An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0212
Sector:	Insurance
Product / Service:	Income Protection and Permanent Health
Conduct(s) complained of:	Rejection of claim - did not meet policy definition of disability Failure to process instructions in a timely manner
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainant, as a benefit of her contract of employment, was a member of a Group Disability Scheme. The Employer is the policyholder of this Scheme. The Provider is the Insurer, responsible for the underwriting of applications for cover and assessing claims. The purpose of the Scheme is to provide the policyholder with funds to provide sick pay to its employees who are absent from work with a long-term illness.

The Complainant's Case

The Complainant, [occupation redacted], was medically certified as unfit for work from [month redacted] 2017 [age redacted]. On **20 December 2017**, some 4 months later, she completed an Employee's Claim Form advising:

> *"**Please state the exact nature of the incapacity from which you are suffering:***
> *Back and shoulder injury, medical investigations are ongoing. I continue to attend with specialist consultants. Also causes fatigue and anxiety. Previous cortisone injections failed to help*
>
> ***In what way does this incapacity prevent you from following your occupation?***
> *Sitting for extended periods, use of mouse for computer, commuting to/from work"*.

In assessing the income benefit claim, the Provider arranged for the Complainant to attend for a medical examination with Dr D., Specialist in Occupational Health on **29 May 2018**, who concluded in her Report dated 11 June 2018,

> *"In my opinion,* [the Complainant] *does not meet the definition of disability as defined under this policy. I am unable to categorise her as disabled or unable to follow her normal occupation".*

Following its assessment, the Provider admitted the income benefit claim from **6 February 2018**, which marked the end of the policy "deferred period" of 26 weeks, to **19 June 2018**, when it advised the policyholder that the Complainant did not satisfy the policy definition of disabled for a valid claim.

The Complainant appealed this decision by way of furnishing a Report from her Consultant Pain Physician, Dr R. dated **8 August 2018**, in which he concluded:

> *"*[The Complainant] *continues to have persistent pain related to a fall and a compression fracture. She has been referred for the Pain Management Program. This is a holistic approach to pain looking at psychology as well as the physical effects of pain. With regard to work she is unable to work as a result of this pain problem".*

In addition, the Complainant also submitted an Occupational Health Assessment Report from Dr X., Specialist in Occupational Medicine dated **22 August 2018**, which concluded:

> *"I am not certain there is any prospect of a successful return to work should be attempted and from a company occupational health perspective, I believe it is reasonable to accept her assertion that she is currently not fit to carry out her duties. I think this reflects the reality of what would likely happen should an attempt be made to return to work in circumstances where she feels entirely unfit to do so"*.

As part of its appeal process, the Provider arranged for the Complainant to attend for a Functional Capacity Evaluation over a two day period with the Irish Centre for Assessment, Rehabilitation and Ergonomics on **17/18 September 2018**.

In this regard, in her email to this Office dated **12 October 2018**, the Complainant submits, *inter alia*, as follows:

> *"I attended the evaluation, which involved a 120km round trip by car both days. I agreed to attend but I was concerned as to how the travel distance and the evaluation itself would affect my condition. I wanted to do my best to cooperate with all of these requests from* [the Provider] *to progress my case, whether or not it would be to the detriment of my health.*
>
> *At the evaluation I was asked to carry out a number of tasks and exercises, some of which I was able to complete with difficulty and some I could only partially complete. There were other exercises that I was just unable to do. I did my best in all that was asked of me.*

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> *On the morning of the second day I was asked how I felt and I advised the lady carrying out the evaluation of the negative affect the previous days tasks had on me. I was exhausted and had a lot of additional pain, but we carried on with the second day of the evaluation. Since I attended the evaluation I have been experiencing an exacerbation of symptoms"*.

Following its assessment of the appeal evidence, the Provider informed the policyholder that its decision to cease payment of the income benefit claim from 19 June 2018 was upheld.

The Complainant does not accept the findings of the assessments arranged for her by the Provider, nor does she accept the decisions of the Provider in relation to the claim. In her email to this Office dated **18 January 2019**, the Complainant submits, *inter alia*, as follows:

> *"It is clear to me that* [the Provider] *are intent on accepting only the views of their own medical advisors for their own benefit, and completely disregarding the professional opinions of the medical experts who have been treating me. I feel* [the Provider] *have been totally biased"*.

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

> *"I have been out of work since August 2017 and made an application under my employer's* [Group Disability Scheme] *in January 2018 for continued income. I have a severe back, neck and shoulder injury resulting from a previous accident whereby I fractured the vertebrae and my sternum. I have attended a number of specialists and my treatment and pain medication is ongoing. I supplied various specialist medical reports and attended with an Occupational Therapist on behalf of the* [Provider]. [The Provider's] [Occupational Therapist] *felt I was fit to work despite my specialists report. I was given a copy of the* [Occupational Therapist] *report which actually contained a number of factual errors …*
>
> *My claim was denied but* [the Provider] *said they would pay me up to June 2018 and they backdated this to January 2018. I appealed the decision and provided further medical reports from my Pain Specialist. I was then instructed to attend a two day Functional Capacity Evaluation, which I did at an enormous cost to my health. The two days of tests significantly exacerbated my symptoms …*
>
> *Regardless of all of this,* [the Provider] *continue to decline my claim …*
>
> *The process has been extremely long and distressing, and I believe it has been delayed considerably as it is almost eleven months since I submitted my application to claim … I feel that my medical situation has not been taken seriously and that I am being treated unfairly"*.

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In addition, in her email to this Office dated **14 January 2020**, the Complainant submits, *inter alia*, as follows:

> *"I am now diagnosed with Chronic Pain Disease, which developed as a result of the severe accident I had in 2014 in which I fractured vertebrae T2, T5, T8 and T9 as well as my sternum. Chronic Pain Disease is a defect in the Nociceptive System, which is the sensory nervous system's controller of pain.*
>
> *I attended the Pain Management Programme under the direction of Specialist Consultant in Pain Medicine,* [Dr R.]*, beginning on 18th November 2019 full time for three weeks … This is quite a debilitating disease and as yet there is no cure. Medical treatment and lifestyle changes are the only ways in which to manage the disease.*
>
> *It seems apparent to me that the* [Provider] *set a number of impossible obstacles in which I was expected to overcome in an attempt to find some disparaging reason to decline my claim for continued income at a time when I was clearly going through a life changing illness and was incapacitated from earning"*.

