Decision Ref: 2020-0038

Sector: Insurance

Product / Service: Payment Protection

Conduct(s) complained of: Complaint handling (Consumer Protection Code)

Outcome: Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainant is an insured person under a Group Income Protection Scheme. Her Employer is the policyholder and the Provider the insurer, responsible for the underwriting of applications for cover and assessing claims.

The Complainant's Case

The Complainant, a customer service advisor, has been absent from work since **31 August 2015**. She completed an income protection claim form to the Provider on 28 September 2015 wherein she listed her illness and condition and how it affects her in the work place, as follows:

> *"Joint pain/backache – flu like symptoms through body, fatigue, painful hands, feet, elbows, knees, neck, arms, elbows, hips, difficulty with movement, sleeping, sitting, traveling in car, walking long distances, diagnosed with osteoporosis/osteoarthritis.*
>
> *I am unable to sit for long periods, my hands are painful so typing is an issue, fatigue makes it hard to concentrate, and pain is getting worse"*.

As part of its claim assessment, the Provider referred the Complainant for an independent medical examination with Dr D., Consultant Rheumatologist on 30 March 2016, who concluded *"that* [the Complainant] *is currently fit to return to her previous work on a full time basis"*. As a result, the Provider declined the Complainant's income protection claim on 12 May 2016 as it concluded that she did not satisfy the policy definition of disability.

The Complainant appealed this declinature and as part of its review, the Provider referred her for a Chronic Pain Abilities Determination on 21 February and 23 February 2017. Following the completion of its review, the Provider upheld its decision to decline the Complainant's income protection claim on 5 April 2017.

In her email to this Office dated 24 April 2019, the Complainant submits, *inter alia*, as follows:

> *"I have attended numerous HR doctor reviews, clinics, rheumatology, my own doctor and social welfare. My diagnosis of diffuse osteoarthritis and fibromyalgia was an immense shock, we had to sell our home as without my income we could not meet the mortgage repayments. If I could work, I would …*
>
> *Osteoarthritis is a degenerative disease, I have visible bony growths on my fingers, am in constant pain. I am allergic to penicillin, anti-inflammatories and some over the counter medications so I find it hard to control the pain.*
>
> *Regarding the fibromyalgia aspect, it's not easy. Add the two conditions together and its difficult"*.

In this regard, the Complainant sets out her complaint, as follows:

> *"I was diagnosed with osteoporosis, osteoarthritis and fibromyalgia. I am unable to work and am on invalidity pension.* [The Provider] *have refused to pay out on an income protection policy which* [my Employer] *have for all members of staff. Osteoarthritis is a degenerative disease, and I have it in my hands, hips and wrists"*.

Shortly after the Provider affirmed its decision to decline her income protection claim on 5 April 2017, her Employer referred the Complainant for an occupational health assessment on 29 June 2017 with Dr N., who concluded that *"this lady remains unfit to work and her prognosis with regard to returning to work at a future date is guarded"*.

Later, in March 2018 the Occupational Therapy Department at Hospital [X.] provided the Complainant with a right wrist thumb brace and a radial thumb Spica splint. In addition, in her email to this Office dated 24 January 2019, the Complainant notes,

> *"I have also had further nerve tests, pertaining to my numbness in my fingers. The results are not yet available …I have to wear the* [thumb splint and wrist support], *which are restrictive, while doing anything that aggravates the pain in my hands and wrists"*.

The Complainant does not consider that she is fit to work and thus seeks for the Provider to admit her income protection claim.

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The Provider's Case

Provider records indicate that the Complainant, a customer service advisor, completed an income protection claim form on 28 September 2015, which the Provider received in November 2015, wherein she noted her first date of absence as 31 August 2015 and listed his illness as *"joint pain/backache – flu like symptoms through body, fatigue, painful hands, feet, elbows, knees, neck, arms, elbows, hips, difficulty with movement, sleeping, sitting, traveling in car, walking long distances, diagnosed with osteoporosis/osteoarthritis"*.

The Provider also received a Practitioner Report from the Complainant's GP, Dr O. in January 2016, wherein she detailed the nature and cause of the Complainant's disability as *"OA* [osteoarthritis]*, still being investigated"*. Dr O. also furnished copies of medical reports and test results. In this regard, the Provider notes that the enclosed scans of the lumbar and cervical spine were essentially normal and the blood tests were not suggestive of any haematological disease, with negative rheumatoid factor noted. In addition, a review of the Complainant in the Rheumatology Clinic at Hospital [Q.] on 23 July 2015 had revealed no convincing signs of an inflammatory arthropathy and conservative treatment had been recommended with a Physiotherapist and Occupational Therapist, with no rheumatological follow-up required at that time.

In order for an income protection claim to be payable, a member of the Group Income Protection Scheme must satisfy the policy definition of disability, as follows:

> *"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 occurrence of which the benefit under the policy becomes payable, after the deferred period"*.

In order to determine whether she satisfied this policy definition of disability, the Provider arranged for the Complainant to attend for an independent medical examination with Consultant Rheumatologist Dr D. on 30 March 2016. During the course of his examination, Dr D. found that the Complainant's wrists, elbows, shoulders, knees, hips, ankles and feet were essentially normal, with good range of motion. Occasional trigger points were identified as well as minimal changes of early stage osteoarthritis in the hands, but no active synovitis was noted. Dr D. also noted a possible component of fibromyalgia, however he noted that this was not being actively treated and should be considered. Nevertheless, in his resultant report, Dr D. advised, *inter alia*, *"It is however my opinion that* [the Complainant] *is currently fit to return to her previous work on a full time basis"*.

As a result, the Provider concluded that the Complainant was fit to carry out the material and substantial duties of her normal occupation and that she did not satisfy the policy definition of disability and it wrote to her Employer on 12 May 2016, to advise that it was declining her income protection claim.

