Decision Ref:	2018-0181
Sector:	Insurance
Product / Service:	Income Protection and Permanent Health
Conduct(s) complained of:	Rejection of claim - did not meet policy definition of disability Claim handling delays or issues Delayed or inadequate communication Dissatisfaction with customer service
Outcome:	Partially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainant is a member of a group income protection policy taken out by her employer with the Provider. Benefits under the policy are payable in the event of disablement. While the Complainant is not the policy holder, she is eligible to make a complaint to this Office as an actual or potential beneficiary under the policy as provided for under Section 44 (i) of the Financial Services and Pensions Ombudsman Act 2017.

This complaint relates to the decision by the Provider to cease payments and also to the lack of communication from the Provider to the Complainant in relation to her appeal. The Provider relies on medical evidence received by it in support of its original decision to cease the payments under the terms and conditions of the policy and points to the existence of robust appeal procedures in its decision to reinstate the claim. It further argues that it corresponded at all times with the policyholder, who is the Complainant's employer and not the Complainant herself, in relation to the claim and the appeal.

The Complainant's Case

The Complainant submitted a claim under the policy in May 2015 which was accepted in August 2015. After a review, a decision to cease the payments was taken by the Provider on 29 August 2016. An appeal was submitted by the Complainant in September 2016, which was rejected. A further appeal was submitted in December 2016 and further supporting

documentation was sent by the Complainant in January and February 2017. A further review was also undertaken by the Provider and a decision to reinstate the claim was made in May 2017 which was backdated to the original decision to cease payments.

The Complainant states that she suffers from severe back pain which became difficult to live with in November 2014 and she had surgery in January 2015 which didn't help. She had seven nerve blocks over the next two years as well as a nerve burning procedure.

The Complainant states that after the decision was taken by the Provider on 29 August 2016 she got a call from her employer's head office on 17 September 2016 to say that it had been cancelled as she no longer met the definition of disability. She states that she survived on social welfare benefits. She states that she wrote to the Provider in December 2016 and her letter was not acknowledged. She asserts that she tried to call the Provider but was only getting a message to say that the mailbox was full so she gave up and instead called her own employer to see if it had heard from the Provider. The Complainant states that it wasn't even about the money; she just wanted some acknowledgement from the Provider.

She states that she managed to speak to a representative of the Provider on 23 February 2017. She informed the Provider that a further surgery had been arranged for her which was to be long and severe. She states that the representative told her that the Provider had made an appointment for her to go to a physio on their behalf and she agreed to this and went on 1 March 2017. She states that the session was over six hours long and although she was totally exhausted and in pain, she did the session. She states that the physio couldn't figure out why the Provider requested the session when it knew that there was another surgery ahead. She states that she had to take painkillers to make it through the session and informed the physio of this. The Complainant asked for a copy of the physio report and she was told to contact the Provider directly. The Complainant states that she wrote to the Provider in March 2017 to request a report and once again received no reply.

The Complainant states that she made a call to this office on 2 May 2017. She also informed her employer about the complaint and within 24 hours, her employer informed her that the Provider had agreed to reinstate her benefits from the end of May 2017 and back benefits to November 2016. She argues that this only happened because the Provider discovered that she had contacted this office. She states that she was as yet to receive a copy of the physio report.

By letter to this office dated 15 December 2017, the Complainant states that she tried to call the Provider on a large number of occasions but the mailbox always seem to be full and when she couldn't get in touch she returned to her employer to see if it had heard directly from the Provider. She states that she only received eight days' notice of the Provider's decision to cease payments to her in November 2016 and had to apply for a moratorium on her mortgage. She states that the worry and stress of dealing with this financial situation on top of the pain was simply too much to cope with. She noted feelings of stress, loneliness, worry, and suggested she had given up hope. She argues that the Provider did not feel she continued to meet the disability definition but emphasises how real her pain is and the level of drugs that she requires to take every day, in addition to 3 surgeries, seven nerve block

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injections and a burning of her nerves in the last three years. She suggests that she was made to feel like a criminal.

The Provider's Case

In response to queries raised by this office, by letter dated 8 March 2018 the Provider noted that the Complainant is a member of a group income protection policy insured with it.