Similarly, in her email to this Office dated 13 February 2020, the Complainant submits, *inter alia*, as follows:

> *"I feel strongly that I was dealt with in a very insensitive and haphazard manner throughout, considering I am now diagnosed with chronic pain disease".*

As a result, the Complainant submits in her Complaint Form, as follows:

> *"I am asking that the* [Provider] *agrees to cover me for continued income as I have provided evidence from specialists to confirm that I am unfit for work at this time. I am under desperate strain and unable to pay my mortgage or bills. At this point, my home is at risk. All of which is compounding the already difficult and stressful situation in which I find myself in. I am unable to calculate myself what income would be payable to me as I understand that it is two thirds of salary after normal tax deductions"*.

<u>The Provider's Case</u>

Provider records indicate that the Complainant, [occupation redacted], was medically certified as unfit to work from 8 August 2017 and completed an Employee's Claim Form on 20 December 2017, wherein she advised:

> *"**Please state the exact nature of the incapacity from which you are suffering:***

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> *Back and shoulder injury, medical investigations are ongoing. I continue to attend with specialist consultants. Also causes fatigue and anxiety. Previous cortisone injections failed to help.*
>
> ***In what way does this incapacity prevent you from following your occupation?*** *Sitting for extended periods, use of mouse for computer, commuting to/from work"*.

In addition, the policyholder completed an Employer's Claim Form on 3 January 2018 wherein it stated the nature of the Complainant's disability as *"Musculoskeletal (Back)"*.

In order for an income benefit claim to be payable, the member must satisfy the policy definition of disabled, as follows:

> *""**Disabled**" in respect of a Member means that he is in the opinion of the Insurer's Chief Medical Officer totally incapable by reason of illness or injury of following his normal Occupation and is not following any other occupation for remuneration, profit or reward, and "Disability" exists in respect of a Member when he is Disabled and has completed the Deferred Period"*.

As the Complainant was certified an unfit for work on 8 August 2017 and the policy deferred period is 26 weeks, any Provider liability was due to commence from 6 February 2018.

As part of its claim assessment and as the Complainant had listed him as her medical attendant on the Claim Form, the Provider requested a medical report from Consultant Orthopaedic Surgeon Dr S. on 10 January 2018. The Provider experienced significant delays obtaining this report, despite reminders sent by post on 8 February 2018, by email on 6 March 2018 and by telephone with his secretary on 8 March 2018, when she confirmed that the report was partially prepared and typed and would be in contact once it had been finalised.

As the medical report had still not been received by the end of March 2018 and in order to expedite the assessment of the claim, the Provider then arranged for the Complainant to attend for an independent medical assessment on 3 April 2018 and sent details of this appointment to the policyholder. This appointment was later cancelled, as the policyholder was unable to make contact with the Complainant by telephone or email.

On 25 April 2018, the Provider received a medical report from Dr S. dated 26 February 2018, wherein he noted a background history of an accident in 2014, resulting in several fractures with ongoing symptoms of right shoulder pain. The Provider notes that Dr S. felt that this was likely a soft tissue injury and was currently precluding the Complainant from undertaking heavier and more strenuous physical activity.

As her job was primarily desk based, with no heavy or strenuous physical activity involved, the Provider considered that there was insufficient medical evidence to suggest that the Complainant was totally incapable of carrying out her occupational duties and therefore an independent medical assessment was scheduled with Dr D., Specialist in Occupational Health for 15 May 2018. This was rescheduled for 29 May 2018 at the Complainant's

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request. The Complainant furnished Dr D. with a Report from Consultant Pain Physician Dr R. dated 22 May 2018, which provided a history of her medical conditions, and the investigations and therapies undergone.

Dr D. noted that the Complainant had a history of chronic neck, shoulder and back pain as a result of suffering several fractures in a serious fall in 2014. Dr D. confirmed that these fractures subsequently healed and there was no requirement for surgery. The Complainant had been transferred from the care of the orthopaedic team, to a pain clinic and the goal of further treatment was symptom control. As there was no objective evidence to indicate that the Complainant lacked the physical or mental capacity to return to work and perform her work reliably, safely and effectively, and no evidence that a return to work wold have an adverse effect on her health, the Provider notes that it was the opinion of Dr D. that the Complainant was medically fit to return to her desk based role.

The Provider wrote to the policyholder on **19 June 2018** confirming that its assessment of the claim had been completed and that the medical evidence received confirmed that the policy definition of disabled had not been met. However, bearing in mind the delays experienced in obtaining medical evidence and the fact that the Complainant had been absent from work since August 2017, the Provider advised the policyholder that it was prepared to accept that the Complainant had been unfit for work up until the date of its claims decision.

For that reason, a gross benefit payment of €11,097.84 was made to the policyholder for the period 6 February 2018 to 19 June 2018. In addition, the Provider offered to support an occupational health rehabilitation programme, over a four week period, to assist in the implementation of a phased return for the Complainant to full-time duties.

The decision to cease payment of the income benefit claim was appealed by way of the submission of a medical report from Consultant Pain Physician Dr R. dated 8 August 2018, wherein he advised that the Complainant was suffering persistent pain related to a fall and compression fracture and had been referred for a Pain Management Programme. In addition, an Occupational Health Assessment Report from Dr X., Specialist in Occupational Medicine, addressed to the policyholder and dated 22 August 2018 was submitted, wherein Dr X. advised of ongoing musculoskeletal symptoms as the Complainant herself had reported and felt it reasonable to accept her own assertion that she was not fit to carry out her duties. The Provider notes that Dr X. indicated that the Complainant's physical examination was surprisingly reassuring with a good range of movement but some areas of tenderness.