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The Complainant appealed this decision by way of submitting various correspondence from her treating doctors. The Provider notes that the evidence and test results submitted were normal. In correspondence dated 22 December 2016, the Complainant's treating Consultant Rheumatologist Dr G. noted that there was no evidence of an inflammatory arthropathy which might explain the level of widespread joint pain. Hence there was no obvious clinical cause of the symptoms that the Complainant continued to report. Dr G. felt that the symptoms were consistent with fibromyalgia and referred the Complainant to a fibromyalgia programme with a trial of Cymbalta and a review in 1 year. The Provider notes that overall, the appeal evidence was not suggestive of a disabling medical complaint which could prevent the Complainant from working and there was no suggestion that she could not have continued to work whilst undertaking the treatment recommended.

Nevertheless, in order to fully assess her appeal, the Provider arranged for the Complainant to attend for a Chronic Pain Abilities Determination (CPAD) on 21 February and 23 February 2017. In his resultant report, Mr N. advised, *inter alia*, as follows:

> *"Whilst* [the Complainant] *demonstrated a significant level of disability due to her various conditions, which would appear to prevent her from returning to her normal form of employment, a review of the CPAD physical results on both days of testing indicate that she performed with very poor reliability of effort and there is evidence of symptom exaggeration present …*
>
> *Based on the above inconsistencies and discrepancies, the results of the CPAD cannot represent* [the Complainant's] *true working capabilities and one must assume that her actual abilities are far greater than she was willing to demonstrate on formal testing"*.

In this regard, the Provider concluded that the physical and cognitive tolerances demonstrated by the Complainant during this CPAD assessment could not be used to infer any barrier preventing her from working.

Following a thorough review of her claim, the Provider remained of the opinion that the Complainant did not satisfy the policy definition of disability. As a result, the Provider wrote to the Complainant's Employer on 5 April 2017 to advise, as follows:

> *"As you know* [the Complainant]*'s claim was declined on the 12/05/2016 following a review of the findings received from the independent medical examination which* [the Complainant] *attended on the 30/03/2016. IME report findings at that time indicated that:*
>
> > *"It is however my opinion that* [the Complainant] *is currently fit to return to her previous work on a full time basis."*
>
> [The Complainant] *then appealed this decision with new medical evidence.*

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In order to consider the appeal further we arranged a Chronic Pain Abilities Determination over two days on the 21/02/2017 & 23/02/2017. Based on the findings of the CPAD and a review of all medical records on file including the appeal documents submitted and 2 independent assessments that [the Complainant] *attended, it is our opinion that* [the Complainant] *does not meet the definition of disability as set out in the policy and I must advise therefore that we are unable to admit this claim.*

Under the terms of the policy, the definition of disability states:

> *"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 occurrence of which the benefit under the policy becomes payable, after the deferred period."*

With due consideration to the findings of the Independent Medical Consultant Examination on the 21/02/2017 & 23/02/2017, we must be guided by the weight of the objective evidence obtained which, in our opinion, clearly indicates that [the Complainant] *does not meet the definition of disablement under the policy and is medically fit to resume her normal occupation.*

The independent Consultant states;

> *"A review of the CPAD physical results on both days of testing indicate that* [the Complainant] *performed with very poor reliability of effort and there is evidence of symptom exaggeration present. This conclusion is based on the number of inconsistencies and discrepancies demonstrated by her throughout the assessment."*
>
> *"Based on the above inconsistencies and discrepancies, the results of the CPAD cannot represent* [the Complainant's] *true working capabilities and one must assume that her actual abilities are far greater than she was willing to demonstrate on formal testing."*
>
> *"Furthermore, the physical work-day tolerances demonstrated by* [the Complainant] *cannot be used to infer any barriers preventing her from returning to her normal role"."*

In order for an income protection claim to be payable, a claimant must satisfy the policy definition of disability. The purpose of income protection is to support employees who demonstrate work disability supported by the objective medical evidence. In arriving at its decision, the Provider must be guided by the weight of the objective evidence.

In this case, the Provider noted that the objective clinical findings of the Complainant's MRI scans, bone scan, CT scan and blood tests do not support a diagnosis of inflammatory osteoarthritis which might explain the level of pain symptoms that she is reporting.

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In addition, the Complainant was reviewed by an independent Consultant Rheumatologist, Dr D., who confirmed the absence of inflammatory arthropathy and deemed her fit for work. Furthermore, the Provider arranged for the Complainant to undergo a functional assessment to determine her abilities to carry out the duties of her occupation. In this regard, the Provider notes that the results of this Chronic Pain Abilities Determination and the general observations noted bore no correlation to the high pain levels that the Complainant reported over the two days and it was concluded that her actual capabilities were much greater than that demonstrated on the days of the test.

The Provider notes that the Complainant has received a diagnosis of fibromyalgia, however fibromyalgia is a functional disorder which is subjective by nature, as no lab or clinical tests can confirm it, and diagnosis is typically made by a patient's self-reporting of pain for more than 3 months. In any event, the Provider notes that the diagnosis of a medical condition is not sufficient to determine claim validity, nor does it automatically equate to work disability.

In this regard, evidence based treatment for fibromyalgia includes anti-depressant medication, pain relief, cognitive behavioural therapy and exercise therapy, and there is no evidence before the Provider to suggest that the Complainant could not continue to work whilst undergoing these conservative treatments.

Whilst her Employer referred the Complainant for an occupational health assessment on 29 June 2017 with Dr N. who concluded *"this lady remains unfit to work and her prognosis with regard to returning to work at a future date is guarded"*, the Provider cannot comment as to why the Employer chose to arrange its own occupational health assessment when the Provider, as the Employer's disability provider, had already advised that the Complainant was not incapable of working.

