DRN-4324136

The complaint

Miss B complains that Legal & General Assurance Society Limited (L&G) has stopped paying benefit for an incapacity claim she made on a group income protection insurance policy.

What happened

Miss B is insured under her employer's group income protection insurance policy. In 2019, Miss B was signed-off from work, suffering from both physical and mental health conditions. Her employer made an incapacity claim on her behalf, which L&G accepted in 2020. Monthly benefit was paid to Miss B.

In line with the policy terms, L&G kept Miss B's claim under periodic review. It requested additional evidence so it could consider whether Miss B continued to meet the policy definition of incapacity. It received evidence from Miss B's GP, which suggested that she'd been able to stop taking some of her pain medications. On that basis, L&G appointed a third-party company to carry out a chronic pain abilities determination (CPAD) assessment with Miss B. This assessment took place in April 2022.

Briefly, the CPAD report concluded that there was evidence of significant symptom exaggeration in both the physical and cognitive assessments which were carried out. And it stated that the results couldn't be used to infer any barriers which prevented Miss B from returning to work. L&G also referred Miss B's claim to its medical officer (MO), who concluded that Miss B's mental health conditions wouldn't prevent a graded return to work.

On that basis, in May 2022, L&G decided that Miss B no longer met the policy definition of incapacity and therefore, it decided to terminate her claim. It wrote to Miss B's employer to let it know that it would be terminating the claim on 12 July 2022, after paying benefit to reflect the graded return to work plan its MO had recommended.

Miss B was unhappy with L&G's decision and she appealed. However, L&G maintained its stance, so Miss B asked us to look into her complaint.

Our investigator thought it had been fair for L&G to stop paying Miss B's claim. He thought it had been fair for L&G to rely on the CPAD report and its MO's opinion to conclude that Miss B no longer met the policy definition of incapacity.

Miss B disagreed and so the complaint's been passed to me to decide.

What I've decided – and why

I've considered all the available evidence and arguments to decide what's fair and reasonable in the circumstances of this complaint.

Having done so, whilst I'm very sorry to disappoint Miss B, I think it was fair for L&G to terminate her incapacity claim and I'll explain why.

First, I'd like to reassure Miss B that while I've summarised the background to her complaint

and her detailed submissions to us, I've carefully considered all that she's said and sent to us. I was very sorry to hear about Miss B's ill-health and I don't doubt what a worrying time this has been for her. Within this decision though, I haven't commented on each point or on each piece of evidence and nor do our rules require me to. Instead, I've focused on what I think are the key issues.

I should also make it clear that this decision will only consider L&G's decision to turn down Miss B's claim. Miss B has sent in some information about her employer. However, L&G isn't responsible for any action on the part of Miss B's employer and I have no power to consider employment disputes, in any event. So I won't be commenting on any concerns Miss B may have about her employer.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. So I've considered, amongst other things, the terms of the group policy and the available medical evidence, to decide whether I think L&G treated Miss B fairly.

I've first considered the policy terms and conditions, as these form the basis of the contract between Miss B's employer and L&G. Miss B's employer made a claim on the policy after Miss B became incapacitated by a number of mental and physical health conditions. So it's clear that when it accepted the claim in 2020, L&G was satisfied that Miss B met the following 'own occupation' policy definition of incapacity:

'Own occupation

Means the insured member is incapacitated by illness or injury that prevents him from performing the essential duties of his occupation immediately before the start of the deferred period.'

The policy explains the duration for which L&G will pay benefit. It says:

'*Subject to production to us of evidence of the insured member's entitlement to benefit, in such format and at such times as we may reasonably require, and to the remaining provisions of this Section, payment of member's benefit will continue so long as the insured member is a disabled member but not in any event after the benefit termination date or, if earlier, the death of the insured member.'*

And the policy also explains when benefit will be terminated. It says:

'We will immediately end payment of benefit…if the insured member ceases to be a disabled member.'

