Decision Ref:	2020-0147
Sector:	Insurance
Product / Service:	Personal Accident
Conduct(s) complained of:	Rejection of claim – partial rejection Disagreement regarding Medical evidence submitted
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainant holds two policies of insurance with the Provider. The Complainant made a claim under one of the policies following a fall in **November 2017**. The Provider admitted this claim for the period **25 November 2017** to **29 January 2018**. The Complainant subsequently underwent knee replacement surgery and made a claim under both policies by way of continuation claim form. The Provider declined to indemnify the Complainant's continuation claim because the accident giving rise to his knee injury in **November 2017** was not the sole reason for his knee replacement.

The Complainant's Case

The Complainant states that on **25 November 2017** he

> *"… had a fall … on decking and injured [his] knee and lower back."*

The Complainant states that in **February 2018** he required a knee replacement because of his fall. The Complainant submitted a claim under his policy which the Provider admitted and paid the Complainant disability benefit for the period **25 November 2017** to **29 January 2018**. The Complainant submits that the Provider declined to indemnity him any further after **29 January 2018**.

The Complainant states that his doctor and consultant disagree with the findings of the Provider and that his claim under the policy for the months following his fall, relates directly to an injury caused by the fall (i.e. an accident) and was not the result of a sickness.

The Provider's Case

The Provider states that it received a claim from the Complainant on **5 February 2018** listing soft tissue injury to his lower back and left knee caused by slipping on wet decking at his home. The Provider states that two policies relate to the Complainant's claim however, as no hospital inpatient stay was required, the only applicable policy was the Complainant's Full Cover policy.

The Provider submits that only Section C and Section D of this policy apply to the Complainant's claim. To qualify for the benefits of this policy, the Provider points out that the terms and conditions state:

> *"If the insured suffers accidental bodily injuries received while the Policy is in force and in no way caused or contributed to by sickness, disease or physical disorder (called in this Policy "Bodily Injury") then provided the premium has been paid [the Provider] will pay the following benefits …"*

The Provider states that section 7 provides that:

> *"the Claimant shall give to [the Provider], at the Claimant's expense, proof of claim satisfactory to [the Provider], including employers certificates, and medical certificates and other medical information [the Provider] may require from a duly qualified and registered Medical Practitioner who, and any hospital which, has treated the Insurer."*

The Provider cites section 8 of the policy as follows:

> *"If in the opinion of the Chief Medical Officer appointed by [the Provider] at the losses claimed (sic) are excessive for the Bodily Injury sustained then [the Provider] reserves the right to make a settlement limited to the CMA assessment of reasonable losses for that Bodily Injury."*

The Provider states that the Complainant's doctor provided medical evidence in support of his claim. The Provider states that it also holds letters from the Complainant's Orthopaedic surgeon and that the matter was also referred to its internal Chief Medical Officer. The Provider submits that based on the medical evidence supplied/available to it, and the coverage under the policy, the applicable benefit was paid to the Complainant.

The Provider states that the Complainant's doctor completed the Claim Form and Continuation Claim Form and provided a written statement dated **27 April 2018**, confirming:-

> *"'In conclusion then, although he had an underlying osteoarthritis, it was a result of the fall that he required the knee replacement.'"*

/Cont'd…

The Provider refers to a written statement from the Complainant's consultant dated **30 November 2018**, confirming the *"'Sole cause for the knee replacement was osteoarthritis'."* The Complainant's consultant also pointed out that the Complainant was originally referred to him in **2012** for that reason and that the

> *'fall was not the reason for the knee replacement, osteoarthritis was leading factor for knee replacement. Knee replacement would not have happened if there was a fall.'"*

The Provider states that it *"… cannot establish a disagreement over the findings … in relation to the claim, more a disagreement between medical professionals into the cause of the surgery."*

The Provider advises that the Complainant's claim was assessed for the period **25 November 2017** to **29 January 2018** and was reviewed using the Complainant's claim form, medical records and the Medical Disability Guidelines (MDG). The Provider states that the medical report from the Complainant's doctor verifies the circumstances of the accident, the injuries sustained, the treatment received and the duration of the ongoing Total Disability at **29 January 2018**.

