Cabinet Office

Medical Reviews and Appeals Guide

Principal Civil Service Pension Scheme
Civil Service Injury Benefit Scheme

Making government work better

Index

1 Medical retirement and early payment appeals

Background

1.1 The Medical Retirement Appeals process relates solely to:

- a decision on whether to issue a medical retirement or refusal certificate
- a decision to award medical retirement benefits at the lower tier level (applies only to **premium**, **classic plus** and **nuvos** members)
- a refusal to issue a member a medical retirement certificate retrospectively
- a refusal to issue a medical retirement certificate for early payment of a preserved award (EPPA) (applies only to **classic** members)

Note: Successful appeals against refusal of medical retirement allow the member to receive medical retirement benefits. These are backdated if the member's service was terminated before the conclusion of the appeal.

Criteria

1.2 The criteria applied when considering a case under the Medical Appeal process are the same as for medical retirement, but depend on whether the person is a member of **classic** or **premium/classic plus/nuvos**:

1.3 classic

The criteria for medical retirement in classic are that an individual is prevented by ill health from discharging his/her duties and that the ill health is likely to be permanent.

classic plus premium and nuvos

There are two levels, or tiers, of medical retirement. What tier is given depends on the effect of the incapacity on the member's ability to carry out work. The medical adviser can recommend a provisional award at the rate most appropriate at the time if they are unable to decide which of the criteria is met.

- Upper tier: an individual has suffered a permanent breakdown in health and the resulting incapacity prevents them from discharging their duties and of undertaking any other gainful employment
- Lower tier: an individual has suffered a permanent breakdown in health and the resulting incapacity prevents them from discharging their substantive duties. the resulting incapacity prevents them from discharging their substantive duties.

Definitions:

Prevented / *prevents* ~ means having a significant incapacity. It does not mean "unwilling", "disinclined to" or "inconvenient" to undertake the duty. The employer will have obtained occupational health advice to identify any employment adjustments to possibly overcome obstacles to working. The individual will usually have co-operated with this. The employer will only consider medical retirement if they conclude that such adjustments are on

balance unreasonable or unfeasible to implement. Collusion between employer and employee to manipulate the pension scheme is considered fraud.

Discharging his/her duties **~** means providing regular and efficient service in the normal duties of their responsibility level. It does not mean "all work" in the Civil Service context.

> *Note:* Individuals do not have to be incapable of attending work but rather incapable of providing acceptable levels of performance or attendance. What is 'acceptable' is governed by the requirement to make reasonable adjustments for those with health problems and, particularly if they are likely to fall within the scope of the Disability Discrimination Act 1995.

Ill health / *breakdown in health* ~ means a recognised medical condition which gives rise to the incapacity. Diagnosis must be supported by appropriate clinical findings.

Likely ~ means 'on a balance of probabilities'. The permanence of the ill health does not have to be 'beyond reasonable doubt' but rather more likely than not.

Permanent ~ means until pension age. Not only does the ill health have to be permanent but it also has to result in permanent incapacity. Many permanent medical conditions (e.g. asthma, diabetes, epilepsy, etc) do not normally prevent individuals from working normally.

Incapacity ~ means unable to work due to the breakdown in health.

Incapable of undertaking other gainful employment ~ the individual's functional ability to carry out any reasonable paid employment should have been impaired by more than 90%. That is, they may be capable of undertaking some types of job, but this is severely restricted by their loss of function caused by the illness.

Incapable of doing his own or a comparable job ~ incapable of doing their own job or a comparable one within their Civil Service pension scheme employment. They will however be capable of a range of other types of work.

Pension age ~ means the earliest age at which a member can take their pension without it being reduced because of early payment.

