explain the decision to the customer if they contact. Include details about assessment of new medical information and the outcome of the MAT Assessment
	• procedure ends here

5	**MAT recommends manifest medical eligibility** + Read more ...
	
	The SME must check customer's residence details and determine if a Continuing Inability To Work (CITW) assessment is required, and has been assessed.
	
	If a CITW assessment is required and not assessed:
	
	• use the 47E(d) **Fast Note**, 47E(d)
	• annotate the 47E(d) **DOC** to advise referral to MAT to assess CITW and hold for 7 days
	• apply Hold to User
	
	Once CITW has been assessed, continue assessment on non-medical eligibility. See Streaming a new claim for Disability Support Pension.
	
	If non-medical eligibility is met:
	
	• finalise claim as outlined in Granting Disability Support Pension (DSP) (manifest)
	• make genuine attempts to contact the customer and complete the 47E(d) **DOC**
	
	If contact is:
	
	• **successful**:
	  ○ explain the decision
	  ○ use the 47E(d) 47E(d) script with outcome **Decision** 47E(d)
	• **not successful**:
	  ○ use the 47E(d) 47E(d) script with outcome **Decision** 47E(d)
	  ○ 47E(d) inviting customer to contact to discuss the decision

	If non-medical eligibility is not met make genuine attempts to contact the customer and explain medical eligibility has been met, but customer is not eligible for DSP due to non-medical eligibility. If contact is: • **successful**: ○ use the 47E(d) script and select the outcome 47E(d) ○ if the customer wishes to apply for a formal review, in the script, 47E(d) 47E(d) the 47E(d) script • **not successful**: ○ use the 47E(d) script and select the outcome 47E(d) • 47E(d) inviting customer to contact to discuss the decision • procedure ends here See Using
6	**MAT recommends JCA Referral** + Read more ... MAT **must** take 47E(d) **DOC** off hold so work item presents to SME for actioning. The SME must make genuine attempts to contact the customer. **If customer contact is successful**: • explain further assessment of medical eligibility is needed • to make sure a thorough assessment, the decision will be referred to an Authorised Review Officer who will undertake a formal review • use the 47E(d) script and finalise the request for an explanation: ○ select the **Outcome** 47E(d) ○ in the **Reason for outcome**, 47E(d) 47E(d) 47E(d) ○ key 47E(d) as the date the customer applied for a formal review ○ 47E(d) confirming the referral to ARO • Refer to JCA, use **Fast Note** - 47E(d) 47E(d) ○ In the **Fast Note** text, select 47E(d) ○ Make sure the question regarding Residence/Qualifying Residence Exemption is answered correctly, see Disability Support Pension Residence Screens Checklist • where the rejected DSP claim was lodged before 1 April 2023, tell the customer the Impairment Tables used to assess medical eligibility for DSP have changed from 1 April 2023. Direct the customer to the Services Australia website, for more details • procedure ends here **If customer contact attempt is unsuccessful**: • use the 47E(d) script and finalise the request for an explanation: ○ select the outcome 47E(d) ○ in the **Reason for outcome**, 47E(d) 47E(d) 47E(d) ○ key 47E(d) as the date the customer applied for a formal review. See 47E(d) 47E(d) script ○ 47E(d) confirming the referral to ARO • **cancel the** 47E(d) and issue a **manual** letter. In 47E(d) ○ go to the 47E(d) screen. The 47E(d) of the letter will be 47E(d) ○ 47E(d) The letter status will change to 47E(d) ○ 47E(d) ○ send a 47E(d) to notify the customer that the decision has been referred to an ARO who will undertake a formal review. See suggested text on the Resources page ○ use the 47E(d) **Fast Note** 47E(d) • procedure ends here
7	**DSP claim rejected on the basis of DMA recommendation** + Read more ...

	The SME must:
	
	• investigate the original decision
	• check for any errors or information that was not considered in the original decision. For example, information on medical condition which was previously provided but not considered in the DMA report
	• review new medical evidence and determine if further assessment of the medical evidence is required. For example, further assessment would not be required if:
	  ○ the medical evidence is the same as the evidence that has already been assessed, or
	  ○ it is clear the new evidence will not impact medical eligibility as it relates to a condition which is likely to persist for less than 2 years
	
	If the SME determines a further medical assessment is:
	
	• not required, go to Step 8
	• required, go to Step 9

8	**SME determines further medical assessment is not required** + Read more ...
	