It notes the definition of 'disablement' under the policy as the member's "*inability to perform the material and substantial duties of their normal insured occupation as a result of their illness or injury*".

The Provider states that the Complainant completed a claim form on 4 May 2015, detailing her illness as "*lower back pain, pain down left leg and numb left foot, discectomy done 2 January 2015*". It states that it received a report from her general practitioner dated 31 July 2015 on 5 August 2015 wherein the GP advised the nature and cause of disability as "*acute disc prolapse*". Her employer advised that her absence from work commenced on 12 January 2015 and noted that the policy had a 26 week deferred period. The Provider states that the claim was accepted on the basis of the medical evidence supplied at the point of the claim and in its acceptance letter issued to the employer dated 14 August 2015, the Provider advised that the claim was under active review and that it would be requesting updated medical evidence.

The Provider notes that the claim review commenced on 16 February 2016 and as part of the process, the Provider requested completion of the employee review form by the Complainant and completion of the healthcare practitioners form by her GP. The completed forms were reviewed when they came in in March 2016. To review the claim, the Provider notes that it arranged for an independent medical examination with a Consultant Orthopaedic Surgeon, PN, on 18 May 2016. In his report dated 1 June 2016, PN is reported to have noted that the pain management treatment of the Complainant is conservative with the possibility of further new nerve root injections under consideration as well as spinal cord stimulation. He notes that the ongoing symptoms appear to be similar to what was present before her surgery in early 2015 with persistent back and leg symptoms. PN states that the Complainant is active and functions well as long as she avoids prolonged sitting and standing. PN concluded that he felt that it was "*reasonable to attempt to return back to work in a part-time capacity initially working 20 hours per week and then full-time after six to eight weeks having had returned to work*." He noted that he does not feel that her work practice would greatly change her ongoing symptoms which he feels are largely permanent but are manageable and will either be improved or dis-improved with time.

On the basis of this report, the Provider states that it was of the opinion that the Complainant did not continue to satisfy the definition of disablement and as a result of this, its decision was to cease the payment of the claim. It communicated the cessation decision to the employer on 29 August 2016 and outlined its appeals process. It states that it received appeal documents from the Complainant dated 15 September 2015 and forwarded a copy of the documents received to PN for further consideration but that he did not change his opinion or feel that the Complainant was disabled from working. In this updated report, PN

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was noted to have concluded that ongoing treatment was not a barrier to the Complainant returning to work. He noted an assessment from [Occupational Healthcare Specialist] which recommended a return to work for two hours per day up to ten hours per week for two months but PN was of the view that this was not a realistic or practical way of returning to the workforce and agreed that could not be facilitated. He reiterated his view that the Complainant had completed the cycle of active intervention to a large degree and that although she was left with residual pain, his view was that the symptoms were largely similar to those present in 2015 when she was at work. He concluded that it was reasonable to attempt to return to work part-time for 20 hours a week for a period of time up to six to eight weeks and full-time after that.

The Provider notes that on 14 November 2016, it communicated its decision and stated that following the appeal evidence submitted, and having considered all the new evidence and based on the medical evidence on file, it was the Provider's opinion that the Complainant did not meet the definition of disability as set out in the policy and that it was therefore unable to make further payments on the claim.

The Provider states that it received a further letter on 12 January 2017 from the Complainant dated 22 December 2016 to confirm that she was re-appealing the decision to cease the claim. In order to consider the appeal, the Provider notes:

> "*That it arranged for a functional capacity evaluation with a physiotherapist on 1 March 2017. It notes that the appointment was issued directly to the Complainant on 20 February 2017. The Provider states that the functional capacity evaluation is a rigorous assessment composed of various objective tests which evaluate an individual's workday tolerances and abilities to perform the duties of their normal occupation. The Provider states that on 1 March 2017, it also received a letter from the Complainant enclosing a copy of a letter from her consultant neurosurgeon, DOB, whom she attended on 22 February 2017 in which DOB confirmed he would offer Complainant a bilateral L5 and bilateral S1 nerve root compression, though no date for surgery was provided at the time. It states that it was for this reason that the Complainant was asked to attend the functional capacity evaluation with the physio*".