In addition, in order to consider any work disability in relation to March 2018, when the Occupational Therapy Department at Hospital [X.] provided her with a right wrist thumb brace and a radial thumb Spica splint, the Complainant would have had to have returned to work sometime before March 2018 and at least attempted to carry out her work duties. The fact that she did not return to work since cannot be an issue for the Provider and it is not reasonable for the Provider to consider whether she was disabled from working in March 2018, when it had already declined the claim in May 2016, a decision it later upheld on appeal in April 2017. Similarly, any additional reports submitted by the Complainant in March 2019 cannot be considered retrospectively in relation to the original claim decision in May 2016 and appeal decision in April 2017.

In summary, the Provider fully considered the Complainant's income protection claim against the policy definition of disability in May 2016 and on appeal in April 2017 and found that the Complainant was at that time fit to return to work and it is satisfied that it made the correct decision on both occasions.

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In this regard, the objective test results and commentary provided by the Complainant's own treating doctors, together with the outcome of the independent medical examination she had with Consultant Rheumatologist Dr D. on 30 March 2016 and the findings of the Chronic Pain Abilities Determination she underwent on 21 February and 23 February 2017, do not support her income protection claim for work disability.

Accordingly, the Provider is satisfied that the Complainant did not meet the policy terms and conditions for a valid claim and thus that it correctly declined her income protection claim, in accordance with the terms and conditions of the Group Income Protection Scheme that she is a member of.

The Complaint for Adjudication

The Complainant's complaint is that the Provider wrongly or unfairly declined her income protection claim.

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

A Preliminary Decision was issued to the parties on 27 January 2020, 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.

Following the consideration of additional submissions from the parties, the final determination of this office is set out below.

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The complaint at hand is that the Provider wrongly or unfairly declined the Complainant's income protection claim. The Complainant is a member of a Group Income Protection Scheme. Her Employer is the policyholder and the Provider the insurer, responsible for the underwriting of applications for cover and assessing claims. In this regard, the Complainant sets out her complaint, as follows:

> *"I was diagnosed with osteoporosis, osteoarthritis and fibromyalgia. I am unable to work and am on invalidity pension.* [The Provider] *have refused to pay out on an income protection policy which* [my Employer] *have for all members of staff. Osteoarthritis is a degenerative disease, and I have it in my hands, hips and wrists"*.

I note that the Complainant, a customer service advisor, has been absent from work since 31 August 2015. She completed an income protection claim form to the Provider on 28 September 2015 wherein she listed her illness and condition and how it affects her in the work place, as follows:

> *"Joint pain/backache – flu like symptoms through body, fatigue, painful hands, feet, elbows, knees, neck, arms, elbows, hips, difficulty with movement, sleeping, sitting, traveling in car, walking long distances, diagnosed with osteoporosis/osteoarthritis.*
>
> *I am unable to sit for long periods, my hands are painful so typing is an issue, fatigue makes it hard to concentrate, and pain is getting worse"*.

In addition, the Complainant's GP, Dr O. completed a Practitioner Report form for the Provider on 5 January 2016, wherein she advised the nature and cause of the Complainant's disability as *"OA* [osteoarthritis]*, still being investigated"*. Dr O. also enclosed copies of medical reports and test results. In this regard, I note the results of the DXA DEXA EXAM performed at Hospital [Y.] on 8 January 2015, as follows:

> *"T score of lumbar spine is -2.5 suggesting osteoporosis associated with high-risk of fracture. T score of the left hip is -2 in keeping with osteopenia associated with increased risk of fracture. LVA shows no vertebral collapse"*.

In addition, in his letter dated 11 March 2015, Consultant Haematologist Dr R. advised:

> *"I reviewed this pleasant lady in clinic today* [13 January 2015]*. You referred her with a history of hypogammaglobulinemia with a low IgG and IgA. A number of investigations were done by us and they show negative ANA and rheumatoid factor. No serum paraprotein. Normal B12, folate and ferritin. Her full blood count is normal with white cells of 8.4, neutrophils of 5.7, haemoglobin of 14.7 and platelets 222. I note she is having ongoing investigations for joint pain. As there is no suggestion of haematological disease or plasma cell dyscrasia, I am happy to discharge her to your care, but certainly we will see her again in the future if required by you"*.

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I note a report from the Rheumatology Department, Hospital [Q.] dated 23 July 2015 that advised, *inter alia*, as follows:

> *"**Diagnosis:***
> *Diffuse Osteoarthritis …*
>
> *The plan of care for* [the Complainant] *includes:*
> ***Plan and Recommendations:***
> *Referred to the Occupational Therapist (Hand OA)*
> *Referred to physiotherapist (Hips and neck)*
> *No follow-up required at this time*
>
> ***Assessment Summary:***
> *There are no convincing signs of an inflammatory anthropathy today on assessment.* [The Complainant]'s *signs are consistent with diffuse OA. I do not think she has a significant inflammatory component at this stage. I think her main issues are as follows:*
>
> 1. *Moderate Hip OA R>L (may require orthopaedic opinion in the future regarding surgery)*
> 2. *Cervical Spondylosis*
> 3. *Hand OA*
>
> [The Complainant] *does no exercise and has not tried any conservative management therefore I think this is the first line of treatment choice. Her CRP was raised which should be rechecked in the future. She declined a right greater trocahnetr injection as she did not feel the pain warranted it at this stage. If you feel her symptoms deteriorate and she requires a review please refer her back"*.

I note the results of the XR LUMBAR SPINE performed at Hospital [Y.] on 18 November 2015, as follows:

> *"Normal vertebral body alignment. No vertebral body collapse or disc space narrowing. No degenerative change. The sacroiliac joints appear normal"*.

I note too, the results of the XR CERVICAL SPINE, also performed at Hospital [Y.]on 18 November 2015, as follows:

> *"Normal vertebral alignment. No vertebral body collapse or disc space narrowing. Minor marginal osteophyte formation noted at C4 level. Normal appearances otherwise"*.