	The SME must make genuine attempts to contact the customer.
	
	If customer contact is **successful**, explain:
	
	• new medical evidence has been considered but outcome has not changed
	• where the rejected DSP claim was lodged before 1 April 2023, tell the customer the Impairment Tables used to assess medical eligibility for DSP have changed from 1 April 2023. Direct the customer to the Services Australia website, for more details
	• explain their review and appeal rights including:
	  ○ they can apply for a formal review at any time
	  ○ it is important to apply for a formal review within 13 weeks of being notified about the decision. If their application is made more than 13 weeks after being notified of the decision and the decision can be changed, they may only receive their entitlement from the date they applied for the formal review
	• use the 47E(d) script and finalise the request for an explanation with outcome 47E(d) 47E(d)
	• if the customer wants to apply for a formal review of the decision, in the script, 47E(d) 47E(d) 47E(d) select 47E(d) See Using script
	• procedure ends here
	
	If the customer contact attempt is **unsuccessful**:
	
	• use the 47E(d) script and finalise the request for an explanation with outcome 47E(d) 47E(d)
	• 47E(d) inviting them to contact to discuss the decision
	• procedure ends here

9	**SME determines further medical assessment is required** + Read more ...
	
	The SME must make genuine attempts to contact the customer.
	
	If customer contact is **successful**, explain:
	
	• further assessment of medical eligibility is needed
	• to make sure a thorough assessment, the decision will now be referred to an Authorised Review Officer who will undertake a formal review
	• use the 47E(d) script and finalise the request for an explanation:
	  ○ select the outcome 47E(d)
	  ○ in the **Reason for outcome**, key 47E(d) 47E(d)
	  ○ key 47E(d) date as the date the customer applied for a formal review
	• 47E(d) confirming the referral to ARO

	• procedure ends here
	
	If customer contact is **unsuccessful**:
	
	• use the 47E(d) script and finalise the request for an explanation
	  ○ select the outcome 47E(d)
	  ○ in the **Reason for outcome**, key the text 47E(d)
	  47E(d)
	  ○ key 47E(d) date as the date the customer applied for a formal review
	  ○ 47E(d) confirming the referral to ARO
	• **cancel the** 47E(d) and issue a **manual** letter. 47E(d)
	  ○ go to the 47E(d) screen. The 47E(d) of the letter will be 47E(d)
	  ○ 47E(d) the letter. The letter status will change to generated 47E(d)
	  ○ 47E(d) the letter
	  ○ send a 47E(d) to notify the customer that the decision has been referred to an ARO who will undertake a formal review. See suggested text on the Resources page
	• procedure ends here

10	**Implementing ARO/AAT decisions for DSP medical decisions** + Read more ...
	
	When ARO or AAT make a decision regarding DSP medical eligibility that requires implementation by a SME, the instructions are recorded on a **DOC** and allocated to a SME.
	
	When implementing ARO/AAT decisions:
	
	• review the decision and update the customer's record as per the instructions provided
	• check if updates are required to the 47E(d) and 47E(d) screens
	• if the DSP claim was originally rejected on the basis of a MAT Recommendation, there will be no corresponding JCA line present on the s47E(d) screen and a **Manual JCA** activity may be required
	• refer to Service Support Officer (SSO) via 47E(d) where 47E(d) overrides or Manual JCA coding is required. Details of the updates required must include:
	  ○ ARO/AAT decision, medical conditions, impairment ratings, work capacity, POS (if applicable), and relevant DSP decision date
	• annotate the 47E(d) **DOC** to advise referral to SSO been made
	• Hold to User for 28 days
	
	Note: **do not index a DSP** 47E(d) **activity while awaiting updates to be made**.
	