The contract terms state that

'Disabled member: Means an insured member who at any time,

> *i. meets the incapacity definition, and*
>
> *ii. is not engaged in any other occupation, other than one which causes payment of a partial benefit in accordance with Part 3, Section 7 of this policy.'*

In summary, I think the policy terms make it sufficiently clear that L&G will regularly review a claim it's paying to check whether a policyholder remains incapacitated in line with the policy terms. And that if L&G thinks the evidence shows a policyholder is no longer incapacitated, it will stop paying the claim. In my experience, neither of these terms are unusual in income

protection insurance policies. And generally, I think an insurer is entitled to periodically review a claim to ensure a policyholder still meets the policy definition of incapacity.

I've looked carefully at L&G's notes. I can see that it undertook regular reviews of Miss B's claim while it remained in payment. And it appears to have asked for appropriate and relevant medical information. Previously, L&G had understood that the majority of Miss B's incapacity was caused by her physical conditions. So it wrote to her GP to ask for more information. Miss B's GP sent L&G a letter in December 2021.The letter referred to Miss B having 'come-off' strong pain and sedative medication. They referred to Miss B taking an anti-depressant and anti-spasmodic medication, alongside a privately prescribed cannabinoid medication. The GP's letter also said:

'On 18 June 2021 appropriate Rheumatologist gave a result of MRI scan of spine which did not show any significant pathology and she was discharged back to the GP care.

As above she has reported that she is aiming to go back to work in August 2021 therefore, it would be important to carry out occupational assessment. She has reduced her medication burden significantly and is on [sic] *couple of medication from us. She is not on any pain relief medication prescribed by us in the past few months so it appears her pain is managed well.'*

L&G concluded that based on the GP's letter, it needed further evidence to decide whether Miss B remained incapacitated by her physical conditions, in line with the policy terms. I don't think this was an unreasonable position for L&G to take, given the GP's letter indicated that Miss B's pain was managed well. And I don't think it was unfair for L&G to ask a third-party provider to carry out a CPAD assessment with Miss B.

Miss B undertook the CPAD assessment in April 2022. I've considered the CPAD report in detail and I've set out below what I think were the assessor's key findings:

'*Despite reporting severe exertion, pain, and disability during CPAD testing there was no evidence of organic signs (constant breathlessness and sweating) and at any time…All of which indicates evidence of significant symptom exaggeration present on both days of CPAD testing.*

There should, in normal circumstances be a consistent correlation between an individual's ratings of perceived exertion and the corresponding heart rates measured following each individual test. However, Ms B's perceived exertion levels did not correlate with the heart rates measured in the majority of physical tests undertaken over both days of CPAD, indicating further that there is evidence of significant symptom exaggeration during testing…

Miss B ambulated very slowly during formal testing on both days of CPAD. However, during the history taking she advised she is occasionally able to walk for 20-30-minutes. Indicating that she attempted to demonstrate a greater level of disability during direct testing than is the case…

Based on the above inconsistencies and discrepancies, it is concluded that Ms B attempted to simulate weakness and disability during the CPAD physical tests, and therefore her reported severe disability, fatigue, pain, and exertion levels, and demonstrated markedly restricted and limited workday tolerances during formal testing cannot be viewed as barriers preventing her from returning to her normal role.

With regards to the battery of cognitive tests undertaken during the CPAD assessment, Ms B scored 28 on both days of CPAD in…tests, and therefore it is concluded that she did not demonstrate any level of cognitive impairment during this test on either day of CPAD.

On the assumption that a person provides reliable and consistent effort during the CPAD assessment it is possible using the detailed protocols contained within the assessment to objectively determine their level of functional (physical and cognitive) ability and therefore fitness for work. However, in Ms B's case, she performed with very poor reliability of effort and there was also evidence of significant symptom exaggeration in the physical and cognitive tests on both days of CPAD. Therefore, Ms B's demonstrated level of function cannot be relied upon to reflect what she is truly capable of performing, and the CPAD results cannot therefore be used to infer any barriers preventing her from returning to her normal role.'