I note that the Provider considered these medical reports and test results and concluded that the scans of the lumbar and cervical spine were essentially normal and the blood tests were not suggestive of any haematological disease, with negative rheumatoid factor noted.

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In addition, the Provider noted that the review in the Rheumatology Clinic at Tallaght Hospital on 23 July 2015 had revealed no convincing signs of an inflammatory arthropathy and that conservative treatment had been recommended with a physiotherapist and occupational therapist, with no rheumatological follow-up required at that time.

Income protection policies, like all insurance policies, do not provide cover for every eventuality; rather the cover will be subject to the terms, conditions, endorsements and exclusions set out in the policy documentation. In this regard, **Section 5, 'Claims'**, of the applicable Group Income Protection Policy Conditions provides, *inter alia*, at pg. 12:

> *"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"*.

As a result, in order for an income protection claim to be payable, a claimant must satisfy the policy definition of disability. In this regard, the '**Interpretation**' section of these Policy Conditions provides, *inter alia*, at pgs. 4 - 5:

> *"**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 occurrence of which the benefit under the policy becomes payable, after the deferred period.*
>
> *The member must not be engaged in any other occupation"*.

In order to assess whether the Complainant satisfied this policy definition of disability, the Provider arranged for her to attend for an independent medical examination with Dr D., Consultant Rheumatologist on 30 March 2016. I note from the documentary evidence before me that in his resultant report, Dr D. advised, *inter alia*, as follows:

> *"**PRESENTING COMPLAINT:***
> *Ongoing absence from work related to profound fatigue and joint pain.*
>
> ***HISTORY OF PRESENTING COMPLAINT:***
> [The Complainant] *gives a longstanding history of episodes of back and joint pain. She dates these initially back to 19xx when she had a fall and following this developed low back pain. She noticed that this recurred from time to time following this with flare ups lasting for a week or so. About two years ago this became more problematic. She began to notice increasing amounts of low back pain. This tended to happen after she would bend down to pick something up and she found herself unable to straighten up again. This would then lead to ongoing pain in the back which would last for about a week at a time.*

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Around this time she also began to notice discomfort over the lateral aspect of both hips. This had first become a problem in June 2014 when she remembers an episode where it seems like her hips locked after a long car journey. She was seen by her GP at the time. She underwent blood tests which she thinks were normal.

As part of this work up she also had a DEXA scan performed which showed her to have evidence of osteoporosis and she was started on treatment with Fosamax. She was also referred at that stage to the Rheumatology Department in [name redacted] Hospital.

The patient was seen in [name redacted] Hospital in the summer of 2015 by a Physiotherapy Specialist. She was found to have evidence of what was felt to be osteoarthritis and trochanteric bursitis. According to the report it was recommended that she have an injection over the lateral aspect of the hip however the patient declined to have this done. She subsequently underwent a course of physiotherapy, occupational therapy and subsequent aquatic therapy. With these interventions she feels there has been no significant improvement in her symptoms and she continues to have ongoing daily pain involving her hands which seem to be all over the hands rather than localised to any particular joints. She also has ongoing pain in her knees and in her feet. She gets episodes of back pain in an intermittent basis involving the lumbar spine.

She also continues to complain of significant fatigue which she feels is getting slowly worse. She described a poor sleep pattern at night. She wakes frequently during the night because of pain and will usually not feel refreshed on waking in the morning time. She has been tried on several medications. She has difficulty tolerating Tramadol because of severe drowsiness and is currently taking a Versatis patch which she finds of some help …

PHYSICAL EXAMINATION

She was in no acute distress. She was able to get on the examination couch unassisted. Examination of her hands showed no evidence of active synovitis and very minimal changes of early osteoarthritis. There was palmar erythema noted bilaterally. Examination of her wrists was normal. Examination of her elbows showed no evidence of effusion or tenderness and there was normal range of motion. There was normal range of motion of both shoulders.

Examination of her spine showed normal alignment. There was tenderness over the paraspinal muscles particularly in the cervical region but throughout. There were occasional trigger points noted. There was good range of motion of both hip joints. There was marked tenderness over the greater trochanters bilaterally. Examination of her knees was normal. Examination of her ankles and feet was normal. Pulses were present in both feet.

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Neurological examination showed normal straight leg raising. The reflexes were normal and there was no focal sensory loss. Chest was clear to auscultation. Abdomen was soft and non tender. There was no lymphadenopathy.

DIAGNOSIS:

1. *Minimal osteoarthritis*
2. *Bilateral trochanteric bursitis*
3. *Possible component of fibromyalgia*

RECOMMENDATIONS:

I feel that [the Complainant] *has several musculoskeletal issues. She has only very mild osteoarthritis affecting her hands. There is minimal degeneration in her neck x-ray and normal x-ray of her back. I therefore do not feel that osteoarthritis is the main cause of her ongoing symptoms. She also lists osteoporosis as a problem; this is not contributing to any of her current symptoms either.*

She does have evidence of tenderness over the muscles of her upper and lower back and I think she has a component of fibromyalgia contributing to her current symptoms and this would normally respond to specific medications which she is currently not taking and therefore should be considered.

She also has localised pain over the lateral aspect of her hips. This seems to represent some trochanteric bursitis which may be aggravated by fibromyalgia.

The symptoms of this would normally improve with steroid injection but she has declined this in the past. The other treatment is physiotherapy and she has completed a course of this without significant improvement in these symptoms.

The patient also complains of significant fatigue. She has the finding of palmar erythema in her hands and had previous blood work which showed hypogammaglobulinaemia. In view of these issues she may require further blood tests if they have not already been performed to out rule liver disease or other abnormalities and I think this work is currently underway.