	SSO will review the ARO/AAT decision and action as follows:
	
	• complete 47E(d) overrides per Overriding Medical Conditions and Work Capacity recommendations in a Job Capacity Assessment (JCA) report, or
	• refer to Level 2 Policy Helpdesk to request Manual JCA coding. 47E(d) coding is required when there is no existing ESAt/JCA entry on 47E(d) for the Event Date of the DSP claim because the medical outcome was determined by a MAT Recommendation or a Current & Valid ESAt/JCA, from an earlier date
	• Level 2 will update 47E(d) and 47E(d) screen details as required, document the record and finalise the Level 2 Enquiry
	• SSO will finalise 47E(d) entry to advise SME that 47E(d) overrides or Manual JCA updates have been finalised
	
	The SME will:
	
	• action claim per normal process, including assessment of non-medical eligibility and run the 47E(d) 47E(d) script in 47E(d) system
	• if the claim is not ready to be finalised for a non-medical reason, do not 47E(d) the claim. Annotate the 47E(d) 47E(d) **DOC** and hold for relevant period with outstanding detail. For example, Request for Information required
	• once the non-medical eligibility has been assessed:
	  ○ 47E(d) and finalise the claim in 47E(d)
	  ○ if no error presents and claim is finalised run the 47E(d) script, and
	  ○ refer to Step 12 to determine if a post appeal ESAt is required

	○ if a DMA Error 47E(d) presents, go to Step 11
11	**DMA Error** 47E(d) + Read more ... **ARO decisions** ARO decisions to grant DSP must be supported by a DMA Assessment (unless customer is manifestly medically eligible). • If decision has been made by ARO, and no DMA is present, SME must contact the ARO, refer to process outlined in SME Explanations, ARO referrals and implementing ARO decisions • If decision has been made by ARO and DMA is present: ○ 47E(d) the claim 47E(d) ○ Make sure non-medical eligibility has been established ○ Finalise claim as outlined in the 47E(d) of Assessing eligibility for Disability Support Pension (DSP) after a Disability medical Assessment (DMA) ○ Run the 47E(d) script ○ Refer to Step 12, to determine if a post appeal ESAt is required • If the DMA Report has been accepted and the 47E(d) error is present: ○ Check the DMA Report has been accepted and outcome appears on 47E(d) screen from the correct Event Date ○ If DMA has been accepted and the error is still present, refer to process outlined in the 47E(d) 47E(d) Assessing eligibility for Disability Support Pension (DSP) after Disability medical Assessment (DMA) **AAT decisions** DMA Error 47E(d) will present where AAT make a decision to grant DSP but no DMA exists. **When implementing an AAT decision and an** 47E(d) **error is present** • 47E(d) DSP new claim activity in 47E(d) and make sure claim fully coded and ready to be finalised • apply all updates within the claim via 47E(d) • go to the 47E(d) screen to make sure there are no other errors presenting on 47E(d) • if 47E(d) overrides or Manual JCA coding is required, this must be completed via the 47E(d) web form as a separate request **before** running the **Fast Note** • use Fast Note 47E(d) 47E(d) • annotate the 47E(d) **DOC** to advise of the referral to SSO for finalisation due to 47E(d) error and place the DSP new claim activity on hold for 5 working days **Service Support Officer (SSO)**: • finalise the claim • record appeal outcome via the 47E(d) script • refer to Step 12, to determine if a post appeal ESAt is required If the SSO identifies any errors or outstanding information/assessments required before DSP claim can be finalised, SSO will: • annotate the 47E(d) • send feedback to SME via Staff Feedback Tool, and • refer back to SME via email to their Team Leader for follow up action
12	**Post appeal ESAt referral** + Read more ... Where 47E(d) and 47E(d) screens are updated by manual overrides of the JCA, the amended work capacity may not be recognised by Employment Services Providers such as, Workforce Australia or Disability Employment Services (DES). Therefore, a post appeal implementation ESAt may be required: • If a JCA assessment was undertaken as part of the ARO/AAT appeal an ESAt referral is not required. Procedure ends here

	• If a manual JCA activity 47E(d)) was coded by Level 2 an ESAt referral is not required. Procedure ends here • If 47E(d) overrides were completed to support the appeal implementation: ○ Check customer's 47E(d) in 47E(d) and view 47E(d) 47E(d) ○ If there is no Provider referral, ESAt referral is not required. Procedure ends here • If customer has a current Provider referral, refer for a DSP Volunteer ESAt: ○ Use Fast Note, 47E(d) 47E(d) ○ Add text to ESAt referral - 47E(d) 47E(d) For more information, see Request an Employment Services Assessment (ESAt).