This appeal evidence was reviewed by the Provider's Chief Medical Officer, who recommended that the Complainant attend for a Functional Capacity Evaluation (FCE). The purpose of an FCE is to provide an objective assessment of an individual's abilities to perform a wide variety of tasks, and their level of impairment. A detailed job description is explored with the individual with particular reference to the critical job demands and the physical work strengths required. In addition, the effort provided by the individual and the reliability of pain and disability reports are also determined. The FCE is an effective system of assessment that can determine an individual's ability to return to work and is carried out

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over a two day period in order to measure consistency of effort and maximum functional ability throughout both days of testing.

The FCE was carried out by the Irish Centre for Assessment, Rehabilitation and Ergonomics (ICARE) on 17/18 September 2018. The Provider notes that the clinician selected to carry out this FCE was the closest in proximity to the Complainant's home. The ICARE assessment concluded that the Complainant was fit to undertake all the functional components of her pre-disability role and consequently, she was not totally incapable of performing her pre-disability occupation. Whilst it was noted that the Complainant found the commute to and from work difficult, this is not a factor in determining eligibility for claiming a disability benefit. The findings of the FCE confirmed that the Complainant was fit for the physical demands of her role and on that basis, the Provider's decision to cease payment of the claim remained unchanged. The Provider communicated this decision to the policyholder on **11 October 2018**.

The Provider received a further Report from Consultant Pain Physician Dr R. dated 19 October 2018, which was addressed to the Complainant's GP. The Provider reviewed this Report and notes that whilst he had sight of the ICARE FCE Report when preparing his own, Dr R. gave no indication that he disagreed with its findings, nor did he reference the Complainant's capacity to work. As a result, the Report contained no new information that would prompt further independent assessment or grounds for the Provider to contact Dr R. directly as to his opinion in relation to the Complainant's fitness to return to work.

The Provider is not disputing the diagnosis provided by Dr R., whose role is to diagnose and treat the Complainant. The purpose of the independent assessments carried out by the Provider is to establish how any ongoing symptoms impact on the Complainant's ability to carry out her occupational duties. For a valid claim to arise, the evidence must confirm that her symptoms are of such severity that they render her totally incapable of working. In this regard, the Complainant has a desk based role and the Provider is satisfied that the independent assessments found her fit to carry out her duties.

The Provider notes that the Complainant left the employment of the policyholder, by reason of accepting a voluntary redundancy package, on **16 February 2019**. The Complainant was advised by her employer that termination of her employment contract by way of a voluntary redundancy package would also terminate any entitlement she had to permanent health insurance benefit with effect from 16 February 2019 and she acknowledged she understood and accepted this in her email to the policyholder on 19 February 2019. As a result, no further assessment of the claim took place or will take place.

In relation to the Complainant's comments regarding the independent medical assessment that she attended with Dr D., Specialist in Occupational Health on 29 May 2018, the Provider notes that these independent assessments are generally scheduled for approximately 30-40 minutes, however all the necessary information and clinical and physical examination may be obtained in a shorter timeframe.

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The Complainant highlighted five errors in the Report from Dr D. dated 11 June 2018, however the Provider is satisfied that none of these errors had any impact and certainly do not alter the findings of the Report and the claims decision.

The Complainant states that the use of the phrase *"the fractures have healed"* by Dr D. was an error. Dr D. has advised that this is medical terminology to indicate that the physiological process of bone repair is complete and that the bone or joint is now stable. The process of fracture healing involves several stages including inflammation, granulation, callus formation, bone deposition and remodelling. This process is complete within 2-3 months, unless there is non-union or other complication of healing. In the Complainant's case, however, the bone injury (fractures) have healed.

In addition, the Complainant raised an issue about the number and level of vertebrae given in the Report, on two occasions. The Provider notes that the number and level of fractures listed correlates with the Report from the Complainant's treating Consultant Orthopaedic Surgeon Dr S. dated 26 February 2018. In any event, the Provider notes that Dr D. would be happy to review any radiological imaging reports and amend any factual inaccuracies in her Report, but that she cannot alter her professional opinion as to the Complainant's fitness for work without new or additional clinical evidence.

The remaining two errors highlighted by the Complainant related to the date she first attended a Pain Specialist and that she had her tonsils removed, rather than her adenoids. The Provider does not consider these errors material to the overall outcome of Dr D.'s medical opinion and do not have any impact on the outcome of finding of her Report.

In relation to the Complainant's comments regarding the time it took to assess the claim, the Provider notes that the delay in obtaining a medical report from Consultant Orthopaedic Surgeon Dr S. was outside of its control, though it did its best to speed up the process by writing, emailing and telephoning his office. In this regard, doctors have no contractual obligation to submit medical reports to insurance companies, and the speed at which they are prepared and submitted is completely outside the control of the Provider. The Provider made repeated efforts to obtain a report from Dr S. and impress upon his office, the urgency of this request.

The Provider kept the policyholder regularly updated on the difficulties and delays being experienced and it trusts that the policyholder in turn advised the Complainant. In this regard, as the contract of insurance is between the Provider and the policyholder (the Complainant's employer), the Provider would not engage in any direct communications with a Group Disability Scheme member and therefore, the Provider confirms that it did not correspond with the Complainant, nor did it receive any emails directly from her.

In light of the delays being experienced in obtaining a report from Dr S., the Provider scheduled an independent medical assessment for the Complainant for 3 April 2018 and 15 May 2018, but the Complainant was unable to attend either of these appointments. The Complainant did attend for an assessment on 29 May 2019 and the Provider received the resultant Report on 12 June 2018 and sent its claims decision to the policyholder on 19 June 2018. The Provider has reviewed the timeframes in relation to the independent medical

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assessment and the claims assessment process and considers that this was processed within an acceptable timeframe with no unnecessary delays on its part.