SUMMARY:

It is however my opinion that [the Complainant] *is currently fit to return to her previous work on a full time basis. While she does have some outstanding issues and symptoms that need to be further investigated including her upcoming bone scan which is booked for June I think that she is fit to return to work in the interim while awaiting the completion of her work up.*

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> *She also complains of some symptoms of low mood and I did not address these during my consultation today and recommended that she follow up further with her GP regarding this and also the possibility of starting on some treatment specifically aimed at a fibromyalgia type syndrome"*.

I note that based on the claim documentation submitted, which included the medical reports and test results provided by the Complainant's GP, along with the findings of the independent medical examination, the Provider concluded that the Complainant did not satisfy the policy definition of disability and wrote to her Employer, the policyholder, on **12 May 2016** to advise that it was declining her income protection claim, as follows:

> *"Based on the evidence received, I regret to advise we are unable to consider* [the Complainant]*'s claim for Income Protection benefits. The recent IME* [independent medical examination] *that* [the Complainant] *underwent revealed that she is currently fit to perform the material and substantive duties of her normal occupation on a full-time basis. The physical examination confirmed that there was no objective evidence of any disabling illness that would likely be contributing towards her inability to work. She did not display any acute distress and no major abnormalities were noted throughout the evaluation.*
> *The IME Consultant also recommended that she consult with her GP with respect to commencing on treatment with specific medications that would help with the ongoing symptomology surrounding her condition.*
>
> *If* [the Complainant] *is unhappy with the decision on* [her] *case, there is a facility for her to appeal the decision. It would be up to* [the Complainant] *to provide us with up-to-date objective specialist evidence to support her appeal. This should be submitted by 12 August 2016. The evidence submitted should clearly indicate that she is currently totally disabled from following her normal occupation. If not such evidence is available, our decision will remain unchanged"*.

The Complainant appealed the Provider's decision to decline her income protection claim and as part of this appeal submitted a number of reports from her treating doctors. In this regard, I note that in his letter dated 9 December 2015, Rheumatology Consultant, Dr R. advised, as follows:

> ***"Diagnosis:***
> *Diffuse Osteoarthritis …*
>
> *Due to* [the Complainant's] *ongoing symptoms we will arrange a whole-body nuclear medicine bone scan to further evaluate for any inflammatory joint pains"*.

In correspondence dated 11 May 2016, Dr A., Specialist in Pain Management at the Department of Anaesthesia, Critical Care & Pain Medicine at Hospital [X.] Dublin advised, as follows:

> *"I reviewed this pleasant lady in Pain Clinic today* [25 April 2016]*. She has been with us regarding the multi-axial pain for the last two years. She has been extensively*

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reviewed by the Rheumatology and no obvious cause for her pain is found, it seems to be coming from the osteoarthritis. On history, she is reporting the pain is also in the shoulder, back, neck, hips and also affecting her most of the myofascial plains. It seems like she also has the fibromyalgia. In the past she has tried Nurofen Plus and Tramadol.

She does not have any significant past medical history other than the hypocholesterolaemia. She is taking Atorvastatin. She is allergic to Penicillin. She does have a good social support, living with her husband. She had tried the Physiotherapy, Occupational Therapy with good benefit. Our impression is that her chronic pain is secondary to osteoarthritis and fibromyalgia. We are going to give her a trial of Amitriptyline 25 mg at night time for six weeks. If it does not work, GP can prescribe the Lyrica 25mh twice daily and we will see her back in clinic in three months' time".

I note the results of the NM BONE WHOLE BODY, NM BONE LOCALISED performed at Hospital [Q.] on 29 June 2016, as follows:

"Indication: Evaluate for inflammatory arthropathy …

Findings:
Normal activity is seen along the vertebral column and pelvis. Mild increased uptake seen at the right sternoclavicular junction suggestive of localised degenerative change. Otherwise normal large joint activity at the shoulders, elbows, hips, knees and ankles.
A focal photopenic area is seen in the body of sternum inferiorly extending towards the right parasternal region without associated increased uptake. A focal lytic lesion at this site cannot be excluded.
Activity in the small joints of the hands and feet appears within normal limits.
Excreted activity is seen in the kidneys and urinary bladder.

Impression:
No evidence of inflammatory arthropathy.
Indeterminate photopenic region in the inferior body of sternum, a focal lytic lesion at this site cannot be excluded. Correlation with non-contrast CT of chest may be necessary to exclude aggressive lesion at this site".

In correspondence dated 4 August 2016, the Rheumatology Department at Hospital [Q.] Dublin advised, as follows:

"As you know [the Complainant] *has been suffering from pain and stiffness all over her body but mainly her neck, hips and hands for the last few years. Her recent bone scan did not show any sign of inflammatory arthropathy. On examination she did not have any evidence of synovitis either. I believe her symptoms are due to diffuse OA. She has had physiotherapy in [hospital name redacted] and is performing the exercises at home which seem to help. We will see her in 6 months time to review her symptoms again".*

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In correspondence dated 10 August 2016, Dr C., Pain & Perioperative Physician at the Department of Anaesthesia, Critical Care & Pain Medicine at Hospital [X.], Dublin advised, as follows:

> *"I saw* [the Complainant] *today* [25 July 2016] *and noted her bone scan which was essentially normal for inflammatory arthropathy though she is due to be reviewed by Rheumatology over the next few weeks. I also noted that they had ordered a CT scan which was recommended from the scan as there was an area in the sternum which could not be viewed fully.*
>
> *I note that she has not tolerated neuropathic pain medication, perhaps this was started on too high a dose initially. In the context of fibromyalgia, the recommendation is usually for aerobic exercise and in that context. I have asked our Physiotherapist to review her"*.