The Provider states that it received a copy of the functional capacity evaluation report on 25 April 2017 in which the physio concluded that the Complainant qualified for light work duties at the same level of her previous occupation but noted that she had restrictions on her bending ability, with pain increase sufficient to preclude her from bending activity and that she also had restrictions on squatting, bending and crawling. Following a thorough review of the claim including the new appeal evidence and the results of the functional capacity evaluation, the Provider notes that it agreed to reinstate the claim and communicated its reinstatement decision to the employer on 5 May 2017.

The Provider does not accept the Complainant's comment in relation to the assertion that the mailbox always seem to be full. It states that it has a full team of claim assessors available to answer calls at any time during business hours. It further notes that the Complainant refers to the claim cessation letter only being issued in November 2016. The Provider states

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that the letter was issued in August 2016 which allowed time for the phased return to work suggested by consultant PN. In relation to the more general complaints surrounding a lack of communication between the Provider and the Complainant, the Provider states that the policy is owned by the Complainant's employer and that all communication in relation to start of the claim in terms of an appeal or otherwise is with the policyholder i.e. her employer. The Provider notes that while it may contact the claimant periodically when trying to arrange an independent assessment to confirm dates and attendance, outside of this it usually corresponds directly with the policyholder in relation to the status of the claim.

In relation to the claim review process that the Complainant found very stressful, the Provider notes that this forms part of the ongoing process under its income protection policy terms and conditions which clearly states that the payment of benefit is conditional upon a member continuing to satisfy the definition of disability and a periodic assessment would be carried out. This was further outlined when the claim was accepted in August 2015.

It further points to terms of policy which confirm that it can request updated medical evidence from a member's treating physician and request medical examination by specialists chosen by the Provider as necessary. The Provider notes the Complainant's comment in relation to a request to release a copy of the functional capacity evaluation report to her and states that this has now been released.

The Provider notes its surprise and disappointment with the complaint as it feels that all stages of the claim, it has acted within the terms and conditions of the policy. It states the fact that it overturned its decision on appeal clearly demonstrates that the Provider has a very robust appeals mechanism and it was for this reason that the complaint was reinstated. It states that the complaint is subject to ongoing review. In terms of payment dates, the Provider states that the claim was in payment from the end of the deferred period on 13 July 2015 up till 30 October 2016, the date it ceased the claim. It states that the claim was then appealed and following receipt of the independent medical examination, the Provider reinstated the claim 1 October 2016 and it continues to be in payment.

Decision

During the investigation of this complaint by this Office, the Provider was requested to supply its written response to the complaint and to supply all relevant documents and information. The Provider responded in writing to the complaint and supplied a number of items in evidence. The Complainant was given the opportunity to see the Provider's response and the evidence supplied by the Provider. A full exchange of documentation and evidence took place between the parties.

In arriving at my Legally Binding Decision I have carefully considered the evidence and submissions put forward by the parties to the complaint.

Having reviewed and considered the submissions made by the parties to this complaint, I am satisfied that the submissions and evidence furnished did not disclose a conflict of fact such as would require the holding of an Oral Hearing to resolve any such conflict. I am also satisfied that the submissions and evidence furnished were sufficient to enable a Legally

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Binding Decision to be made in this complaint without the necessity for holding an Oral Hearing.

A Preliminary Decision was issued to the parties 10 September 2018 outlining the preliminary determination of this office in relation to the complaint. The parties were advised on that date, that certain limited submissions could then be made within a period of 15 working days, and in the absence of such submissions from either or both of the parties, within that period, a Legally Binding Decision would be issued to the parties, on the same terms as the Preliminary Decision, in order to conclude the matter.

In the absence of additional submissions from the parties, my final determination is set out below.

Policy Terms and Conditions

Is important to first consider the terms and conditions of the policy in place between the Complainant's employer and the Provider. The following definitions are pertinent:

> *Benefit – "the regular income payable, after a deferred period, if following medical assessment we are satisfied that the member meets the definition of disability."*
>
> *Claiming member – "the member in respect of whom a claim is being made."*
>
> *Disability- "the member's inability to perform the material and substantial duties of their normal insured occupation as a result of their illness or injury; upon consequence of which the benefit under the policy becomes payable, after the deferred period. The member must not be engaged in any other occupation."*
>
> *Normal occupation – "the occupation in which the member was employed or engaged to do immediately before the disability, illness or statutory leave commenced."*
>
> *Policyholder – "the legal owner(s) of the [Provider's] limited policy, named in the policy schedule*."