In conclusion, the Provider is not disputing that the Complainant suffered a back injury resulting in ongoing shoulder and neck pain, however there is no objective evidence to indicate that she lacks the physical or mental capacity to return to work and perform her desk based role reliably, safely and effectively. The Provider is satisfied that the medical evidence it received during both its claim assessment and the appeals process indicate that the Complainant's ongoing symptoms were not of sufficient severity to render her totally incapable of performing her occupation and thus the policy definition of disabled had not been met. In this regard, for a valid income benefit claim to arise or continue, the policy terms and conditions stipulate that the member must be totally incapable of working.

Accordingly, the Provider is satisfied that it ceased payment of the income benefit claim made in respect of the Complainant's illness, in accordance with the terms and conditions of the Group Disability Scheme which the Complainant was a member of.

The Complaint for Adjudication

The Complainant's complaint is that the Provider wrongly or unfairly ceased payment of the income benefit claim made in respect of her illness, submitted under the Group Disability Scheme of which she was a member.

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 5 June 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

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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, within the period permitted, the final determination of this office is set out below.

The complaint at hand is that the Provider wrongly or unfairly ceased payment of the income benefit claim made in respect of the Complainant's illness, submitted under the Group Disability Scheme which she was a member of.

In this regard, the Complainant, as a benefit of her contract of employment, was a member of a Group Disability Scheme. The Employer is the policyholder of this Scheme. The Provider is the Insurer, responsible for the underwriting of applications for cover and assessing claims. The purpose of the Scheme is to provide the policyholder with funds to provide sick pay to its employees who are absent from work on long-term illness.

I note that the Complainant completed an Employee's Claim Form on **20 December 2017**, wherein she advised:

> *"**Please describe in full detail the exact nature of your occupation:***
> *[occupation redacted], office & desk based*
>
> ***Please state the exact nature of the incapacity from which you are suffering:***
> *Back and shoulder injury, medical investigations are ongoing. I continue to attend with specialist consultants. Also causes fatigue and anxiety. Previous cortisone injections failed to help*
>
> ***In what way does this incapacity prevent you from following your occupation?***
> *Sitting for extended periods, use of mouse for computer, commuting to/from work …*
>
> ***Please give the date on which symptoms first commenced***
> *Back – 06/2014, Shoulder – early 2016*
>
> ***When did the incapacity cause you to cease working?***
> *08/08/2017*
>
> ***When do you expect you will be fit enough to return to work?***
> *Unknown as yet*
>
> ***Please give details of any previous period of disability due to this or any other cause:***
> *I had an accident in 2014 and the consultants believe this to be the source of current physical difficulties, I had a period of absence in 2014 from end June to end Nov. following the accident"*.

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Income benefit 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, I note that the '**Addendum to First Schedule'** section of the applicable Group Disability Scheme Policy Document provides, *inter alia*, as follows:

> *""**Disabled**" in respect of a Member means that he is in the opinion of the Insurer's Chief Medical Officer totally incapable by reason of illness or injury of following his normal Occupation and is not following any other occupation for remuneration, profit or reward, and "Disability" exists in respect of a Member when he is Disabled and has completed the Deferred Period*".

In order for an income benefit to be payable, the member must satisfy this policy definition of disabled.

I note that as part of its claim assessment, the Provider requested a medical report from Consultant Orthopaedic Surgeon Dr S. on 10 January 2018. In this regard, in his Report dated 26 February 2018 which the Provider did not receive until 25 April 2018, I note that Dr S. advised, as follows:

> *"*[The Complainant] *was initially referred to me by her general practitioner I think in June of 2016 with predominant concern of right-sided shoulder pain.* [The Complainant] *being involved in serious accident back in 2014, sustained fractures of T2, T5, T7 with fracture of her sternum was noted. By June of 2016,* [the Complainant's] *predominant concern was one of ongoing pain in her right shoulder for which she had undertaken non-operative management in the form of physiotherapy, Pilates etc. She noted difficulties with wide range of activities such as brushing her teeth, heavy lifting and doing laundry, lifting heavy weights with right hand side and had ongoing paraesthesia in her right C8 dermatome. Examination was notable for diminished lateral rotation of her cervical spine in the right hand side and her presentation overall was consistent with mild rotator cuff tendinopathy. To that end she was referred for Pilates and physiotherapy and underwent right subacromial injection under my care.*
>
> *Subsequent to this she had a further injection in February of 2017 of right subacromial joint, attended me again in May of 2017. I noted that at that point that her initial injections had given her good relief, however, the second had not. Her pain was localised to the region of her supraspinatus fossa and over her cervical spine with her shoulder has been exacerbated on shoulder flexion. Her ongoing C8 paraesthesia was noted. An examination was notable for tenderness over the C5/C6 facet, her neurological assessment being unremarkable. Imaging studies were notable for hooked acromion on the right hand side impinging on her supraspinatus tendon with a differential diagnosis at this time point including rotator cuff tendinopathy with possibility of facet related arthropathy on the right C5/C6 and referred pain. Further right subacromial joint injections were undertaken as a diagnostic modality and the next step was considered diagnostic facet rhizolysis and trigger point injections.*

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I referred [the Complainant] *to* [Mr J.] *thereafter. She was seem by* [Mr J.] *in his private rooms and he refuted the possibility of ongoing shoulder pathology.* [The Complainant] *returned to my rooms in January of 2018 with cervical facet arthrosis being the likely ongoing cause for her symptoms in that point she was referred onto* [Dr R.]. *By January of 2018,* [the Complainant] *had exquisite tenderness over her right C4/C5 and C5/C6 facets. Her MRI scan undertaken on the 20th of January demonstrates degenerative changes, but no significant impression of any of the nerve roots. Minimal tendinopathy on the right was noted.*

IMPRESSSION AND PLAN: [The Complainant's] *presentation is most consistent with a soft tissue injury likely incurred at the time of her accident. This is currently precluding her from undertaking heavier and more strenuous physical activity and may require further intervention in terms of potentially shoulder arthroscopy or pain management interventions in relation to her. I have referred* [the Complainant] *for physiotherapy in the first instance".*

In addition, I note that the Provider also arranged for the Complainant to attend for an independent medical assessment. In this regard, the '**Fifth Schedule'** section of the applicable Group Disability Scheme Policy Document provides, *inter alia*, as follows:

*"**Information***

"5.8.3. On a claim being made for Benefits in respect of any Member or at any time whilst Benefits are being paid in respect of any members: …

(b) the Member shall undergo medical examination by a medical examiner appointed by the Insurer at such time and place as the insurer shall reasonably require".