Making a JCA referral for a formal review of decision

Table 5

Step	Action
1	**Customer has requested a review of a decision or has appealed a review officer's decision to the Administrative Appeals Tribunal (AAT) first review** + Read more ... Customer has requested a review of a decision or has requested an AAT first review of a review officer's decision to: • reject a new claim for DSP, or • cancel payment of DSP Tribunals can request Government-contracted Doctors (GCD) to appear before them to give evidence. **Note:** DSP cannot be granted without the claimant having attended a Disability Medical Assessment (DMA) (excluding manifest cases). See Eligibility for Disability Support Pension (DSP). When a review of decision is received: • the JCA will be booked into the 47E(d) as a DSP Appeal by Assessment Services if the request is for a file assessment, the original assessor (where possible) will conduct this assessment, this is due to their prior knowledge of the customer as they have met them in person • the Assessor will then review the previous assessment and additional medical information provided and complete a new report with recommendations A DMA is required where an Authorised Review Officer (ARO) sets aside or varies a DSP claim rejection and: • the claim was manifestly rejected • the JCA report indicated no Diagnosed, Reasonably Treated and Stabilised (DTS) conditions or impairment ratings/s <20 points • the JCA report indicates impairment rating/s >20 points, but: ○ POS not met, or ○ work capacity > 15 hours per week, or ○ inability to work did not occur in Australia
2	**Customer has applied for a second review or has lodged an appeal with the Federal or High Court** + Read more ... Customer is appealing to the: • AAT (second review) • Federal Court, on a point of law only, or • High Court, with leave of the Court To complete a new JCA referral as part of the review and appeal process, there are different teams and roles involved: • Litigation and Information Release (LIR) Branch, go to Step 3

	• Assessment Services National Administration Team (ASNAT) Support Team (ASNAT Support), go to Step 4
	• Assessment Services Director (ASD), go to Step 5
	• Assessment Services Assistant Director (ASAD):
	  ○ to assign the assessment, go to Step 6
	  ○ for quality assurance, go to Step 8
	• Assessor, go to Step 7

3	**Litigation and Information Release (LIR) Branch, Services Australia Legal Division initiate the JCA request** + Read more ... For an AAT second review, or an appeal to Federal Court or High Court, an Advocate from the LIR Branch, Services Australia Legal Services Division will email the ASNAT Support requesting a JCA for the customer. The request should include: • Customer name, contact details and Customer Reference Number (CRN) • Details of original claim • Appeal deadline • Original JCA provider • Prevalent medical conditions and medical evidence. Medical evidence can be obtained by contacting the LIR Branch, Services Australia Legal Services Division • Date the report is required by, and • Additional requests (for example, what the report should concentrate on, report submission details) The LIR Branch are responsible for recording a **DOC** on the customer's record advising an AAT second review, Federal Court or High Court Appeal is in progress and details about the JCA referral. **Note:** the AAT, Federal Court or High Court can request clarification from the Health Professional Advisory Unit (HPAU), in reference to advice the HPAU has previously provided regarding a DSP new claim or DSP medical review.

4	**ASNAT Support - action the JCA request** + Read more ...
	
	On receipt of the emailed request:
	
	• record details of the customer into the 47E(d) as an appeal
	• assign the new assessment to the Assessment Services Director (ASD) responsible for the Zone
	• email the JCA request to the ASD including:
	  ○ Referral reason (either pre 1/7/06 DSP appeal or DSP appeal)
	  ○ Format of assessment (prescribed by the LIR Branch request)
	  ○ Assessor discipline (determined by customer's primary medical conditions)
	  ○ Report date
	  ○ Arrangements for medical evidence (either attached as PDFs or electronic Medical File Envelope (eMIFE))
	  ○ Request for appointment details and the name of the Assessor to be provided to the ASNAT Support
	  ○ Any other specific aspects the Advocate has requested to have addressed or investigated for example, if the customer has indicated there is a specific symptom that requires further investigation
	  ○ Any special interview conditions required for example, Interpreter
	
	The ASD will acknowledge receipt of the email and make sure the details of the appointment time/date and assessor is provided to the ASNAT Support and the Advocate:
	