Process

1.4 The procedure has three separate stages at any of which the appeal may be upheld.

Stage 1

Action by member

1.5 Members must appeal in writing and complete section 2 of form APP1 returning it to the employer or former employer.

1.6 The member must appeal within 3 months of the date when the employer notifies them in writing about the content in the medical retirement or refusal

certificate. The employer must issue a medical appeal form (APP1 section 2) with their decision. Members wishing to appeal against a refusal to grant medical retirement retrospectively or EPPA must do so within 3 months of the date when the employer tells them that their application was not successful. Where a member is unfit to make an appeal personally, a relative, friend or Trade Union representative may – with the member's consent – appeal on their behalf during the 3 month period.

1.7 Members can appeal with or without any significant new medical evidence to support their case. However failure to submit such evidence at this stage of the appeal means that it is most unlikely that the case can progress beyond Stage 2. If the member is not supplying significant new medical evidence with their appeal they should indicate this on the form.

Note: If exceptionally the member cannot meet the 3 month deadline because of delays beyond their control, employers may ask, on their behalf, Civil Service Pensions Division to consider allowing them an extension.

Action by employer

1.8 The employer must forward the complete case file to Capita Health Solutions without delay.

1.9 Applications for medical advice must be made using the order form APP 1.

flag	documents required
1	The original application papers and medical adviser's decision (including evidence gathered by the OH Adviser and Capita Health Solutions' correspondence as scheme medical adviser).
2	Full occupational health records. This includes reports to management from your occupational health (OH) adviser, the clinical notes (including notes of any consultations) upon which such reports are based, and any reports from your employee's doctors that your OH provider has obtained. The last two should be contained in a medical in confidence envelope.
3	Section 2 of the APP 1 form completed by the member and the new medical evidence. This must be from a registered medical practitioner. Copies of reports previously considered do not represent new evidence and are not acceptable. Complete reports are needed. Extracts or part reports are not acceptable. If the appellant wishes the medical evidence can be submitted in a sealed envelope for the attention of the medical adviser.

Note: Any documents sent by post to Capita Health Solutions should be enclosed in two sealed envelopes. They will return them in this way using an outer 'poly' envelope.

1.10 Failure to include any of this material will result in the case being returned by Capita Health Solutions. You must not send any other files (for example personal, HR or Pension files) to them.

Action by Capita Health Solutions

1.11 A senior physician will consider the appeal in the light of the medical evidence previously considered plus any additional reports provided by the appellant and recommend whether the original assessment is supported or overturned. This will usually (but not always) be the senior physician who made the original decision. If the appeal is not supported and the member has not been examined by Capita Health Solutions as part of the decision making process he or she will be offered an appointment, whenever practicable, to gather any additional information and to

explain the reasons for the recommendation.

1.12 Capita Health Solutions will inform the employer of the result of the Stage 1 review and of any further action to be taken. They will aim to clear all cases within 10 working days of receipt. If the senior physician upholds the appeal, the employer must decide whether to accept the assessment, informing the member accordingly. If the employer rejects the senior physician's findings they must give a full explanation to the member of why they do so.

> Note: Where the appeal is against the award of lower tier benefits in premium or classic plus, the pension scheme rules provide that the final decision on tiers rests with the medical adviser, *not* the employer.

1.13 Where the senior physician upholds an appeal against a decision to award lower tier benefits (i.e. he or she decides to award upper tier benefits), the employer should inform the member accordingly.

Stage 2

1.14 Where the appeal is not supported, the senior physician will forward all the papers to Capita Health Solutions chief medical adviser (CMA) to the PCSPS or the deputy at the National Case Referral Centre (NCRC) at Coventry. The CMA, or deputy, establishes whether a reasonable case for appeal exists. If not the appeal is rejected at this stage with an explanation to the employer of the deficiencies. The deficiency may cover a range of issues. The most likely are that there are gaps in the supporting documentation provided by the employer or the member, or that further medical evidence is required in some form.

1.15 The employer may resubmit rejected cases once they have remedied any deficiencies on their part; such a resubmission must be made within 3 months of the letter notifying them of the rejection and deficiencies.