The Complainant attended for an independent medical assessment with Dr D., Specialist in Occupational Health to 29 May 2018.

I note that the Complainant furnished Dr D. with a Report from her treating Consultant Pain Physician Dr R. dated **22 May 2018**, wherein he advised, *inter alia*, as follows:

"[The Complainant] *has had difficulty with neck and back pain since a fall in 2014. She* [description of the accident] *The fall was about ten feet and she landed on her head and spine causing several injuries including fractured sternum, compression fractures thoracic vertebra. She was in* [named hospital] *for about two weeks and was put in a back brace and treated conservatively. She originally had pain in her thoracic area and cervical spine but about a year later she started to have pain in the right shoulder. In the last year or so this has been in the right side of the neck and right shoulder. She feels she has had loss of power, she is right handed. She denies total numbness in her arm but does feel the ulnar side of her hand feels more dead than the right. The pain problem is having a significant impact on her life and she had been out of work for about six months. She was working in an insurance company but the use of a mouse was winding up the pain. She feels her employers are very*

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eager to find out if she can work again. She has not been able to do a lot of the things she did such as Zumba. She was attending the gym at one stage and was swimming but this is not possible. She has attended various specialists over this and a shoulder specialist did not feel she had tears in her shoulder which would be contributing.

Interval Therapy
She has had her shoulder injected on three occasions. The first one helped but not the subsequent two. She had multiple physiotherapy treatments and started Pilates but found leaning of the hands exacerbated the pain. She had to discontinue the exercises. She is taking Difene but this caused gastric upset. Codipar was helpful. She has been put on Lexapro as an anti-depressant as she had a difficult time with anxiety issues because of the pain and also over a family bereavement. She had procedures injecting the facet joints and using a pulsed radio frequency to numb these joints. There has been some benefit from these and she has been scheduled for further procedures. She has also been referred for the Pain Management Program.

Investigations
MRI cervical spine and shoulder …

Examination
She is in no acute distress. Gait normal. Cervical spine movements: flexion is the most difficult. Extension 30 degrees. Rotation normal. Tender facet joints C5-C7 on the right. Rhomboid non tender. Thoracic spine is quite tender around T10. Shoulder range of motion normal.

Impression
[The Complainant] *has been suffering from persistent pain since a fall in 2014. At that time it has been identified that she had a vertebra fracture. She continues to have pain from the cervical and thoracic facet joints. Hopefully she will respond to the procedures and the Pain Management Program. I do not see her being able to get back to work at this time. Hopefully things will improve following the Pain Management Program"*.

Following the independent medical assessment on 29 May 2018, I note that Dr D., Specialist in Occupational Health advised in her Report dated 11 June 2018, as follows:

*"**1. PRESENTATION:***

This [age redacted][occupation redacted] is out of work for the past nine months due to neck and shoulder pain. She is attending a pain specialist.

2. HISTORY OF PRESENTATION (SUBJECTIVE ACCOUNT):

[The Complainant] *tells me that she fell in June 2014 on* [description of the accident]*. She fractured 3 thoracic vertebrae and her sternum. She wore a body brace for four months. She has mid back pain and neck pain since then. She returned to work following the accident.*

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Over the past year, [the Complainant] *developed severe pain in her right shoulder and neck. This became so bad that she was unable to drive to work. An MRI scan showed degeneration in her neck, shoulder, a hooked acromion and bursitis. She had an MRI scan of her neck and shoulder in 2016 and again in January 2018.*

[The Complainant] *is attending a pain specialist since January 2017. She previously attended an orthopaedic spine specialist and an orthopaedic shoulder specialist. Injections were not of any help. She is currently undergoing a course of rhizotomy treatments, which appear to be helping and she is due another procedure later this week. She also takes painkillers and finds the side effects difficult to tolerate.* The Complainant] *is awaiting a place on a pain management programme in* [named] *Hospital.*

[The Complainant] *found counselling helpful in the past. She does mindfulness. She admits that she got quite low in mood following the accident in 2014. She was unable to drive and became quite isolated. Her* [relative] *died in November 2017 and there were a lot of family issues. Her partner's* [relative] *also died in 2017.* [The Complainant] *is taking antidepressants since 2014 and the dose was increased in recent months.*

3. MEDICATION:

Lexapro 20mg; Vimovo 500mg; Codipar PRN; Zanaflex 4mgh; Paracetamol.

4. CURRENT SYMPTOMS:

Neck pain. Mid back pain. Difficulty sleeping. Right shoulder pain. Anxiety. Feeling low in mood. The pain in her neck radiates to her right shoulder and right arm and to the right middle and ring finger. These fingers feel numb and dead …

8. OCCUPATIONAL FACTORS: *…*

She attended her employers' occupational health physician on many occasions. She does not know when she will be fit to return to work. She says it is not possible at the moment because she cannot commute to work and cannot sit at her desk because of chronic pain …

10. CLINICAL EXAMINATION (OBJECTIVE FINDINGS): *…*

Physical examination: *Ear, nose and throat, ophthalmology, cardiovascular, respiratory, abdomen, musculoskeletal, skin and neurology are normal to examine. She had full range of neck and shoulder movement. She complains of tenderness on palpation of the right shoulder, the mid spine and the right side of her neck, However, there are no objective signs of neurological disease or musculoskeletal disease of joint deformity.*

/Cont'd…

11. REVIEW OF MEDICAL REPORTS

The pain specialist confirms the problem of neck pain and back pain which appear to have developed following a fall. She fractured T2, T5, T7 and the sternum. She was managed non-operatively. She also has shoulder pain and had injections. She is awaiting a pain management programme.

