Paul Kruger

Subject: FW: Ombuzz Issue 33: April 2016 - MEDICAL OPINIONS

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OMBUZZ

MEDICAL OPINIONS

In many complaints our office has to deal with medical evidence. At times we need assistance from a medical expert in order to resolve the issues. Such assistance is in the form of an opinion by an expert but the office still makes the complaint decision. This is because it is a legal question whether the claim requirements of a policy have been met, or, whether an insurer can rely on an exclusion clause, or, whether an insurer can repudiate a policy based on non-disclosed information.

The following case studies demonstrate some interesting/unusual medical questions that we resolved with the assistance of medical experts. Some of these medical reports are very technical and the office would not be able to make a correct evaluation without the assistance of a medical expert.

Case Study 1

Mrs B lodged a complaint as she was not satisfied with her insurer's decision to decline her claim which was based on a second trimester miscarriage. The following definition in the policy was the determining provision:

> "Dependent Child -
>
> ....
>
> - a stillborn child who was inside the womb for at least 182 days."

Mrs B would receive 25% of the cover amount if she qualified for the benefit.

We referred this matter, at our expense, to an independent medical specialist for an opinion and his report was as follows:

> *"The report of Dr S* from the Department of Obstetrics and Gynaecology of the Hospital*

the second trimester is currently defined as 26 weeks or 182 days. The duration of pregnancy was confirmed on ultrasound examination of the fetus in utero was measured at +/- 22 week and 2 days or 154 days. The weight of the fetus was 700g correlating with a pregnancy of 5 months 2 weeks and 2 days or 166 days. These measurements indicate the duration of pregnancy was at least 16 days less than the 182 days specified in the contract. The duration of pregnancy calculated from the first day of the last menstrual period cannot be determined because Dr S stated that Ms B said that she was unaware that she was pregnant. There is therefore strong prima facie evidence that Ms B claim does not fall within the terms of the contract with the insurer.

Ms B's claim could only be substantiated if there was some evidence, such as an ultrasound examination of the fetus in utero in the first trimester before 91 days, that the pregnancy was farther advanced than that indicated at the time of her miscarriage when she was admitted to the Hospital in 2015. Ms B however said that she did not know she was pregnant so that any such evidence is lacking."

Based on the information provided, our provisional decision was that the claim did not succeed and we could not assist the complainant.

The complainant accepted the decision.

Case Study 2

1. The policyholder initially consulted her general practitioner who referred her to a Specialist Physician as she was suffering from a chest infection. She was later hospitalised and treated for pneumonia.

2. On 30/04/2014 she was re-admitted with a swollen leg and found to have a large pleural effusion.

3. On 12/05/2014 she was diagnosed with Stage 4 pancreatic cancer and she subsequently passed away on 16/05/2014.

4. The beneficiary's claim for a dread disease benefit was declined by the insurer on the ground that the deceased did not survive the 28 day waiting period after diagnosis as required by the policy. She thereafter complained to the office.

5. The relevant clauses are as follows:

   Payment of Benefits

   "Upon the admission of a dread disease claim before the earlier of the Termination Age and the first day of the month following a Member's sixty- fifth birthday, the insurer shall pay the Dread Disease Benefit to the Policyholder or as the Policyholder may direct, provided the Member is alive at the expiry of the Survival Period."

   Survival Period

   "Survival period shall mean the twenty-eight day period commencing at Date of

Date of Occurrence

"Shall mean the date upon which the dread disease event first manifested itself, as determined by the insurer on the basis of objective evidence obtained in Southern Africa."

Dread Disease Event

"Shall mean the onset or diagnosis of any one or more of the events listed in clause 4."

Discussion

6. The dread disease benefit is payable if the life assured survives the 28 day waiting period after diagnosis or onset of the events, as per the policy terms which would include the pancreatic cancer. The life assured did not meet the requirement of surviving for at least 28 days after <u>diagnosis</u>.

7. The complainant submitted that the life assured survived 28 days after the onset of the condition. The life assured's general practitioner confirmed that it is likely that the cancer was present even though it was not detected when she consulted him and that the other illnesses that she was suffering from could have emanated from the cancer. Her Specialist Physician further confirmed that the medication that the life assured used, would have improved the cancer infiltration, thereby making it less likely to be detected.

8. We forwarded the complainant's arguments to the insurer regarding the survival period and they did not change their stance. We then asked an independent medical specialist for an opinion. The independent medical specialist confirmed that the results of the life assured's CT scan "showed pancreatic abnormalities considered to be the site of the primary malignancy". He noted that there was no evidence to indicate that the life assured or her doctors were aware of the malignant cells until they received the results of the CT scan . He further confirmed that the life assured's clinical presentation was manifestations of an initially "hidden" pancreatic cancer.

9. The insurer considered the report from the independent medical specialist and admitted the claim.

Case Study 3

1. The complainant had a dysfunctional colon, and had several surgical procedures over a period of five years. A nerve stimulator was inserted and this led to improvement in her symptoms but left her with severe pain and discomfort. Her surgeons were reluctant to remove it because of the possibility of spinal cord injury. Eventually she had a colectomy and colostomy which severely limited her lifestyle. She also developed a hernia around the stoma. She had not worked for the last five years.

2. The complainant's claim for an impairment benefit and/or a dread disease benefit was repudiated by the insurer, on the grounds that her condition did not fall within the ambit of any of the covered conditions on her policy. She lodged a complaint with our office.

Discussion

3. The complainant did not meet all the criteria for an impairment benefit, in particular the criterion of being more than 15% below desirable weight; her weight had actually increased over recent years and she had a BMI of 31.