I note the results of the CT THORAX performed at Hospital [Q.] on 29 August 2016, as follows:

> *"Indication: indeterminate photopenic region in the inferior body of sternum on recent bone scan. Further evaluation required.*
> *Technique: Non-contrast study.*
> *Comparison: NM Bone scan 29/6/2016.*
>
> *FINDINGS:*
> *No thoracic lymphadenopathy. No suspicious pulmonary nodule.*
> *No pleural or pericardial effusion.*
>
> *Visualised portions of the upper abdomen are unremarkable. No adrenal mass.*
> *No suspicious osseous lesions are noted. In particular the sternum appears within normal limits and there is no clear correlate with the previously demonstrated photopenic region, this may have been artifactual.*
>
> *IMPRESSION: Since 29/6/2016,*
> *No concerning abnormality"*.

I note the Practitioner Report dated 30 September 2016 wherein her GP, Dr. O. advised the exact nature and cause of the Complainant's disability as *"OA, undergoing further investigations"*.

In correspondence dated 22 December 2016, the Complainant's treating Consultant Rheumatologist, Dr G. advised, as follows:

> *"**Diagnosis:***
> *Diffuse Osteoarthritis*
> *Fibromyalgia*
> *Seronegative …*

/Cont'd…

> [The Complainant] *previously investigated for possible inflammatory arthropathy. Investigations to date including bone scan showed no evidence of IA.* [She] *reports ongoing widespread musculoskeletal pain with poor sleep pattern and multiple tender points on examination consistent with fibromyalgia. She had intolerance to Amitriptyline, Lyrica and Tramadol in the past. Imp-Fibromyalgia. Plan – refer to fibromyalgia program, trial Cymbalta 30 mg OD, transfer care to Naas Hospital, review in 1 year time"*.

I note that the Provider considered that overall, this appeal evidence was not suggestive of a disabling medical complaint which could prevent the Complainant from working and that there was no suggestion that she could not have continued to work whilst undertaking the treatment recommended therein.

In order to fully assess her appeal, I note that the Provider arranged for the Complainant to attend for a Chronic Pain Abilities Determination (CPAD) on 21 February and 23 February 2017. In his resultant report, Mr N. advised, *inter alia*, as follows:

> *"The purpose of the evaluation is to assess the individual's ability to perform tasks within her home and work environments ….*
>
> [The Complainant] *worked as a customer service agent in* [a] *Call centre on a full-time basis.*
>
> *She describes her role as requiring to sit at a desk for 99% of the day using a PC, screen, keyboard and mouse, and wearing a headset, which she reports was painful on the right ear due to the TMJ problem. There was no lifting or carrying involved. According to her, she uses a number of different types of bespoke software programmes.*
>
> [The Complainant] *states that she stopped work on 31 August 2015 due to her feeling that she had "hit a wall" as a result of her severe symptoms.*
>
> [The Complainant] *reports that the barriers preventing a return to her normal working activities are the pain in her hands, her hypersensitivity to bright lights, fatigue (this is a significant factor) and poor concentration and memory …*
>
> *Whilst* [the Complainant] *demonstrated a significant level of disability due to her various conditions, which would appear to prevent her from returning to her normal form of employment, a review of the CPAD physical results on both days of testing indicate that she performed with very poor reliability of effort and there is evidence of symptom exaggeration present. This conclusion is based on the number of inconsistencies and discrepancies demonstrated by her throughout the assessment.*

/Cont'd…

These areas of concern are listed as follows:

- *There was a poor correlation between* [the Complainant's] *self-reported exertion levels and corresponding measured heart rates during most of the tests on day 1, and all of the tests on day 2.*

- [The Complainant] *reported very high pain levels during both days of testing, she was however able to converse normally at all times, as well as frequently laugh and joke throughout the assessment. There was no evidence of any organic signs normally associated with these levels of pain.*

- *Her pain levels at the conclusions of testing on both days were lower than at the start of testing on both days. Furthermore, her pain level at the start of testing on day 2 was higher than in tests which directly stress the reported impaired regions of her body.*

- *Despite reporting increased fatigue and pain on day 2 compared to day 1, her abilities to left and right grip in position 3, left grip in position 4, left REG, perform bilateral bi-manual handling tasks standing, perform bi-manual handling tasks sitting, and perform bilateral bi-manual fine dexterity tasks sitting, all increased on this day.*

- [The Complainant]*'s demonstrated inability to reach out bilaterally on both days, her marked bilateral grip and key pinch (on day 1 and on the left on day 2) strengths deficits, and inabilities to exert any force in the right key pinch on day 2 and bilateral tip and palmar pinches on both days do not correlate with her reported abilities to cook, open tight jars and bottle tops using a nutcracker, use cutlery, load and unload a washing machine, dryer, and dishwasher (even in an adapted way), wash up at the sink, sweep, use a telephone and mobile, perform personal hygiene, do the weekly shop even on one out of ten occasions, get dressed and undressed unaided, shower unaided, self-groom, drive a manual car, or make and change beds even with help.*

- *Whilst* [the Complainant] *demonstrated significant bilateral grip strength deficits on formal testing, these abilities increased on distraction*

- *The 5-position grip strength curves were non-bell shaped in both hands on both days of testing, representing invalid test results.*

- *The palmar pinch forces in both hands on both days did not exceed the tip pinch forces, representing inappropriate test results.*

/Cont'd…

- *Whilst* [the Complainant] *demonstrated on formal testing an inability to tip or palmar pinch in either hand on both days, or key pinch on day 2, as well as her marked pinch deficits on both hands on day 1 and in the left hand on day 2, these abilities increased significantly on distraction.*

- [The Complainant] *also demonstrated on formal testing an inability to reach out with either hand. However, these abilities increased to normal on distraction testing.*

- *Furthermore, her pain and exertion levels in all but one test were higher during the formal reaching out test than performing the same activity on distraction on day 1.*

- [The Complainant] *demonstrated significantly reduced cervical flexion on day 2 and bilateral rotation on both days. However, these abilities were observed to be normal on distraction.*

- [The Complainant] *reported superficial pain during Algometry testing, representing inappropriate pain reporting on both days of testing. Furthermore, she reported pain in three distraction sites which are unassociated with a diagnosis of FM.*