1.16 Similarly where there are deficiencies in the supporting material provided by the member, or where further medical evidence is required, the employer must bring this to the member's attention as soon as Capita Health Solutions advise them of such. The member will have 3 months to remedy any deficiencies from the date of the employer's notification.

> Note: It is for the member to source, provide and pay for any further medical evidence being identified as being required by Capita Health Solutions *not* the employer.
> Note: If the member cannot meet the 3 month deadline because of delays beyond their control, the employer may ask, on their behalf, Civil Service Pensions Division Pension Complaints Branch to consider allowing them an extension.

1.17 The CMA or deputy will inform the employer of the result of the initial review and any further action within 20 working days of its receipt within the NCRC. Any further evidence submitted for consideration after the initial review will necessitate a further review as part of this stage.This further review will be completed within 20 working days.

1.18 If a reasonable case has been made the CMA or deputy, will determine whether the procedural and medical elements have been properly applied, and may uphold the appeal and provide a replacement medical retirement or refusal certificate. If there remains uncertainty whether the criteria for medical retirement are satisfied Capita Health Solutions will refer the case to an independent Medical Appeal Board to consider.

1.19 If the member cannot make a reasonable case within the 3 months allowed to

correct any deficiencies the appeal fails on procedural grounds.

1.20 If the CMA or deputy upholds the appeal, the employer must decide whether to accept the assessment, informing the member accordingly. If the employer rejects the findings they must give a full explanation to the member of why they do so.

1.21 If the CMA, or deputy, overturns a decision to award lower tier benefits (i.e. decides to award upper tier benefits), the employer must tell the member accordingly.

1.22 If the appeal fails at this stage and the member has any concerns about the way the process has operated in their case, they should refer to the Internal Disputes Resolution (IDR) Procedures.

> Note: The IDR procedures allow the member to appeal about the procedural aspects of their medical appeal, not the medical decision that resulted from it.

Appointment of the Independent Medical Appeal Board

1.23 Within five working days the CMA (or deputy) will nominate, from a list approved by the scheme managers, an independent Medical Appeal Board chair (normally an accredited specialist in occupational medicine) who practices in a region of the UK likely to be convenient for the member. Boards will not be held outside the UK.

> Note: The list of approved Medical Appeal Board chairs consists of accredited specialist occupational health doctors, none of whom are employed by or directly involved with Capita Health Solutions. Only doctors who have had no previous involvement in the case in question will be asked to chair a Medical Appeal Board.

1.24 Capita Health Solutions will provide the independent Chair with:

- copies of all the relevant papers
- a summary of the case identifying the key issues to be determined
- any necessary background relating to the rules of the PCSPS and/or the Civil Service

and will ask the Chair to arrange an appointment for the member as soon as is practicable.

1.25 Capita Health Solutions will provide the employer with an estimate of when the appointment is likely to take place together with an information sheet on the procedure that they should pass on to the member.

Stage 3

1.26 The independent Chair will:

- appoint a second accredited specialist to make up the Medical Appeal Board
- arrange for the Board to see the member in an appropriate clinical setting
- give the member at least two weeks notice of the appointment where practicable
- advise the CMA of the date, time and venue of the Medical Appeal Board

1.27 The CMA or deputy will copy this information to the employer. Members may be accompanied to the Board by a relative or friend or, for example, a Trade Union official. If a member does not wish to attend a Board or fails to attend two appointments the Board will consider the case on a papers only basis.

1.28 Having considered all the evidence, which may include an examination of the member, the Board will as soon as is practicable prepare a full clinical report:

- outlining the key features of the case
- stating whether they uphold or reject the appeal
- giving the reasons for their recommendations

Note: The decision of the independent Medical Appeal Board completes the medical aspects of the appeals procedure.
Note: Where the Medical Appeal Board upholds a medical retirement in premium or classic plus recommending that the award should be at the lower tier, the Board's assessment will be taken as final, with no further avenue of medical appeal *on this issue*.