The Provider states that its claims department used the Medical Guidelines as a reference to establish the recovery timeframe for soft tissue injuries and noted that the following periods were given:

> *"A) Medium pain and strain with occasional surgical treatment – the recovery period would be somewhere between 21 to 70 days, with the optimum period being 56 days*
>
> *B) For a very physically active job the optimum period of TD is 14 days; with the max period being 70 days, which was for supportive treatment for anterior cruciate ligament.*
>
> *C) For surgical treatment, arthroscopic repair of anterior cruciate ligament the max period of TD is set at 140 days and optimum 112 days."*

The Provider states that its claims department noted the incident date being **25 November 2017** and the claim form being signed on **29 January 2018**. They also noted the Complainant was in attendance with an orthopaedic surgeon and was awaiting probable knee replacement surgery. On that basis, the Provider submits, it was agreed to pay the benefit using the Medical Guidelines as the period being claimed for was 2 months and 5 days which fell within the 21 to 70 days timeframe noted above.

The Provider states that the Complainant's claim was latterly referred to its Chief Medical Officer who agreed that the period paid (66 days) was fair and sufficient for a soft tissue injury in the knee. The Provider states that a continuation form would then be issued and it would continue to monitor the claim duration as the Complainant may have an underlying knee problem.

/Cont'd…

The Provider's Chief Medical Officer noted that the Complainant's replacement surgery was to address the osteoarthritis which had been present in the Complainant's knee joint since **2002**. The purpose of the surgery was not to repair the putative soft tissue injury and this was supported by the statement of the Complainant's consultant on **30 November 2018** in which he stated that the Complainant's fall was not the reason for the replacement – the osteoarthritis was the leading factor in the surgery.

The Complaint for Adjudication

The complaint is that the Provider wrongfully and/or unreasonably refused to admit and pay the Complainant's continuation 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 3 March 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.

It is important to emphasise that, for the purpose of assessing this complaint, it is not the role of this Office to comment on or form an opinion as to the nature or severity of the Complainant's illness or condition. It is the duty of this Office to establish whether, on the basis of an objective assessment of the medical evidence submitted, the Provider has adequately assessed the Complainant's claim and whether it was reasonably entitled to arrive at the decision it did, following its assessment of the medical evidence submitted.

/Cont'd…

Full Coverage Accident Policy

The Complainant's full cover policy states:

> *"If the Insured suffers accidental bodily injuries received while this Policy is in force and in no way caused or contributed to by sickness, disease or physical disorder (called in this Policy "Bodily Injury") then provided the premium has been paid [the Provider] will pay the following benefits, subject to the following terms and conditions including, in particular, the reductions and exclusions:-"*

Section C of the policy states:

> *"If Bodily Injury shall be sustained by the Insured and shall not result in any loss for which benefit is payable under Sections A or B of this Policy, but shall solely and independently of any other cause and, within thirty days from the date of the accident causing Bodily Injury continuously, necessarily and wholly disable the Insured and prevent the Insured from performing each and every duty of the Insured's usual business or occupation (or usual activities if not engaged if business or employment), then [the Provider] will pay to the Insured periodically during such disability, BEGINNING WITH THE FIRST DAY OF DISABILTIY, for a period not exceeding six months, benefit at the monthly rate shown in the Schedule of Benefits under C."*

Section D of the policy states:

> *"If Bodily Injury shall be sustained by the Insured and shall not result in any loss for which benefit is payable under Sections A or B of this Policy, but shall solely and independently of any other cause and within thirty days from the date of the accident causing Bodily Injury or immediately following a period of total disability for which benefit is payable under Section C, prevent the Insured from performing one or more important duties of the Insured's usual business or occupation (or usual activities if not engaged in business or employment), [the Provider] will pay to the Insured periodically during such disability, BEGINNING WITH THE FIRST DAY OF DISABILITY, or upon the termination of benefit under Section C (whichever is later), for a period not exceeding one month benefit, at the monthly rate shown in the Schedule of Benefits under D."*

Conditions 8 and 9 of the policy state:

> *"(8). PROOF OF CLAIM AND TIME FOR PAYMENT OF CLAIM: …If in the opinion of the Chief Medical Officer appointed by [the Provider] the losses claimed are excessive for the Bodily Injury sustained then [the Provider] reserves the right to make a settlement limited to the Chief Medical Officer's assessment of reasonable losses for that Bodily Injury. In such event [the Provider] will allow the Claimant 28 days in which to submit any additional proofs of loss. If these are not received by [the Provider] within such period or if received they are unsatisfactory [the Provider] shall be deemed to have met its liability in full.*