- *The coefficients of variation (CV) on day 1 in the left and right REG tests, and left key pinch; and on day 2 in the right grip position 2 test, and left and right REG tests, were all greater than expected and represent further invalid results.*

Based on the above inconsistencies and discrepancies, the results of the CPAD cannot represent [the Complainant's] *true working capabilities and one must assume that her actual abilities are far greater than she was willing to demonstrate on formal testing.*

Furthermore, the physical work-day tolerances demonstrated by [the Complainant] *cannot be used to infer any barriers preventing her from returning to her normal role.*

Notwithstanding the above areas of concern, a comparison between the results on day 2 of physical testing and [the Complainant's] *self-reported job description suggests that the minimum demonstrated work-day tolerances by her on day 2 of CPAD indicate that she would, with appropriate adaptations at the workplace (such as ergonomic seating and a sit/stand desk) as determined through an Ergonomic Assessment (EA), be able to undertake all the physical components of her normal role over an 8-hour working day on a full-time basis …*

The above conclusion is based on [the Complainant's] *following demonstrated minimum work-day tolerances on day 2 of CPAD:*

/Cont'd…

- *She is able to constantly (over 67% of the working day) sit, perform bi-manual fine dexterity tasks sitting, and perform bi-manual handling activities standing, all with regular breaks*
- [The Complainant] *is able to frequently (33-66% of the working day) stand, perform bi-manual fine dexterity tasks standing, and perform bi-manual handling activities sitting, all with regular breaks*
- [The Complainant] *is able to occasionally (1-33% of the working day) walk, frequent breaks*

With respect to the Rey-15 and MMSE cognitive tests, the results over both days of testing indicate that [the Complainant] *performed without any evidence of symptom exaggeration or cognitive barriers preventing a return to work.*

In the CNSVS cognitive battery of tests, [the Complainant] *did however perform with evidence of symptom exaggeration. This conclusion is based on 12 of the 14 measures being classified in the very low percentile level over both days of CPAD. These scores are comparable to patients suffering from severe brain injury, mental retardation and early dementia and not with those suffering from FM or chronic pain.*

Additionally, these very low percentile level scores are not consistent with her demonstrated normal cognitive function in the MMSE tests, nor with her abilities to follow and recall test instructions, converse normally, drive a car, use a laptop, use a mobile phone, or self-medicate.

Therefore, [the Complainant's] *demonstrated level of cognitive impairment on the CNSVS tests on both days of testing cannot be used to infer any barriers preventing her from returning to her normal role".*

I note that the Provider concluded that the physical and cognitive tolerances demonstrated by the Complainant during this CPAD assessment could not be used to infer any barrier preventing her from working and following a thorough review of her income protection claim, the Provider remained of the opinion that the Complainant did not satisfy the policy definition of disability. As a result, the Provider wrote to the Complainant's Employer on 5 April 2017, as follows:

"As you know [the Complainant]*'s claim was declined on the 12/05/2016 following a review of the findings received from the independent medical examination which* [the Complainant] *attended on the 30/03/2016. IME report findings at that time indicated that:*

> *"It is however my opinion that* [the Complainant] *is currently fit to return to her previous work on a full time basis."*

[The Complainant] *then appealed this decision with new medical evidence.*

/Cont'd…

In order to consider the appeal further we arranged a Chronic Pain Abilities Determination over two days on the 21/02/2017 & 23/02/2017. Based on the findings of the CPAD and a review of all medical records on file including the appeal documents submitted and 2 independent assessments that [the Complainant] *attended, it is our opinion that* [the Complainant] *does not meet the definition of disability as set out in the policy and I must advise therefore that we are unable to admit this claim.*

Under the terms of the policy, the definition of disability states:

> *"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 occurrence of which the benefit under the policy becomes payable, after the deferred period."*

With due consideration to the findings of the Independent Medical Consultant Examination on the 21/02/2017 & 23/02/2017, we must be guided by the weight of the objective evidence obtained which, in our opinion, clearly indicates that [the Complainant] *does not meet the definition of disablement under the policy and is medically fit to resume her normal occupation.*

The independent Consultant states;

> *"A review of the CPAD physical results on both days of testing indicate that* [the Complainant] *performed with very poor reliability of effort and there is evidence of symptom exaggeration present. This conclusion is based on the number of inconsistencies and discrepancies demonstrated by her throughout the assessment."*
>
> *"Based on the above inconsistencies and discrepancies, the results of the CPAD cannot represent* [the Complainant's] *true working capabilities and one must assume that her actual abilities are far greater than she was willing to demonstrate on formal testing."*
>
> *"Furthermore, the physical work-day tolerances demonstrated by* [the Complainant] *cannot be used to infer any barriers preventing her from returning to her normal role"."*

Similarly, in its more recent correspondence to this Office dated 30 May 2019, I note that the Provider submits, as follows:

"As part of the claim assessment in addition to the independent medicals we also considered several copies of medical reports submitted by [the Complainant's] *own GP* [Dr O.]*. The test results confirmed that the scans of the lumbar and cervical spine were essentially normal; blood tests were not suggestive of any haematological disease; negative rheumatoid factor noted.*

/Cont'd…

It was also noted from a review of the appeal evidence from [Dr G.]*, Con. Rheumatologist in December 2016 that there was no evidence of an inflammatory arthropathy which might explain the level of widespread joint pain.*

[The Complainant] *is correct in that it is an invisible disability however it cannot be proven through any pathological tests, it is a functional disorder and we are not disputing the diagnosis of fibromyalgia. However the objective clinical findings of the MRI scans, Bone scans, CT scans, and blood tests, do not support a diagnosis of an Inflammatory Osteoarthritis which might explain the level of pain symptoms that* [the Complainant] *was reporting.*

The diagnosis of a medical condition does not result in claim approval nor does diagnosis of a medical condition automatically equate to work disability.