1.29 The CMA or deputy, will forward the Board's findings and any appropriate certificate to the employer.

1.30 The employer will then decide whether to accept the Board's findings and will inform the member accordingly. If the employer rejects the Boards findings, they must give the member a full explanation of why they do so.

1.31 This completes the medical retirement appeal arrangements. If the member has any concerns about the way the process has operated in their case, they should refer to the IDR Procedures.

Note: The IDR procedures allow the member to appeal about the procedural aspects of their medical appeal, not about the medical decision that resulted from it.

1a Upper tier review appeals

Background

1.32 The upper tier review appeal process relates solely to a decision that the conditions for upper tier top-up benefits are no longer satisfied. The individual can appeal against this decision. When considering the appeal there are 2 different outcomes open to the medical adviser:

- Uphold the appeal returning the case to Civil Service Pensions that upper tier criteria are satisfied.
- Reject the appeal and then the case is automatically referred onto an independent Medical Appeal Board for a further review.

Process

1.33 The procedure has two stages

- Appeal to the Chief or Deputy Chief Medical Adviser
- Subsequent appeal to an independent Medical Appeal Board.

Note: This differs from the three stage medical retirement appeal process because before recommending the conditions for upper tier are no longer satisfied, the Scheme Medical Adviser will have already offered the member a consultation and a senior physician will have considered the case.

Action by member

1.34 Members must appeal in writing using the annex form issued with their decision outcome letter. They should return the appeal to Civil Service Pensions at the address shown on the annex. The member must appeal within 3 months of the initial decision when Civil Service Pensions notifies them in writing. If the member cannot make a reasonable case within the 3 months allowed then the appeal would fail on procedural grounds.

Note: Where a member is unfit to make an appeal personally, a relative, friend or Trade Union representative may with the member's consent appeal on their behalf during the 3 month period.

Note: Members can appeal with or without any significant new medical evidence to support their case. However failure to submit such evidence means that it is most likely that the appeal will be unsuccessful.

Note: If the member cannot meet the 3 month deadline because of delays beyond their control, Civil Service Pensions may ask, on their behalf, the Complaints Branch to consider allowing them an extension.

Action by Capita Health Solutions

1.35 The Chief or Deputy Chief Medical Adviser (CMA) will consider the appeal in the light of current information and any new medical evidence provided by the individual. The physician who considers the appeal will be a different physician from

the one who made the original decision.

1.36 If there are deficiencies in supporting medical evidence the Scheme Medical Adviser will bring this to the individual's attention. The individual will have three months to remedy any deficiencies from the date of the notification.

> Note: it is for the appellant to source, provide and pay for any further medical evidence.

1.37 A further consultation may be required with the Chief Medical Adviser.

> Note: The pension scheme rules provide that the final decision on tiers rests with the scheme medical adviser, not Civil Service Pensions.

1.38 The CMA or deputy will inform Civil Service Pensions of the result of the initial review and any further action within 20 working days of its receipt within the NCRC. Any further evidence submitted for consideration after the initial review will necessitate a further review as part of this stage. This further review will be completed within 20 working days. If the CMA or deputy is unable to support the appeal Capita Health Solutions will refer the case to an independent Medical Appeal Board to consider.

Stage 2

Appointment of the Independent Medical Appeal Board

1.39 Within five working days the CMA (or deputy) will nominate, from a list approved by the scheme managers, an independent Medical Appeal Board chair (normally an accredited specialist in occupational medicine) who practices in a region of the UK likely to be convenient for the member. Boards will not be held outside the UK.

> Note: The list of approved Medical Appeal Board chairs consists of accredited specialist occupational health doctors, none of whom are employed by or directly involved with Capita Health Solutions. Only doctors who have had no previous involvement in the case in question will be asked to chair a Medical Appeal Board.

1.40 Capita Health Solutions will provide the independent Chair with:

- copies of all the relevant papers
- a summary of the case identifying the key issues to be determined
- any necessary background relating to the rules of the PCSPS and/or the Civil Service.