/Cont'd…

(9). PAYMENT OF CLAIMS: Where this Policy provides for periodic payment of benefits these will be paid monthly upon receipt of satisfactory evidence of continuing disability provided by the Claimant …"

Accident Hospital Indemnity Policy

The Complainant's hospital policy states:

"NOW THIS POICY WITNESSESTH that if the Insured shall suffer accidental bodily injuries received while this Policy is in force and in no way caused or contributed to by sickness, disease or physical disorder (herein called "Bodily Injury") then the Company shall pay the benefit or benefits hereinafter specified according to the event which happens and subject to the Conditions, Exceptions and Reductions attached thereto as follows:"

Claim Form

The Complainant submitted a claim form to the Provider in respect of his knee and lower back injury resulting from his fall in **November 2017**. The Complainant states that the accident occurred when *"I was walking to the clothes line when I slipped on the wet decking."*

The Complainant describes the cause of the accident as: *"The timber was wet and slippery with moss."* The form sets out the injury caused by the accident as: *"Soft tissue injury to lower back and left knee."* The Complainant ticked *Yes* when asked whether the injury prevented him from performing all of his usual work activities or usual activities if not in paid employment.

The claim form also states that the Complainant's injuries were ongoing. Describing how his injuries prevented him from performing these activities the Complainant answered: *"Cannot put pressure on left knee and has a lot of pain on walking and bending."* The form also states that the Complainant received no treatment for his injuries and was given painkillers.

The Complainant's doctor, in completing the relevant section of the claim form, considered that the Complainant satisfied the definition of *totally disabled* as a result of the accident. The Complainant's doctor also noted that the Complainant was *"[a]ttending orthopaedic surgeon and is waiting probable knee replacement."*

In an undated letter, the Provider wrote to the Complainant informing him that having considered the claim for his accident, it was paying him the sum of €1,237.99 for the period **25 November 2017** to **29 January 2018** and was accepting liability for his claim in respect of this period only.

/Cont'd…

Continuation Claim Form

The Complainant submitted a continuation claim form dated **26 March 2018**. The Complainant's claim was said to be the result of an accident and the primary cause of the injury was stated to be: *"Injury to the left knee (Soft tissue)."* The form states that the Complainant was unable to undertake his daily activities due to his knee replacement surgery and that the Complainant's knee was *"… still swollen and painful and requires physiotherapy."* The form further states that the Complaint first suffered total disability on **25 November 2017** and that the last date of total disability was **26 March 2018** and was still ongoing.

The Complainant's Consultant

By letter dated **26 January 2018**, the Complainant's consultant orthopaedic surgeon wrote:

> *"[The Complainant] attended my clinic. You probably are aware that I have seen him previously in 2012. He has an old cruciate injury.*
> *That time he had established medial compartment osteoarthritis.*
>
> *He managed away, however in November 2017 he had another fall that made his knee more troublesome, He complains of pain and difficulty with walking.*
>
> *Clinically and radiologically he has advanced predominantly medial compartment osteoarthritis. I have explained to him with regard to Knee Replacement including potential risks …"*

The Provider wrote to the Complainant's consultant on **27 November 2018** with certain questions regarding the Complainant's claim. The consultant replied by letter dated **30 November 2018** as follows:

> *"These are the answers to the questions you posed in your letter of inquiry.*
>
> ***Do you believe the fall suffered by [the Complainant] was the sole cause of the need for a total knee replacement?***
> ***Doctor Response:*** *No. The sole cause for the knee replacement was Osteoarthritis.*
>
> ***Under the terms of [the Complainant's] policy is he entitled to benefit when unable to carry out all his daily activities as a result of an accident. In this case we have paid a total of two month's benefit, based on the time taken to recover from a soft tissue injury alone. In the absence of any underlying condition, do you feel this would be a reasonable period of recovery for the injury sustained?***
>
> ***Doctor Response:***
> *[The Complainant] had significant Osteoarthritis of his left knee and was known to me in 2012.*
> *I do not have a defined injury to a fall to comment on. People with Arthritis can have more symptoms following a fall.*

/Cont'd…

Please provide any comments on the opinion of [the Complainant's doctor] that the fall was the reason that the total knee replacement was required.

Doctor's Response:
The fall was not the reason for the knee replacement.
Osteoarthritis was the leading factor for the knee replacement.
The knee replacement would not have happened if there was no arthritis."