The following explanation is provided of the 'group income protection policy':

> "*The policy provides insurance to cover benefit for a member who, after a specified period of time, is unable to work due to accident, illness or injury and who meets the definition of disability. This policy is issued by [the Provider] (referred to as 'we' or 'us') in response to a written proposal and declaration from the policyholder (referred to as 'you' from now on) named in the enclosed policy schedule. The policy evidences the legal contract between you and us and takes effect from the commencement date*.
>
> . . .
>
> *The policy records that:*

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. . .

2. The policy does not create or intend to create any legal relationship between the member and us."

The policyholder's express obligations include the following:

- *"advise us if a member, in your view, meets the definition of disability*
- *submit any claims in line with the process outlined in the claims section of this document*
- *pass on the appropriate benefit paid under the policy to the member"*.

In Section IV entitled "Claims", the following clauses are relevant to the present dispute:

"***When are Benefits Payable?***

The benefit shall be payable to the policyholder at the end of the deferred period once we are satisfied that the member meets the definition of disability.

Information Required

You will inform us of a member who you consider meets the definition of disability as soon as possible after the member is unable to perform the material and substantial duties of the normal occupation and in all cases six weeks before the end of the deferred period. . . .

All income protection claims are determined after taking into account available medical evidence regarding the member's ability to carry out the material and substantial duties of their normal occupation.
. . .

Evidence on Claims

You must provide us with any documentation and information we need to assess and process the claim including:

- *completed employer and employee claims forms*
- *absence records for the previous 12 months*
- *copy of the member's job description*
- *. . .*
- *medical certificate from the member's general practitioner and/or treating physician*
- *. . .*
- *results of any independent medical assessment carried out.*

We reserve the right to seek additional documentation if necessary to process the claim.
. . .

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The Claim Process

When we have received the initial information requested from you, we will appoint a case manager to the claim who will respond within five working days confirming that we have requested medical history from the insured's treating physician(s) and outlining what additional information we need to obtain to assess the claim.

We reserve the right to use any appropriate and legal means to investigate the claim.

We will arrange any such independent examinations with any physician chosen by us as may be reasonably required to assess our liability under the claim and cover the cost of the independent examination. We will not be liable for any costs incurred by you or the claiming member in attending the examination or supplying information for the purpose of the claim.

Failure by you or the member to provide the required information or by the member to undergo any required test or examination may result in a delay or suspension of benefit payments.
. . .

Policy Beneficiary

The policy has been taken out by you to provide cover in the event that a member is unable to perform the material and substantial duties of their normal occupation.

You are the only beneficiary under this policy and we will not be liable for any decision taken by you in regards to the benefit received.
. . .

Claim Review

Payment of benefit is conditional on the claiming member continuing to satisfy the definition of disability and we will conduct a periodic assessment of the member's ability to carry out the material and substantial duties of their normal occupation.

The frequency of these reviews will be determined by the medical evidence received. When a claim is admitted we will confirm when the claim review process will commence.
. . .

As part of the process we will request updated medical evidence from the claiming member's treating physician. We may also request a medical examination by a specialist chosen by us, or other types of medical evidence as necessary.
. . .

Declined Claims

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In the event that a claim is declined or payment is to discontinue we will communicate the decision to you confirming a rationale for reaching this decision whilst at all times ensuring that the confidentiality of medical information is protected.

On receipt of a request from you the rationale for our decision to decline or discontinue the claim will be sent to the employee's general practitioner or treating physician as appropriate.

If you disagree with any of our decisions in relation to the non-admittance or discontinuance of the claim you can request an appeal. To appeal a declined claim, you should:

- *communicate the request for appeal by email or in writing to us within three months of receiving the claim decision*
- *outline in detail the reasons why you feel the claim is valid*
- *where appropriate, provide new relevant medical evidence obtained at your or the member's expense.*

In the event of an appeal the claim file together with any fresh medical evidence, if applicable, will be independently reviewed by our claims appeal panel are not part of the original claims assessment and decision-making process.
When a new medical opinion provided by you contradicts or challenges the original medical evidence obtained by us, we reserve the right to have the opinion independently assessed.