They will ask the Chair to arrange an appointment for the member as soon as is practicable.

1.41 Capita Health Solutions will provide Civil Service Pensions with an estimate of when the appointment is likely to take place together with an information sheet on the procedure that they should pass on to the member.

1.42 The independent Chair will:

- appoint a second accredited specialist to make up the Medical Appeal Board
- arrange for the Board to see the member in an appropriate clinical setting
- give the member at least two weeks notice of the appointment where

practicable
- advise the CMA of the date, time and venue of the Medical Appeal Board.

1.43 The CMA or deputy will copy this information to Civil Service Pensions. Members may be accompanied to the Board by a relative or friend or, for example, a Trade Union official. If a member does not wish to attend a Board or fails to attend two appointments the Board will consider the case on a papers only basis.

1.44 Having considered all the evidence, which may include an examination of the member, the Board will as soon as is practicable prepare a full clinical report:

- outlining the key features of the case
- stating whether they uphold or reject the appeal
- giving the reasons for their recommendations.

Note: The decision of the independent Medical Appeal Board completes the medical aspects of the appeals procedure.

1.45 The CMA or deputy, will forward the Board's findings and any appropriate certificate to Civil Service Pensions and they will notify the individual of the outcome.

1.46 This completes the upper tier appeal arrangements. If the member has any concerns about the way the process has operated in their case, they should refer to the IDR Procedures.

Note: The IDR procedures allow the member to appeal about the procedural aspects of their medical appeal, not about the medical decision that resulted from it.

2 Injury benefit formal appeals

Background

2.1 The formal Injury Benefit Appeal process relates solely to:

- The medically assessed level of apportionment for injuries sustained on or after 1 April 2003.

- The medically assessed level of earnings impairment for injuries sustained on or after 1 April 2003.

Note: Unless previously supplied, the employer should give the appellant details of the scheme's qualifying criteria. It will also be helpful to provide a copy of this Guide. The member should be encouraged to give a copy of whatever is provided to their medical carers as background.

Criteria

2.2 The criteria applied when considering a case under the formal Medical Appeal process are the same as for Injury Benefit.

2.3 A person is eligible for a permanent injury benefit when they suffer *a qualifying injury that impairs their earning capacity.* Impairment of earnings capacity is assessed when the person is leaving employment (there may be other circumstances, such as moving to a lower grade or undertaking part-time working because of the injury – these are covered fully in the CSIBS rules). Impairment of earnings capacity is a medical assessment of the extent to which the member's earnings capacity for the remainder of their expected working life has been impaired by the qualifying injury, and must always be carried out by the scheme medical adviser. It is part of the overall evidence that the APAC/employer must look at when making a decision about awarding injury benefits.

Impairment of earning capacity is assessed in five bands:

Not appreciably affected	10% or less (no award is made)
Slight impairment	11% - 25%
Impairment	26% - 50%
Material impairment	51% - 75%
Total impairment	over 75%

2.4 The assessment of impairment to earning capacity relates only to the effects of the injuries sustained through the causal incident(s).

Apportionment

2.5 In addition to an impairment of earnings assessment, for qualifying injuries sustained on or after 1 April 2003 the APAC/employer must ask the scheme medical adviser to advise on whether the illness is "wholly" (more than 90%) or "mainly" (more than 50% but less than 90%) attributable to the nature of the duty.

2.6 If the scheme medical adviser considers that the illness is less than 50% attributable to duty, it cannot be considered as "mainly" attributable to duty and the injury benefit claim will fail.

2.7 Where a person meets the mainly attributable test then the scheme medical adviser will go on to apportion the extent to which their duties caused their injury.

Apportionment is assessed in three bands:

Low	50 – 70% attributable to duty
Medium	71 – 90% attributable to duty
High	above 90%

2.8 The formal Injury Benefit Appeal procedure has only 1 stage but 2 separate appeals can be made within the appropriate period (12 months of the initial award decision).