The Complainant's Doctor

By letter dated **27 April 2018**, the Complainant's doctor wrote:

"[The Complainant] has seen an orthopaedic consultant … in 2012 regarding his left knee pain. He was diagnosed with osteoarthritis, but he managed well on conservative treatment only.

In November 2017 he had a fall with an injury to the knee. Since then, he could not manage the pain in the knee and required a knee replacement as a result.
In conclusion then, although he had an underlying osteoarthritis, it was as a result of the fall that he required the knee replacement."

Declinature of Continuation Claim

The Provider wrote to the Complaint on **9/10 April 2018** stating:

"… Attached to the continuation claim form received is a letter addressed to [the Complainant's doctor] dated 26/01/2018 from [the Complainant's consultant]. In the letter [the Complainant's consultant] advised that he had seen you previously in 2012, that you had an old cruciate injury and that at that time you had established medial compartmental osteoarthritis.

He went on to advise that you managed well but that you had another fall in November 2017 that made your knee more troublesome and you complained of pain and difficulty with walking.

[The Complainant's consultant] further advised in the letter that clinically and radiologically you have advanced predominantly medial compartment osteoarthritis.

Advanced predominantly medial compartment osteoarthritis is a sickness condition.

…

Your claim, together with all of the medical information received, has been reviewed by our Chief Medical Adviser.

/Cont'd…

In view of the above and taking into consideration your occupation, the medical evidence received, and the terms and conditions of your policy, our Chief Medical Adviser feels that the total disability benefit previously paid to you from 25/11/2017 to 29/01/2018 is a fair payment for the injuries you sustained in the accident, in the absence of your underlying sickness. …"

Following this, the Provider again wrote to the Complainant on **21 May 2018** referring to correspondence received from the Complainant's doctor:

"We have reviewed the letter received, and note that [the Complainant's doctor] confirms that you were diagnosed with osteoarthritis of the left knee in 2012. In addition, we note the contents of a letter dated 26th January 2018 from your consultant orthopaedic surgeon … which states that you were suffering from "advanced predominantly medial compartmental osteoarthritis".

Based on the information listed above, it must be noted that while you required knee replacement surgery in the months after the fall, the accident suffered in itself would not have been sufficient to require knee replacement surgery, were you not already suffering from osteoarthritis in the knee – as such, the accident cannot be held as the sole cause of your disability, regardless of whether you were symptomatic prior to the date of your fall. As such, it is also therefore clear that your condition has been contributed to by a physical disorder (namely, osteoarthritis), for which benefits are excluded under the terms and conditions of your policies.

We must therefore consider what benefits would be due in the absence of any underlying sickness or degenerative condition, and as such consider a payment of two months and five days to be a fair period for the injuries sustained with that fall on their own. We also confirm that, as the fall would not in itself have been sufficient to require a knee replacement in the absence of osteoarthritis, there are no benefits due under your Hospital Indemnity Plan."

Analysis

In order for a claim to be admitted under either of policies the Complainant must show that the bodily injury for which he is claiming was *"… in no way caused or contributed to by sickness, disease or physical disorder …"* The Provider accepted that the Complainant's initial claim arose from his fall on the decking, and admitted the claim for benefit payments based on his total disability for 66 days. The subsequent continuation claim however, arose in the context of the Complainant's surgery. The Provider examined the medical evidence available and classified the Complainant's osteoarthritis as a sickness/physical disorder. Furthermore, on the basis of that medical evidence which included the views expressed by the Complainant's consultant, that the Complainant's knee replacement was not necessitated by the fall and his doctor's acknowledgment of his underlying arthritis, the Provider declined the Complainant's claim because his knee replacement was *caused or contributed to by sickness, disease or physical disorder* being his osteoarthritis and was not specifically required as a result only of the fall he suffered in **November 2017**.

/Cont'd…

While the Complainant's policies do not expressly define the terms *sickness, disease or physical disorder*, I am not satisfied that the Provider, in its interpretation of the terms of the policies and its consideration of the medical evidence, acted contrary to the provisions of the ***Financial Services and Pensions Ombudsman Act 2017***, in declining the Complainant's continuation claim. Therefore, I do not consider it appropriate to uphold this complaint. I take the view that the Provider's position in declining the continuation claim, was a reasonable one, based on the medical evidence available and taking into account the policy provisions in place. Consequently, I am satisfied that the complaint against the Provider cannot reasonably be upheld.

Conclusion

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
DEPUTY FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

20 April 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.