The final decision of the claims appeal panel will be sent to you in writing."

The group income protection policy schedule confirms that the policyholder is the Complainant's employer and confirms matters such as the deferred period (26 weeks), the benefit calculation, and the eligibility conditions.

A guide to staff income protection issued by the Complainant's employer has also been provided which sets out the definition of disability under the policy and states that "*once the staff member is deemed fit to return to their normal occupation, payment of benefit ceases*."

The document states that in submitting a claim, standard claim forms will be sent to the staff member for completion which should be completed and returned to the insurer within 16 weeks of the date that the staff member is first absent and that the insurer may not accept late claims. The document further states that the benefit is payable for as long as the staff member meets the definition of disability as assessed by the insurer. It notes that "*once the staff member is deemed fit to return to work by the insurer, [the employer's human resources] will help the staff member plan their return to work with their management*." The document notes that the insurer assesses each claim on its individual merits in accordance with its own procedures and criteria and that the employer cannot influence the assessment. The document confirms that the employer pays the full cost of the insurance and that the income protection benefits are paid to the staff member through its payroll

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system. It states that the staff member may be required to attend for an independent medical review as part of the assessment of the claim, either at the time of the claim submission, while the claim is in payment, or if an appeal is being considered. The document further confirms that a person who has a claim rejected or whose benefit ceases may appeal the decision and will be informed of the appeal procedure at the time of the decision. The document confirms that the benefit will not be paid if the medical evidence does not indicate that the claimant meets the definition of disability and as a result the claim is not accepted by the insurer. The document confirms that claimants may be asked at any time to submit medical evidence or undergo medical examination by the insurer or by the employer. It is made clear that regular reviews are intended.

The Original Claim

In the employee referral form dated 20 April 2015 and submitted to the Provider by the Complainant's employer, the Provider was informed that the Complainant has been absent following back surgery since 12 January 2015. I note that the Complainant has taken issue with the suggestion from the Provider that she was absent from 2015 rather than December 2014 but I note that this confusion is likely to have arisen from the information provided by the claimant's employer to the Provider.

Certain information was provided to the Complainant by the Provider in an employee claim form submitted by the Complainant date 4 May 2015. The form explains that the group income protection policy is affected between the Complainant's employer and the Provider and is governed by the policy terms and conditions. It sets out that the Provider will send updates on the assessment process to the employer. It confirms that it may be necessary for claimant to attend independent medical examinations which will be agreed at mutually convenient times and locations. It further states as follows:

> *"Once sufficient information has been received to reach a decision on the claim, this decision will be communicated to your employer who will inform you.*
>
> *In the event that a claim is declined, [the Provider] will outline the rationale for the decision.*
>
> *If your employer is unhappy with the decision they can lodge an appeal against this decision within three months of receiving the decision."*

The form also confirms the claims are subject to periodic reviews and ongoing assessment of the claimant's ability to perform the duties of their occupation and that cooperation with these reviews as part of the policy terms and conditions.

In the completed employee claim form, the Complainant states that the first date of absence was 1 December 2014 and indicates her symptoms as "*lower back pain, pain down left leg and numb left foot*." She also indicates that a discectomy was carried out on 2 January 2015. She indicates that she is unable to stand or sit for long periods of time which precludes her from her normal occupation.

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A large volume of medical evidence has been provided confirming the significant back problems which the Complainant has suffered from for the last number of years and specifying the various surgical and other interventions that have been carried out to attempt to alleviate her pain. As the payment protection claim was initially accepted by the Provider on the basis of these reports, I do not propose to recite the details of these as they are not in dispute. Instead I will concentrate on reports submitted to the Provider in deciding to discontinue the claim and in the appeal of this decision. A letter accepting the claim was sent to the Complainant's employer dated 14 August 2015 and noted that the claim would be reviewed in three months when up-to-date medical evidence would be required.