2.5 Any appeal should be made within 12 months of the initial Award decision. The second appeal may be notified up to and including the day the 12 month period ends – under these circumstances the appeal process may go beyond 12 months in its entire duration.

Action by Member

2.6 All appeals must be made in writing. The letter of appeal should set out the basis for the appeal (e.g. against the level of apportionment/or impairment of earnings capacity).

2.7 New medical evidence must be presented with the appeal. Failure to include new medical evidence will result in the case being returned.

Note: it is for the appellant to source, provide and pay for any further medical evidence not the employer.

Action by Employer/APAC

2.8 Applications for injury benefit appeals should be made using the form CSIBS2.

2.9 The following flagged documents must be submitted with each application.

Flag	Documents required
1.	**The new medical evidence.** This must be from a registered medical practitioner. Copies of reports previously considered do not represent new evidence and are not acceptable. Complete reports are needed. Extracts or part reports are not acceptable. If the appellant wishes the medical evidence should be submitted in a sealed envelope for the attention of the medical adviser.
2.	**All relevant information relating to the previous consideration of the case** whether held by the employer or by their occupational health adviser (including the complete sickness absence record and a job description)
3.	**All other paperwork** previously submitted by the employer as part of the original application (including Capita Health Solutions' correspondence as scheme medical adviser).

Note: Any documents sent by post to Capita Health Solutions should be enclosed in two sealed envelopes. They will return them in this way using an outer 'poly' envelope.

2.10 Failure to include any of this material will result in the case being returned. The employer must not send any other files (for example personal, HR or Pension files) to Capita Health Solutions.

2.11 Approaches to the APAC/employer about procedural irregularities, for example, where it seems that a piece of available information was not seen by the person making the final decision or by the medical adviser, *are not part of these appeals procedures.* For all practical purposes such approaches may be dealt with in an administrative ad hoc way as they occur.

Action by Capita Health Solutions

2.12 Whether considering a first or second appeal there are 3 different options open to the medical adviser:

- Uphold the appeal returning the case to the APAC/employer for a final decision.

- Reject the appeal (it goes no further) remitting the case back to the Authorising Authority/employer for a final decision.

- Referring a border-line case to a physician independent of the medical adviser for a further paper-based assessment. Such a referral would only be made by either the chief medical adviser or deputy chief medical adviser to the contract. The independent physician may uphold or reject the case at this final stage, remitting it back to the authorising Authority/employer for a final decision.

A first appeal

2.13 A senior physician will consider the appeal in the light of the new medical evidence provided by the member. The senior physician who considers the first appeal will be different from the one who made the original decision.

2.14 The appeal is normally considered on the basis of the information submitted. However, a consultation may be required if the physician considers it necessary.

2.15 The first appeal may uphold the original decision or result in an increase to the level of award.

A second appeal

2.16 Any second appeal is considered by a medical adviser physician different from either the one who gave the original advice and/or who considered the first appeal – in most cases the physician considering the second appeal will be either Capita Health Solutions CMA or the deputy CMA.

2.17 Any second appeal may do as the first appeal but can, in addition, lower the level of apportionment and/or earnings impairment if the new medical evidence justifies it.

2.18 This completes the formal Injury Benefit Appeal arrangement. If a member has any concerns about the way the process has operated in their case, they should refer to the Independent Disputes Resolution (IDR) Procedure.

3 Injury benefit reviews

Background

3.1 There is no formal appeal procedure against the APAC/employer decision in not deeming an injury as a qualifying injury (for injuries sustained at any time), and/or about the level of earnings impairment (for injuries sustained on or before 31 March 2003).

3.2 A member can request a review (informal appeal) against the APAC/employer decision

- not deeming an injury as a qualifying injury (for injuries sustained at any time)
- about the level of earnings impairment (for injuries sustained on or before 31 March 2003).