The objective test results and commentary provided by [the Complainant's] *own doctors together with the outcome of the CPAD and the independent medical examination findings form the attendance with* [Dr H.]*, Consultant Rheumatologist on 30 March 2016 do not support the claim for work disability …*

We are satisfied that [the Complainant] *was not medically disabled from working and our decision to decline the claim was correct".*

In order for an income protection claim to be payable, a claimant must satisfy the policy definition of disability. In this regard, the '**Interpretation**' section of the applicable Group Income Protection Policy Conditions provides, *inter alia*, at pg. 4:

"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 occurrence of which the benefit under the policy becomes payable, after the deferred period.

The member must not be engaged in any other occupation".

Income protection insurance decisions are based on objective medical evidence and the job demands of the occupation, to ascertain whether the claimant meets the policy definitions for a valid claim. In this regard, I accept the Provider position that the diagnosis of a medical condition is not, in and of itself, sufficient to validate a claim. Rather the weight of the objective medical evidence before it must clearly indicate that the claimant is unfit to perform the material and substantial duties of his or her occupation as a direct result of that diagnosis.

/Cont'd…

Having considered the medical evidence before it and which I have cited from at length, and which includes reports and test results from the Complainant's own treating doctors, I am satisfied that it was reasonable for the Provider to conclude that the Complainant did not satisfy the policy definition of disability. As a result, I am satisfied that the Provider declined the Complainant's income protection claim in accordance with the terms and conditions of the Group Income Protection Scheme of which she is a member of.

I note that in her email to this Office dated 24 April 2019, the Complainant commented on the Chronic Pain Abilities Determination assessment that she underwent on 21 February and 23 February 2017, as follows:

> *"When I was attending the CPAD assessment I raised my concerns about the medical aspect of this test with both* [the Provider] *and* [my Employer's] *HR, as it was being held in a hotel room, by an osteopath … It was inferred that* [Mr N.] *was a doctor, and I had to follow procedures and my understanding of these tests were that they would prove my incapability, could not be tampered with, so I attended.* [Mr N.] *seems to have omitted to comment on a part of the test when I asked for a break as I was having difficulty with the lighting and concentration as I was tired and could not focus, I was told once the test started it had to be completed. I was very close to tears. I could dispute his comments on phone usage (I took out my phone to turn it off). I have strings on my handbag to help with the zip, as I have difficulty with just the little piece of metal on the zipper itself. There were other things, but I would have to read all the report and that is just overwhelming for me"*.

In this regard, the Provider has advised that the CPAD testing was carried out by Mr N., an osteopath and qualified functional capacity evaluator with significant experience in the area of occupational health and who has undertaken in excess of 4,500 assessments. It further advised that the CPAD protocol was devised by a group of professionals who are experts in the field, including an Irish Rheumatologist, Neuro-psychiatrist and Physician, and was published in the Irish Medical Journal in 2008.

I note that the Chronic Pain Abilities Determination assessment is undertaken over a two day period, with an intervening rest day in between, and generally takes 4-5 hours in total to complete over the two days. It was designed to specifically objectively measure the work capacity of an individual suffering from fibromyalgia with respect to their normal occupation over an 8-hour working day, utilising an extensive combination of valid and reliable testing, the results of which are free from both the examiner's and individual's subjectively. It is a comprehensive evaluation of an individual's then current physical and cognitive capabilities to perform work-related tasks in order to determine whether or not they meet the physical demands required to undertake their normal working activities.

/Cont'd…

As a result, I am satisfied that it was reasonable for the Provider to refer the Complainant for a Chronic Pain Abilities Determination assessment and for it to consider the results of this assessment in conjunction with the objective medical evidence before it, which included the medical reports and test results provided by the Complainant's treating doctors.

In addition, following its decision to uphold the declinature of her income protection claim in April 2017, I note the Complainant advised that her Employer had referred her for an occupational health assessment on 29 June 2017 with Dr N., who concluded in her report dated 9 May 2018 that *"this lady remains unfit to work and her prognosis with regard to returning to work at a future date is guarded"*. In addition, I note from the documentary evidence before me that in March 2018 the Occupational Therapy Department at Hospital [X.] provided the Complainant with a right wrist thumb brace and a radial thumb Spica splint. Furthermore, in her email to this Office dated 24 January 2019, the Complainant submits,

> *"I have also had further nerve tests, pertaining to my numbness in my fingers. The results are not yet available…I have to wear the* [thumb splint and wrist support]*, which are restrictive, while doing anything that aggravates the pain in my hands and wrists"*.

I note that the Provider previously considered the Complainant's income protection claim against the policy definition of disability in **May 2016** and on appeal in **April 2017** and on both occasions found that she did not satisfy this definition of disability and was fit to carry out the material and substantial duties of her normal occupation. As already stated above this was a conclusion based on the weight of the objective medical evidence before it, and was a reasonable conclusion for the Provider to make.

I accept the Provider's position that any additional subsequent reports submitted by the Complainant in 2018 and/or 2019 cannot be considered retrospectively in relation to the original claim, when it already declined this claim in the first instance in May 2016 and on appeal in April 2017. In addition, as the Complainant did not attempt a return to work thereafter, I also accept the Provider's position that any contemporary medical reports cannot be considered as a new income protection claim. Similarly, the medical issues which the Complainant encountered during May/June 2019, details of which are set out in the Complainant's email to this office dated 10 January 2020, were not relevant to the Provider's consideration of her income protection claim in May 2016 and on appeal in April 2017, some years earlier.

Although I note the Complainant's comments that this outcome is very disappointing to her, on the evidence before me, I take the view that this complaint cannot be upheld.

/Cont'd…

<u>Conclusion</u>

My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is rejected.

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.

MARYROSE MCGOVERN
DIRECTOR OF INVESTIGATION, ADJUDICATION AND LEGAL SERVICES

28 February 2020

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.