The CPAD report specifically mentioned that the assessment didn't include a mental health assessment. I note too that an occupational health adviser also felt it would be appropriate for L&G to obtain a medical opinion on Miss B's mental health. So L&G asked its MO to review the claim and I think this was an appropriate step for it to take. I've copied what I think are the MO's key conclusions below:

'While (Miss B) continues to engage in some form of psychological therapy on an ongoing basis, this would be considered part of her long-term condition management and not a barrier to work, in my opinion. I note she has scored mild-moderate for depression and anxiety on the recent May 2022 CS assessments using the GAD and PHQ scales, which is further supportive of relative stability with her psychological well-being, alongside her demonstrated functional ability…

Overall, my impression is this member has sufficient functional ability to resume her own occupation in a graded manner. Given the prolonged absence, this would be a phased return over 6-8 weeks or so. Any remaining talking therapy or medical input can continue alongside work, in my view.'

Miss B has provided us with a copy of an occupational health report dated July 2022 – which post-dated the termination of the claim. The report was completed by a Doctor of Occupational Medicine. They concluded:

*'Based on my assessment today and Miss B's reported chronic symptoms, I felt that a medical report from her GP would be required in this case in order for me to comment on fitness to work…' T*hey concluded that Miss B *'was currently unfit for work but medical report from GP would be necessary.'*

I've thought very carefully about the evidence that was available to L&G at the time it terminated Miss B's claim and issued its final response to the complaint. It's important I make it clear that I'm not a medical expert. In reaching a decision, I must consider the evidence provided by both medical professionals and other experts to decide what evidence I find most persuasive.

And having considered all of the evidence, I don't think it was unfair or unreasonable for L&G to rely on the CPAD assessor's report – an independent third-party - when it considered whether Miss B still met the policy definition of incapacity. It seems that based on the report, L&G had concerns that Miss B's symptoms may no longer have been barriers to her returning to work, despite her reporting severe symptoms. And given the assessor's findings, I don't think it was unfair for L&G to conclude that the CPAD assessment didn't show, on balance, that Miss B continued to meet the policy definition of incapacity. I appreciate Miss B had concerns about the CPAD assessor, whether they were suitably qualified and about how they'd handled her assessment. But I find L&G took appropriate steps to put Miss B's concerns to the assessor, who didn't alter their conclusions.

Neither do I think it was unfair for L&G to ask its MO to also review the available medical

evidence – particularly from a cognitive point of view. They are a specialist in their field and on balance, I find their view persuasive and reasoned evidence that Miss B no longer met the policy definition of incapacity.

L&G listed the medical evidence it reviewed when it considered Miss B's complaint in its final response letter. The July 2022 occupational health report isn't listed and I haven't seen a copy of it in L&G's file. So it isn't at all clear that L&G has had an opportunity to review this evidence. That means I don't think it would be reasonable for me to make any particular finding on the report. I do note though that the occupational health doctor referred to Miss B's symptoms being 'reported' and that the doctor appears to have felt that they needed a GP's medical report in order to comment on Miss B's fitness to work.

Overall, despite my natural sympathy with Miss B's position, I don't think L&G acted unreasonably when it relied on the medical evidence of its MO and the independent CPAD assessment findings to conclude that Miss B no longer met the policy definition of incapacity. That means that I don't find L&G acted unfairly when it terminated Miss B's claim in July 2022, based on the evidence it had at that time. It's open to Miss B to provide L&G with further evidence to support her position should she wish to do so. If she's unhappy with the outcome of any assessment of new medical evidence she may send to L&G, she may be able to bring a new complaint to us about that issue alone.

My final decision

For the reasons I've given above, my final decision is that I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss B to accept or reject my decision before 13 October 2023.

Lisa Barham
Ombudsman