12. CONCLUSION AND RECOMMENDATIONS:

12.1 Medical issues:

[The Complainant] *has chronic neck pain, shoulder pain and back pain. This appears to be related to a fall four years ago, during which she fractured multiple thoracic vertebrae and her sternum. She required a period of immobilisation in a back brace and this was a difficult time for her. However, the fractures have healed and there is* [no] *evidence of any serious pathology apart from degenerative disease. She does not require surgery and has been transferred from the orthopaedic team to a pain clinic.*

The goal of further treatment is symptom control. I am pleased that she has been referred to a pain management programme. I believe she would benefit from learning self-management strategies to help her cope with her symptoms and move forward with her life. The focus of further treatment is restoration of normal social and occupational functioning and promoting self-management.

12.2 Occupational Issues:

In my opinion, the time has come for [the Complainant] *to return to work and I believe she is medically fit to do so. Her job is sedentary and desk based. She should be provided with a workstation that conforms to ergonomic standards and may even have the option of a sit stand desk to allow her to vary her work posture. The commute to work is not an issue for her insurance, but I see no medical reason why she cannot drive or take public transport.*

There is no objective evidence to indicate that [the Complainant] *lacks the physical or mental capacity to return to work and perform her work reliably, safely and effectively. There is no evidence that returning to work will have an adverse effect on her health benefits of gainful employment, whilst remaining on long term sick leave puts her at risk of the adverse health effects of long term worklessness I believe the treating doctors should encourage her to return to work as part of her recovery program.*

I support a short occupational health rehabilitation programme, whereby [the Complainant] *returns to work on a phased basis over three to four weeks. I recommend appropriate HR and occupational health intervention to facilitate and encourage her return to work.*

/Cont'd…

12.3 Suitability for insurance benefit:
In my opinion, [the Complainant] *does not meet the definition of disability as defined under this policy. I am unable to categorise her as disabled or unable to follow her normal occupation"*.

As a result, I note that the Provider wrote to the policyholder on 19 June 2018 to advise, as follows:

> *"The medical evidence on file confirms a history of significant back injury resulting in ongoing shoulder and neck pain. The* [Complainant] *continues to have ongoing symptoms and is receiving appropriate care and treatment. There is no objective evidence to indicate she lacks the physical or mental capacity to return to work and perform her work reliably, safely and effectively. Her ongoing symptoms are not of sufficient severity that they render her totally incapable of performing her desk based role.*
>
> *I note this claimant was last at work in August 2017 and the end of the deferred period is 5th February 2018. As there was a significant delay in obtaining a medical report from* [Dr S.] *and a subsequent delay in her attending for an independent medical assessment we are prepared to give her the benefit of the doubt and accept that she was unfit up until todays date, 19th June 2018. As the* [Complainant] *has been absent from work for close to a year we shall support an occupational health rehabilitation programme, over a 4 week period, to assist in the implementation of a phased return to full-time duties"*.

I am of the opinion that it was reasonable for the Provider to conclude from the objective medical evidence before it that the Complainant was at that time, fit to carry out her normal occupation.

Nevertheless, I note that the Provider took the decision to admit the income benefit claim from the end of the policy deferred period to the date of its claim decision, when it concluded that the Complainant was at that time fit to carry out her normal occupation, (that is, from 6 February 2018 to 19 June 2018) which I am satisfied was a generous approach for the Provider to adopt, given the objective medical evidence before it. This resulted in the Provider making a gross benefit payment of €11,097.84 to the policyholder. In addition, I note that the Provider offered to support an occupational health rehabilitation programme, over a four week period, to assist in the implementation of a phased return for the Complainant to full-time duties.

I also note that the Provider's decision to cease payment of the income benefit claim from 19 June 2018 was appealed by the Complainant. As part of the appeal evidence furnished to the Provider, I note the Report from the Complainant's treating Consultant Pain Physician, Dr R. dated 8 August 2018, wherein he advised, as follows:

/Cont'd…

*"**Details of Injury and Symptoms***
This is supplementary to a report given in May of this year.
[The Complainant] *continues to have chronic pain affecting her neck and back. All of this stems back to a fall in her garden in 2014. Her condition remains much the same. She has great difficulty carrying out normal activities. She remains in constant pain. The worst area of pain is affecting the rhomboid and trapezius muscles, the shoulder and neck area. She has had procedures to try and dampen down this pain with mixed benefit. She had been referred for the Pain Management Program which will help in a more comprehensive way. As mentioned in the previous report, a lot of the pain might relate to the vertebral compression fracture she suffered. There should be a response to certain medications for this and there should be improvement with time but certainly it can be quite dragged out for several years.*

Opinion
[The Complainant] *continues to have persistent pain related to a fall and a compression fracture. She has been referred for the Pain Management Program. This is a holistic approach to pain looking at psychology as well as the Physical effects of pain. With regard to work she is unable to work as a result of this pain problem".*

In addition, I also note the Occupational Health Assessment Report from Dr X., Specialist in Occupational Medicine to the policyholder, dated 22 August 2018, as follows:

"This lady is out of work now for a year. She has ongoing musculoskeletal symptoms that she dates back to her accident in 2014. She attends a pain consultant, but has failed to achieve any sustained benefit from the care received. She is now awaiting a place on a pain management programme, although she has received no date for this yet.

She articulates ongoing daily symptoms, primarily musculoskeletal in nature, but also low mood and mental health difficulties arising out of her chronic pain and the predicament she finds herself in .

In her current day, she says she is leading a sedentary routine within her home with few hobbies or activities.

In an occupational context, she feels she would be entirely unable to return to work given her complaints.

Physical examination was surprisingly reassuring. She demonstrated a good range of movement throughout her musculoskeletal system, but some areas of tenderness to light touch.

IMPRESSION

This lady has an evolved pain syndrome and I hope that she finds benefit from the pain management programme.

/Cont'd…

It is hard to determine the precise underlying musculoskeletal nature of her complaints. I gather she has been declined income protection on the basis that she was assessed independently and found fit for work.