The medical report provided by consultant Orthopaedic Surgeon, PN, dated 1 June 2016 and based on a clinical assessment carried out on 18 May 2016 has been relied on by the Provider in making a decision in August 2016 to cease paying the benefits under the policy. The report notes that the Complainant had been out of work for a year and a half and still complains of residual low back pain which radiates into her left leg with associated numbness. It notes that the Complainant finds it particularly difficult to sit or stand for prolonged periods but that she is nevertheless active from a day-to-day point of view and walks, go to the gym, uses the treadmill, swims and cycles regularly to keep fit. The report notes that her back is permanently stiff and she gets night pain with some sleep disturbance and that she is taking medication for the pain. The report accepts that the customer services job that the Complainant had undertaken over 26 years is a desk related job and requires periods of standing and sitting. The report states that the Complainant has ongoing back and left leg pain and that she has had two discectomies for a leg symptoms but that this has not resolved either her back pain or a leg symptoms. She is noted to have been left with chronic back syndrome due to mechanical degenerative low back pain and that there is no further surgical solution to her problems at this stage. It notes that the mainstay of treatment is conservative with pain management of medication and a possibility for future nerve root injections and consideration for a spinal-cord stimulator. The report states that the symptoms appear to be similar to what was present prior to her surgery in early 2015. The report notes that her recovery from surgery has been slow and has made no difference to ongoing disability. The report states that the Complainant is still under the care of a pain specialist who is considering further injections and a spinal-cord stimulator.

PN expresses the view that a further rehabilitative program is unlikely to improve her ongoing symptoms. He accepts that she has genuine back pain made worse by sitting or standing for prolonged periods and that her disability is similar to what it was prior to her 2015 surgery when she was still at work.
As no further surgical intervention was anticipated, PN expressed his view that there was no reason why the Complainant could not attempt to return back to work.

He states that while there may be consideration of a spinal-cord stimulator in the future, this was not in itself a barrier for attempting to return to work. He concluded that it was reasonable *"to attempt to return back to work in a part-time capacity initially working 20 hours per week and then full-time after six to eight weeks having had returned back to work."*

On the basis of this report, the Provider wrote to the Complainant's employer dated 19 July 2016 and stated its decision that based on the findings of the independent medical

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examination and a review of all medical records, it was of the view that the Complainant no longer met the definition of disability as set out in the policy. The letter stated that it was happy to support the phased return to work proposed by PN commencing on 1 September 2016 with full time hours reintroduced from 20 October 2016. The letter noted that there was a facility to appeal the decision and the appeal had to be submitted within three months with the Complainant to provide up-to-date objective specialist evidence to support the appeal. It noted that the evidence submitted should indicate why she is totally disabled from following her normal occupation.

I accept that the Provider was entitled to rely on the independent medical evaluation undertaken by PN in making its initial determination to cease the payment income protection benefits to the Complainant on a phased basis and that there was sufficient objective evidence to support the Provider's opinion that she no longer met the definition of disability as set out in the policy, subject to appeal. I am somewhat concerned, however, as to when this letter was actually notified to the policyholder. Although the employer was informally informed of the recommendation that the Complainant returned to work on a phased basis on 19 July 2016, the cessation letter does not appear to have been sent until an email dated 29 August 2016. This is a period of some six weeks after the purported date of the cessation letter. Despite the purported date of the letter, therefore, I consider true date of notification of cessation to have been 29 August 2016, a mere two days before phased return to work proposed was due to commence. This anomaly has not been explained by the Provider.

First Appeal

The Complainant appears to have immediately appealed the decision and her appeal letter appears to have been received on the 14 September 2016, though it was not dated. In her appeal letter, she stated that she continued to struggle with back and leg pain and was undergoing different procedures with JF, her pain specialist. She noted that she took five painkillers on a daily basis for her symptoms. Her appeal letter enclosed a letter from the Complainant's consultant pain surgeon, JF, dated 22 August 2016, JF notes that the Complainant is still struggling with pain despite recent nerve root injections, though she finds medication helps to a degree. He suggests that spinal-cord stimulator is under consideration but will not do much for her back pain. In an [Occupational Healthcare Specialist] report dated 1 September 2016 from Dr CB, her fitness to work was stated as "*fit to work with restrictions*". Dr CB expressed the view that the Complainant was not fit to return to her full normal role at present and that given her progress to date, she was unlikely to return to her normal role for at least six to 12 months. He notes that she may be fit for some work on a limited basis and would be happy to discuss options available.

An email from the Provider to PN dated 12 October 2016, the Provider noted that the Complainant's employer had advised it that the [Occupational Health] doctor, CB, recommended that the Complainant return to work for a maximum of two hours per day for a total of 5 to 10 hours per week over a two-month period before further review but that this was not a practical option for the business and cannot be facilitated.