	• Advocates must be informed of the time/date of assessment so that:
	  ○ medical information can be provided to the assessor
	  ○ to allow the AAT or Court to be informed of the date the assessment will be completed
	• the ASNAT Support team will update the Appeals database with the assessment details once provided by the Assessment Services Assistant Director (ASAD), including the Assessor and appointment date/time
	• when ASNAT Support is advised who the Assessor is, the ASD will check their qualifications meet requirements, and notify the LIR Branch of the details of the assessment
	• two days before the due date, ASNAT Support will check on progress, and send a reminder of the due date to the ASD. When the report has been submitted and received by ASNAT Support, they will send a clearance email to the Director with a coversheet detailing expert witness guidelines and a request for the assessor to lodge a claim for reimbursement in the 47E(d) for reimbursement from the Department of Social Services

	Any additional paperwork received from the LIR Branch needs to be forwarded directly to the Assessor. **Note:** ASNAT Support must monitor appeal assessment due dates by checking the 47E(d) each morning.
5	**Assessment Services Director (ASD) - assign the request** + Read more ... Acknowledge the email request from ASNAT Support and assign the assessment to the appropriate ASAD. Make sure the details of the appointment time/date and Assessor is provided to ASNAT Support and the Advocate. If the assessment is not submitted by the day before the due date, a reminder will be received from ASNAT Support to ASD to follow up with the ASAD.
6	**Assessment Services Assistance Director (ASAD) - assign the assessment** + Read more ... Assign the JCA assessment request to a team Assessor with the appropriate qualifications to undertake the new assessment, **or** the requested Assessor. The ASAD makes sure the assessor is aware that: • they may be required to attend the AAT or Court hearing to give evidence about the content of their report and assessment of the customer • they must use a Contributing Assessor if the Impairment Table(s) used are not within their area of expertise Provide ASNAT Support with the Assessor details, along with the customer's appointment time/date once arranged.
7	**Assessor - complete the DSP Appeal JCA report** + Read more ... Review the medical information, particularly any additional information which was not available for the original assessment and consider the specific request/requirements detailed in the email. If unable to contact the customer's doctor and get clarification about a medical condition, contact the Health Professional Advisory Unit (HPAU) and discuss. Where required conduct a face to face assessment. This is required where evidence is provided about a new condition that was not previously assessed. Engage a Contributing Assessor if the Impairment Table(s) used is not within the assessor's area of expertise. When completing the report make sure: • all medical information particularly any additional information which was not available for the original assessment has been reviewed • specific request/requirements provided by the LIR Branch were addressed/investigated • if required, a face to face assessment was conducted • the report includes any differences in assessed work capacity or impairment ratings from the original report and the reasons for these differences, or confirms there is no change with the additional information Once the draft JCA has been completed, arrange for the ASAD to apply the quality assurance process to the assessment. The ASNAT Support will send a claim form to the Assessor for them to complete to claim reimbursement from the Department of Social Services once the appeal assessment has been completed.
8	**ASAD - quality assurance** + Read more ... In completing a quality assurance (QA) check of an appeal report, the ASAD is required to make sure: • the Assessor discipline is appropriately matched to the medical condition and the correct version of the Impairment Tables • if the report was a file assessment, the report includes advice the Information Sharing Arrangements was **not read** to the client • the Advocate's requests were met • the Contributing Assessor was used where required