I am not certain there is any prospect of a successful return to work should be attempted and from a company occupational health perspective, I believe it is reasonable to accept her assertion that she is currently not fit to carry out her duties. I think this reflects the reality of what would likely happen should an attempt be made to return to work in circumstances where she feels entirely unfit to do so".

As part of its appeal process, I note that the Provider arranged for the Complainant to attend for a two-day Functional Capacity Evaluation with the Irish Centre for Assessment, Rehabilitation & Ergonomics on 17 and 18 September 2018. In this regard, in her ensuing Summary Report dated 18 September 2018, I note that Ms D. advised, as follows

*"**THERAPSIT OBSERVATIONS***

COOPERATION: [The Complainant] *was cooperative in that she attended on both days of testing & attempted all activities requested of her to her maximum functional ability throughout both days of testing.*

CONSISTENCY OF PERFORMANCE: [The Complainant] *gave a consistent performance as demonstrated by the following:*

1. *Weighted capacities were consistent between days 1 & 2 of testing.*
2. *Weighted capacities were consistent between all lifts, pushes, pulls & carries.*
3. *With grip strength testing* [the Complainant's] *results did not plot a Bell-shaped curve but this was secondary to pain & fatigue in her upper extremities in gripping.*
4. *Pull force was greater than push force.*
5. *Increased functional capacities were consistently limited secondary to pain & fatigue in her bilateral upper & mild thoracic spine throughout both days of the test.*
6. *On initial musculoskeletal assessment* [the Complainant] *had decreased right arm swing on ambulation. This was consistent during the test with decreased right arm swing during the walking test.*
7. *On initial musculoskeletal assessment* [the Complainant] *had slight decreased right grip strength. This was consistent during testing with right grip = 10Kg, left = 12Kg.*
8. *On initial musculoskeletal assessment* [the Complainant] *had slight decreased strength right upper extremity on all movements, with pain. This was consistent during both days of testing with* [the Complainant] *tending to fatigue quicker on the right side & reports of pain were more right sided.*

/Cont'd…

PAIN BEHAVIOUR: [The Complainant] *demonstrated appropriate pain behaviour in that she reported pain only when it increased significantly. Reports of increased pain were consistent with increased physiological responses of increased heart rate, increased respiration rate & recruitment of appropriate accessory muscles of movement. Reports of increased pain were limited to her mid thoracic spine & right neck & shoulder only throughout both days of testing & were consistent with underlying pathology.*

SAFETY: [The Complainant] *gave a safe performance as demonstrated by appropriate pacing, good body mechanics & a general awareness of safe techniques.*

QUALITY OF MOVEMENT: *Movement was smooth & controlled throughout both days of the test.* [The Complainant] *tended to keep her right arm very still on all activities throughout both days of the test.*

SIGNIFICANT ABILITIES:

1. *Good ability to push & pull.*
2. *Good bilateral grip strength.*
3. *Good ability for sustained trunk flexion in sitting & standing.*
4. *Good ability for un-weighted rotation in sitting & standing.*
5. *Good ability to crawl, kneel, crouch & squat.*
6. *Good ability for sustained sitting & standing.*
7. *Good ability to walk.*
8. *Good ability to climb stairs.*
9. *Good ability to balance in a forward & backward direction on a balance beam.*
10. *Good bilateral upper extremity hand dexterity.*

SIGNIFICANT DEFICITS:

1. *Decreased ability for weighted capacities in excess of 7.5Kg.*
2. *Decreased ability for sustained overhead activity.*

JOB DESCRIPTION EXPLORED: [Complainant] *works as a [occupation redacted]…She has not worked since [month redacted] 2017. The following is a Job Description explored for a [occupation redacted] as outlined by the* [Complainant] *on an ICARE Job Description Form.*

/Cont'd…

JOB DESCRIPTION EXPLORED

CRITICAL JOB DEMANDS	***PHYSICAL WORK STRENGTHS***	***JOB MATCH YES/NO***
Sit Constant	*Sit Constant*	*YES*
Stand Occasional	*Stand Constant*	*YES*
Walk Occasional	*Walk Constant*	*YES*
Bend Occasional	*Bend Constant*	*YES*
Reach Frequent	*Reach Frequent*	*YES*
Un-weighted Rotation Frequent	*Un-weighted Rotation Constant*	*YES*
Climb Stairs Occasional	*Climb Stairs Constant*	*YES*
Turn/Bend Wrist Occasional	*Bilateral upper Extremity Hand Dexterity Constant*	*YES*
Grasp Forcefully Occasional	*Grasp 10Kg Occasional*	*YES*

RECOMMENDATIONS:

1. [The Complainant] *is fit for the physical demands of her job as outlined above & as such there is no physical reason at this time why she cannot return to work.*

2. [The Complainant] *finds the commute into & out of work difficult, but she is physically fit for the job itself/*

3. *A sit/stand desk would help to allow for positional change as* [the Complainant] *finds it easier to stand"*.

I am of the opinion that it was reasonable for the Provider to conclude from the objective findings of the FCE that the Complainant was fit for the physical demands of her desk based role, and on that basis, that she was fit to carry out her normal occupation and did not satisfy the policy conditions for a valid claim. I note that the Provider wrote to the policyholder on 11 October 2018 to advise that it was affirming its previous decision to cease payment of the income benefit claim.

I note that the Complainant does not accept the findings of the assessments arranged for her by the Provider, nor does she accept the decisions of the Provider in relation to the claim.

The purpose of the Group Disability Scheme of which the Complainant was a member, is to provide the policyholder with funds to provide sick pay to its employees who are absent with a long-term illness and who demonstrate work disability that is supported by the objective medical evidence.

/Cont'd…

In this regard, income benefit insurance decisions are based on the objective medical evidence and the job demands of the occupation, to ascertain whether the member meets the policy definitions for a valid claim. The diagnosis of a medical condition is not, in and of itself, sufficient to determine claim validity, nor does it automatically equate to work disability; rather the weight of the objective medical evidence must clearly indicate that the member is *"**totally incapable**"* to carry out his or her occupation, as stated in the policy definition of disabled. It is in determining whether this standard is met that the severity of the medical condition is relevant.