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Consultant orthopaedic surgeon, PN, was asked to review the medical evidence provided by way of appeal and in a letter dated 26 October 2016, PN suggested that the fact that the Complainant was still attending JF was not in itself a barrier for her returning to the workforce. He suggested that an [Occupational Healthcare Specialist] recommendation that she return to work for two hours a day up to 10 hours a week for two months was not realistic or practical and could not be facilitated. He stated that nothing in the correspondence or medical evidence changed his opinion as he was of the view that the cycle of active intervention was completed to a large degree and that while she was left with residual pain in her back, he was of the view that the symptoms were similar to what was present in 2015 when she was at work. PN was of the view that it was reasonable to attempt to return to work for 20 hours per week for a 6 to 8 week period.

By letter dated 9 November 2016, the Complainant wrote to the Provider referring to her previous letter noting that she still struggles daily with back pain and requires significant numbers of painkillers per day. She stated that she is waiting to hear back from her doctor about a spinal-cord stimulator and asked for their continued support. This letter was marked as received on 16 November 2016 and was therefore not received before the appeal decision letter of 14 November 2016. In a letter dated 14 November 2016 to the Complainant's employer, the Provider referred to the Complainant's appeal and informed the employer that their opinion remained unchanged and was that the Complainant no longer met the definition of disability as set out in the policy. It stated that this decision was guided by objective evidence and that the appeal documents were sent to the consultant who carried out the original independent medical evaluation. A segment of the views of PN were set out. This letter was forwarded to the Complainant by her employer by letter dated 18 November 2016 in which the employer confirmed that the Provider had declined the appeal and requested that the Complainant attend a review with its occupational health physician to plan her return to work.

Second Appeal

By letter dated 22 December 2016, the Complainant wrote to the Provider requesting a further review of the decision to stop payments of the payment protection insurance. She also sought reasons why she no longer met the definition of disability as set out in the policy and as referred in the response letter dated 14 November 2016. She stated that she was unable to perform day-to-day duties without medication and has from time to time lost complete independence. Her letter noted incidents where she was unable to look after herself and where she fell as a result of the pain. She states that she last worked in December 2014 and not 2015 as referred by the Provider consultant and that this was only with the help of prescription medication as she had been struggling prior to leaving work to complete tasks and was in constant pain. She notes that she is still engaging with her pain specialist regarding spinal-cord stimulation.

She states that her consultant, her GP and her employer do not feel she is fit to return to work at present and enclosed letters from them confirming same. She finally requested a copy of the report from the Provider's consultant that carried out the independent medical examination under freedom of information legislation.

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Further medical evidence was provided with the appeal. In a letter dated 7 November 2016, consultant pain specialist JF concluded that the persisting pain had not responded to medication management and injections or the spinal surgery and that the Complainant was being considered for spinal-cord stimulation which may give some relief. An [Occupational Healthcare Specialist] assessment report dated 1 December 2016 declared the Complainant as not fit to work. The occupational health physician, DM, expressed the view that the Complainant has a genuine medical issue that prevented her from returning to work at this time and that she is engaged in appropriate medical intervention to facilitate recovery. He suggested a further medical review in three to six months to monitor her progress and advice on her fitness to return to work. By letter dated 22 December 2016, the Complainant's GP declared her "*completely unfit for work due to severe lower back pain*".

There is a further discrepancy in relation to the date that this letter was received. I note that the letter is dated 22 December 2016 and accept that some delay might be expected with the postal service at Christmas time. I note that the letter is stamped as having been received on 30 December 2016. I am concerned, however, that in its response to this office dated 8 March 2018, the Provider states that the letter of 22 December was not received by it until 12 January 2017. This is some two weeks after the letter is stamped as having been received so the Provider's statement in this regard is neither correct or acceptable. I am therefore satisfied that the letter was in fact received on 30 December 2016 as stamped. The Provider has stated that it arranged a functional capacity evaluation in order to further consider the appeal and that the appointment was issued directly to the Complainant on 20 February 2017. In a copy of a referral form provided to this office seeking a full channel capacity evaluation, the date of the referral is 23 February 2017 so it is difficult to understand how an appointment could be issued for the same evaluation three days prior to the referral being made.