	• the report reviews the customer's present eligibility for DSP and contains comments relating to eligibility for DSP at the time of the original claim, plus 13 weeks • all decisions are supported by medical evidence • details of any contact with or attempts to contact the treating doctor were made (where required) are recorded • any specific requests by the Advocate have been addressed • all recommendations in the report are fully justified and provide a clear rationale as to how they were reached including an explanation of why any outcomes may differ from the original report • high quality presentation ensuring the report has no typographical or grammatical errors The National Support Professional Services Team can offer support and guidance to assist in the completion of complex appeals. Once the QA check has been completed, the report is to be submitted. The ASAD is to ask the Assessor to submit the report and provide a copy of the submitted report to the ASD to forward to the ASNAT Support. A copy is also to be forwarded to the LIR Branch where appropriate. **Note:** if the report is opened and changed by the Assessor they must advise the LIR Branch of the changes made. The ASNAT Support will send a claim form to the Assessor to complete to claim reimbursement from the Department of Social Services once they have completed the appeal assessment. The ASAD will make sure that a claim for the time spent on the appeal is sent to ASNAT Support. The ASAD will make sure that: • the LIR Branch receives a copy of the submitted report, and • a claim is sent for work done an Appeal Assessment to ASNAT Support The National Support Professional Services Team will incorporate into the Quality Framework, random sampling of this work to make sure that consistency and quality of AAT Appeal reports is maintained.
9	**When an 'Appeal Outcome' JCA is required** + Read more ... An 'Appeal Outcome' JCA will be required where it is decided, following a review of decision, that the customer's medical condition/s, impairment rating/s or work capacity is different from the most recent JCA report. This must be conducted as a file assessment. The referral is arranged using one of the following reasons: • a JCA using 47E(d) Appeal Outcome (DSP) reason will require completion of 'with intervention' work capacity • a JCA completed using 47E(d) Appeal Outcome (DSP pre 1/7/06) reason will require completion of 'with mainstream intervention' work capacity There should generally be no need to override the original JCA recommendations on the 47E(d) 47E(d) screens as the review of decision outcome will be applied to the customer's record once the new report is accepted. The Assessor completing the 'Appeal Outcome' JCA report must make sure the recommendations in the report (including medical conditions, impairment, work capacity and referral recommendations) are consistent with the delegate's decision taking into account relevant medical evidence. Staff accepting a submitted 'Appeal Outcome' JCA report must make sure that: • recommendations about medical conditions, impairment and work capacity are consistent with the review of decision • the correct Event Date is recorded, consistent with the decision being reviewed • appropriate action is taken to connect customers with mutual obligation requirements with the recommended services (such as Disability Employment Services (DES)) DSP customers with participating requirements are identified.
10	**Finalise the review** + Read more ...

	To finalise appeal 47E(d)

Making an ESAt or JCA referral when a review of a previous decision is pending

Table 6

Step	Action

1	**Pending review of a previous decision** + Read more ...
	
	In most cases there should be a **DOC** on the customer's record showing the progress of their review request and a contact person.
	
	If required to confirm the identity of the contact person go to the 47E(d) screen in the 47E(d) system 47E(d). Select the relevant appeal record.
	
	Check the 47E(d) screen and identify the current review level. Go to the following screens:
	
	• for Subject Matter Expert (SME), go to the 47E(d) screen and check the 47E(d) field
	• for Authorised Review Officer (**ARO**), go to the 47E(d) screen and check the 47E(d) field
	• Administrative Appeals Tribunal (AAT **first** review)
	  ○ for matters still current at the AAT, go to the 47E(d) screen
	  ○ for matters finalised at the AAT, go to the 47E(d) screen and check the 47E(d) 47E(d)
	• for Administrative Appeal Tribunal (AAT **second** review), go to the 47E(d) screen and check the 47E(d) 47E(d) field
	
	If the deferral **DOC** is due, go to Step 4.
	
	Is a review of decision underway?
	
	• **Yes**, go to Step 2
	• **No**, continue making an ESAt or JCA referral. Procedure ends here

2	**Consultation required to determine if referral should be deferred** + Read more ... Determine if a new assessment may affect the outcome of the review of decision: • for an internal review, check with the SME or ARO • for an AAT first time review (current), check with the ARO • for an AAT first time review (finalised and returned to the agency), check with an Advocate in the Legal Services Division

	• for an AAT second review (regardless of progress), check with an Advocate in the Legal Services Division This is important if the review request is concerned with medical or work capacity issues affecting entitlement and mutual obligation requirements.
3	**Deferring or proceeding with a referral** + Read more ... Does this consultation indicate a new assessment should be deferred until after the current review of decision is finalised? • **Yes**, create a Note/**DOC** on the customer's record. Do not finalise the Note/**DOC**. Resubmit the Note/**DOC** for the expected decision date of the review (up to a maximum of 28 days) • **No**, continue making an ESAt or JCA referral. Procedure ends here
4	**Finalise the decision** + Read more ... When the review of decision has been finalised: • record the outcome of our review • record any action take on the referral • finalise the **DOC** If still required make a new ESAt or JCA referral.

Resources

Suggested 47E(d) text

Letter text

47E(d)

Intranet links

Assessment Services Branch

Contact details

Assessment Services

Training & Support

Add the course number to the **Search** field in the Learning Portal (LMS) in ESSentials:

- **CLK01303** - The Internal Review Process (CSDG only)
- **CLK01252** - The SME role in Internal Review