In this regard, I note that the Provider has never disputed that the Complainant had a medical condition. Indeed if it had, it would not have made the decision to admit the income benefit claim for a period. Instead, I note that the Provider concluded from the objective medical evidence before it, that the severity of her condition at the time of her independent medical examination with Dr D. on 29 May 2018 was such that it did render her totally incapable to carry out her normal occupation at that time.

I am therefore satisfied that the Provider ceased payment of the income benefit claim made in respect of the Complainant's illness in accordance with the terms and conditions of the Group Disability Scheme which she was a member of.

I also note that a further Report from the Complainant's treating Consultant Pain Physician, Dr R. dated 19 October 2018 was submitted to the Provider, wherein he advised, as follows:

> *"**History***
> [The Complainant] *has had difficulty with pain since a fall in 2014 which led to a fracture of her thoracic vertebra. She has gone on to have a type of Fibromyalgia condition with pains in various places. She has had an exacerbation recently as she was put through the mill by the insurance company. She is trying to claim for income support, they claim she can work. She is starting the Pain Management Program soon and will be evaluated for this at the end of the month. She has not been helped by Zanaflex and she should switch to Gabapentin to see if this would help.*
>
> ***Medications***
> *Vimovo one daily.*
> *Lexapro 20mg daily.*
> *Codipar one-two at night.*
> *Zanaflex 2mg two at night.*
>
> ***Impression***
> [The Complainant] *has chronic pain since a fall some years ago.*
>
> ***Plan***
> *For Pain Management Program. Start Gabapentin 100mg and build up to 600mg daily".*

/Cont'd…

In addition, I note from the documentary evidence correspondence from the Department of Pain Management, [named] Hospital dated 29 January 2020, which states:

> *"This is to confirm that* [the Complainant] *attended a Pain Management Programme in* [named] *Hospital from 18th November 2019 to 6th December 2019 for the treatment of Chronic Pain Disease"*.

In this regard, I note that the Provider has advised that it reviewed the Report from Dr R. dated 19 October 2018 and that whilst he had sight of the ICARE FCE Report when preparing his own, he gave no indication that he disagreed with its findings, nor did he reference the Complainant's capacity to work. As a result, I accept the Provider's position that this Report contained no new information that prompted further independent assessment or grounds for it to contact Dr R. directly, as to his opinion in relation to the Complainant's fitness to return to work.

In relation to the Complainant's concerns regarding the time it took the Provider to assess the claim, I note that the policyholder submitted the claim to the Provider in early January 2018. The Provider wrote to the Complainant's then treating Consultant Orthopaedic Surgeon Dr S. on 10 January 2018 requesting a medical report. I note there was a delay in the Provider obtaining this report, despite it having sent reminders by post on 8 February 2018, by email on 6 March 2018 and by telephone on 8 March 2018.

In her email to this Office dated 14 January 2020 the Complainant submits, *inter alia*, as follows:

> *"…at the time of completing the…claim form,* [Dr S.] *was my consultant and had carried out pain injections on three occasions, however I emailed my employer following submission of the claim form, to advise them that my current treating consultant had changed to* [Dr R.]*, and that I was no longer under the care of* [Dr S.]*. I consider that it was of no benefit for* [the Provider] *to spend such a considerable amount of time trying to obtain a report from* [Dr S.] *when he had already referred me on to a different specialist"*.

I am satisfied nevertheless that it was appropriate for the Provider to seek a medical report from Dr S. as part of its initial claims assessment; not only did the Complainant list him on the Claim Form she completed as her medical attendant, she also advised therein that she had *"another appointment scheduled for 05/01/18 with* [Dr S.]*"*.

I note that the Provider did not however receive the Report from Dr S., until 25 April 2018, by which time it had already scheduled an independent medical assessment for the Complainant for 3 April 2018, in order to progress the claim. This appointment had to be cancelled however, as the policyholder was unable to make contact with the Complainant at that time. A second appointment for 15 May 2018 was at the Complainant's request, rescheduled for 29 May 2018.

/Cont'd…

It is noted that the Complainant attended for the assessment on 29 May 2018 and that the Provider received the ensuing report on 12 June 2018, and then sent its claims decision to the policyholder on 19 June 2018. As a result, I do not consider the Provider responsible for any of the delays experienced in processing the claim.

I note that in her email to this Office dated 14 January 2020 the Complainant submits, *inter alia*, as follows:

> *"At no point did* [the Provider] *make contact with* [Dr R.] *and request a comprehensive report from him"*.

I see from the documentary evidence before me that the Provider received three different medical reports from the Complainant's treating Consultant Pain Physician Dr R., dated 22 May 2018, 8 August 2018 and 19 October 2018. It is the Provider's position that the information contained in these reports, when taken as part of the overall medical file, gave no cause for it to contact Dr R. directly. In this regard, I am mindful of the fact that the Provider emailed a copy of the Irish Centre for Assessment, Rehabilitation & Ergonomics' Summary Report of its Functional Capacity Evaluation with the Complainant dated 18 September 2018, to Dr R. on 18 October 2018 and in that regard, I note the Provider's position that Dr R. gave no indication in his subsequent Report dated 19 October 2018, that he disagreed with the FCE findings, nor did he reference the Complainant's capacity to work.

Accordingly, having considered the evidence at length, I am satisfied that the Provider ceased payment of the Complainant's income benefit claim made in respect of her illness, in accordance with the terms and conditions of the Group Disability Scheme which she was a member of. I am satisfied in that regard that on the basis of the medical information available to the Provider in 2018, it was entitled to form the opinion that the Complainant did not meet the policy criteria for payment of benefits. In addition, I am also satisfied that the Provider assessed this claim in an appropriate and timely manner.

It is my Decision therefore, on the evidence before me that this complaint cannot be upheld.

Conclusion

This complaint is rejected pursuant to ***Section 60(1)*** 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.

MARYROSE MCGOVERN
DEPUTY FINANCIAL SERVICES AND PENSIONS OMBUDSMAN
29 June 2020

/Cont'd…

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.