A further letter was also sent by the Complainant to the Provider. By letter dated 22 February 2017, consultant neurosurgeon DOB stated that the Complainant struggles with severe low back pain and associated leg pain and numbness with reduction in legs straightening, reflexes and normal sensation. He noted his present thinking was to offer the Complainant nerve root decompression due to the severity of symptoms. He stated that there is a reasonable chance of improving her symptoms but it is not guaranteed given the long duration of symptoms but he feels this procedure should be offered to the Complainant.

A report was prepared by physiotherapist AS following the functional capacity evaluation which took place on 1 March 2017. As a decision to reinstate the claim was taken on foot of this report and together with the decision to attempt a further surgery, it is not necessary to set out in detail the conclusions of this report that I note that the physiotherapist in question concluded that the Complainant qualified for light work at the same level of her previous occupation with some restrictions in bending squatting kneeling and crawling and further noted high pain reports. I note that the date of the report is stated to be 18 March 2017. The Provider has stated in its reply to this office that this report was not received until 25 April 2017. It appears that the report was in fact sent with a cover letter dated 13 April 2017 which is stamped as received on 19 April 2017.

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I am therefore of the view that the report was received by the Provider on 19 April and not 25 April 2017 as indicated to this office. The Provider notified the Complainant's employer by letter dated 5 May 2017 that based on the appeal evidence received it had decided to reinstate the claim from 1 November 2016. A copy of the report prepared following the functional capacity evaluation was sent to the Complainant's GP by letter dated 11 July 2017 after the Complainant's request for same.

Communication with Complainant

The Complainant is aggrieved by what she describes as a failure of communication to her from the Provider in the course of the appeal. She has highlighted the Provider failure to acknowledge or reply to her letters of appeal and has further stated that her attempts to call the Provider to discuss matters with them were frequently thwarted as her calls were not answered and instead she encountered messages stating that the mailbox was full. I can readily understand the Complainant's frustration in this regard as she was dealing with a very stressful situation in a context where she was experiencing constant pain.

It is evident that the Complainant was suffering serious pain and was already in a stressful situation. I believe the actions and inactions of the Provider exacerbated this already stressful situation.

It is clear from the evidence submitted to this Office that the Provider did not respond in a timely manner or sometimes at all, to the Complainant.

Despite the Provider's suggestion to the contrary, I have no reason to doubt the Complainant's statement that she was unable to contact the Provider by telephone. I believe this is borne out by the lack of response to her written correspondence and the discrepancies in evidence furnished to this Office by the Provider.

I accept that the Provider has an obligation to correspond with the Complainant's employer but this, in my view, does not prohibit it from corresponding or at least replying to the Complainant who is in fact the beneficiary and the person most affected by their decisions. At a very minimum, the Provider could have communicated with the Complainant in relation to how the claim and appeals process operate and explained why it did not propose to communicate with her.

Because of this poor communication and the additional stress it caused the Complainant, I partially uphold this complaint and direct that the Provider pay a sum of €2,000 to the Complainant.

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Conclusion

My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is partially upheld on the grounds prescribed in ***Section 60(2) (b) and (g).***

Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to make a compensatory payment to the Complainant in the sum of €2,000, to an account of the Complainant's choosing, within a period of 35 days of the nomination of account details by the Complainant to the provider. I also direct that interest is to be paid by the Provider on the said compensatory payment, at the rate referred to in ***Section 22*** of the ***Courts Act 1981***, if the amount is not paid to the said account, within that period.

The Provider is also required to comply with ***Section 60(8)(b)*** of the ***Financial Services and Pensions Ombudsman Act 2017.***

The above Decision is legally binding on the parties, subject only to an appeal to the High Court not later than 35 days after the date of notification of this Decision.

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

11 October 2018

Pursuant to *Section 62* of the *Financial Services and Pensions Ombudsman Act 2017*, the Financial Services and Pensions Ombudsman will publish legally binding decisions in relation to complaints concerning financial service providers in such a manner that—

(a) ensures that—

(i) a complainant shall not be identified by name, address or otherwise,
(ii) a provider shall not be identified by name or address,
and

(b) ensures compliance with the Data Protection Regulation and the Data Protection Act 2018.