Note: Unless previously supplied, the employer should give the appellant details of the scheme's qualifying criteria. It will also be helpful to provide a copy of this Guide. The member should be encouraged to give a copy of whatever is provided to their medical carers as background.

Criteria

3.3 The criteria applied when considering a case in which a review has been requested (informal appeal) are the same as for Injury Benefit.

3.4 What criteria are used in determining whether or not a person has suffered a qualifying injury depends on when they suffered their injury. For most purposes a qualifying injury is one which occurs in the course of official duty, or an activity reasonably incidental to it and:

• Injury sustained before 1 April 1997
is directly attributable to the nature of the duty

• Injury sustained between 1 April 1997 and 31 March 2003
is solely attributable to the nature of the duty

• Injury sustained on or after 1 April 2003
is wholly or mainly attributable to the nature of the duty

3.4 The final decision on whether or not a qualifying injury has occurred rests with the APAC. The role of the scheme medical adviser is to provide advice on the medical aspects of a case.

Process

3.5 The review request (informal appeal) should be made at the earliest possible opportunity following the initial award decision. There is no strict time limit in respect of a request for review.

3.6 The review may uphold the original decision or support the grounds of the review request.

Action by member

3.7 All requests for review must be made in writing. The review request should set out the basis for reconsideration (e.g. in relation to the APAC/employer decision in not deeming an injury as a qualifying injury – for injuries sustained at any time, and/or about the level of earnings impairment – for injuries sustained on or before 31 March 2003). The review request should be made through the employer/APAC. Request for review should be on the basis of fresh evidence. This evidence may relate to employment matters or alternatively medical aspects of the case. Fresh medical evidence would certainly be required where the APAC/employer decision not to grant an award has been predominantly on the basis of medical advice provided by the medical adviser.

> Note: It is for the appellant to source, provide and pay for any further medical evidence, not the employer.

Action by employer/APAC

3.8 Where the fresh evidence relates to employment matters the APAC/employer may be able to undertake the review without resorting to further medical advice.

3.9 When the review request focuses on fresh medical evidence and/or employment matters and further medical advice is required, the employer should make an application to Capita Health Solutions using form CSIBS2.

3.10 The following flagged documents must be submitted with each application.

flag	documents required
1	The new medical evidence. This must be from a registered medical practitioner. Copies of reports previously considered do not represent new evidence and are not acceptable. Complete reports are needed. Extracts or part reports are not acceptable. If the appellant wishes the medical evidence should be submitted in a sealed envelope for the attention of the medical adviser.
2	All relevant information relating to the previous consideration of the case whether held by the employer or by their occupational health adviser (including the complete sickness absence record and a job description).
3	All other paperwork previously submitted as part of the original application (including Capita Health Solutions' correspondence as scheme medical adviser).

Note: Any documents sent by post to Capita Health Solutions should be enclosed in two sealed envelopes. They will return them in this way using an outer 'poly' envelope.

3.11 Failure to include any of this material will result in the case being returned by Capita Health Solutions. You must not send any other files (for example personal, HR or Pension files) to them.

3.12 Approaches to the APAC/employer about procedural irregularities, for example where it seems that a piece of available information was not considered *are not part of these review procedures.* For all practical purposes such approaches may be dealt with administratively as they occur.

Action by Capita Health Solutions

3.13 There are 3 different options open to the medical adviser when considering a review application.

- To uphold the grounds for the review of the request remitting the case back to the APAC/employer for a final decision.

- Reject the review request (it goes no further) remitting the case back to the APAC/employer for a final decision.

- Referring a border-line case to the physician independent of the medical adviser for a further paper-based assessment. Such a referral would only be made by either the CMA or deputy CMA to the contract. The independent physician may support or reject the case, remitting it back to APAC/employer for a final decision.

3.14 This completes the Injury Benefit Review arrangements. If a member has any concerns about the way the process has operated in their case, they should refer to the IDR procedures.