4. The **dread disease** benefit "provides cover for people who are concerned about the financial burden of an illness or injury". The benefit was payable for certain stipulated conditions under the specified bodily systems. The full sum assured was R1 million. The contract made it clear that "it is essential that the condition diagnosed fully complies with the applicable definition".

5. Under "Gastrointestinal System" the conditions covered were Crohn's Disease, Ulcerative Colitis and Pancreatic Disorders. The complainant's condition was not any of these. There was no other bodily system under which her condition fell.

6. The policy did, however, make provision for a "Catch-All" dread disease benefit category. This was payable if:

   "The Life Assured is assessed as suffering from a serious physical condition that is considered to be of equivalent severity to a condition that would qualify for a 100% payout under another benefit category. The degree of impairment must result in a Whole Person Impairment of at least 35% and meets the Class 4 impairment criteria specified for the relevant system(s) in the AMA Guide, in order to qualify for a payment under this benefit category".

7. The policy specifically referred to the Whole Person Impairment (WPI) concept, "as published from time to time in the American Medical Association's (AMA) "Guidelines to the Evaluation of Permanent Impairment". This incorporates a complex scoring system for different conditions and allows for objective standards to be applied.

8. The insurer calculated the WPI as 23%, thus below the 35% required for a benefit.

9. We asked the insurer to provide us with the assessment calculation, and then provided this to the complainant's doctor. On his calculation, including the hernia problem, the WPI was 29%. The insurer stood by its decision, as this was still below the required 35%.

10. We accepted that the complainant's condition did not meet the criteria under any of the impairment benefit or specified dread disease categories. However we requested that the insurer reconsider the case on equitable grounds.

11. We noted that one of the criteria for the dread disease Catch-All benefit was that the life assured must be suffering from a serious physical condition considered to be of equivalent severity to a condition that would qualify for a 100% payout (R1 million in the complainant's case) under another benefit category. We pointed out that 100% was payable for Crohn's Disease or Ulcerative Colitis "requiring permanent colostomy or ileostomy". While the complainant did not have these diseases, she had a permanent colostomy, and this was certainly a marker of severity of the burden of her illness. We noted further that the insurer had not disputed that the addition of the hernia problem would place the WPI at 29%, which was not far from the Catch-All requirement of a 35% WPI.

12. According to her doctors, the complainant had severe dysfunctional colon disease with an

burden from her illness, against which the policy was, according to its terms, designed to provide cover. We accepted that the Catch-All benefit did not provide for any graded levels of severity, but stated that in our view the criteria for this category indicated a degree of discretion/flexibility in the assessment. We asked the insurer to consider making an ex gratia payment, of all or part of the sum assured.

13. The insurer responded that, while it still did not believe there was any legal claim as it did not meet the dread disease criteria stipulated in the policy, "in terms of equity" it was prepared to offer a concession payment of 50% of the sum assured to the complainant as a full and final settlement.

14. The complainant accepted the offer, and was paid R500 000.

Case Study 4

1. Mrs W had a policy that provided cover inter alia for cancer. Mrs W underwent ovarian surgery, as malignancy was suspected. A claim was submitted, but the insurer declined the claim because

   "...her initial cytology results (from the fluid of the Pouch of Douglas) appeared to have been consistent with metastatic adenocarcinoma, however further investigations including histology of both ovaries revealed no evidence of infiltrating cancer. Thus we declined the claim on the policy wording of clause 5.2.5: Any skin cancer, cancer-in-situ and any tumour that is histologically described as pre-malignant or showing early change shall not qualify as cancer."

2. We referred the matter to an independent medical consultant for an opinion and he stated the following in his report:

   "Mrs W underwent laparoscopic resection of a right ovarial mass on 05/03/2007. During the procedure the surgeon noted fluid in the Pouch of Douglas and ‘enkele uitsaaiings' at the sigmorectal junction, which, being dangerous to resect, were left in situ, without biopsy - 'dis gevaarlik om hierdie weg te sny'. In addition the surgeon mentions a small area, 1cm x 1cm in the Pouch of Douglas which he suspected to reflect stage IC ovarian carcinoma.

   The resected material was submitted to Laboratory A and the histological diagnosis of the right ovarian tumour was papillary cystadenoma with borderline malignancy.

   Fluid aspirated from the pelvic pouch was sent to Laboratory B. The cytological diagnosis was 'metastatic adenocarcinoma'.
   ...

   This is an unusual case where the histologist was unable to find evidence of infiltrative malignancy at, what presumably was, the primary tumour site, whereas an unequivocal cytological diagnosis of adenocarcinoma was made on examination of cells in the peritoneal fluid, by a cytologist at a different laboratory. This indicates that the cytologist is convinced that the cells are not pre-cancerous but are diagnostic of cancer arising in a solid organ, which in this case would be the ovary. The cancer must have spread to the peritoneum for adenocarcinoma cells to have been present in fluid in the Pouch of Douglas. This indicates metastasising malignancy.

   The cytological diagnosis of carcinoma was supported by the intra-operative observation of the

considered by the surgeon to be malignant invasion. He felt that it would have been dangerous to biopsy these sites.

Unfortunately, the two reports come from different laboratories, presumably unaware of the disparate diagnoses. Probably Laboratory A would have done further resections of the resected tissue, on receipt of the cytological diagnosis, with the probability of finding overt malignancy.

With this data, I would conclude that the diagnosis of invasive adenocarcinoma has been adequately substantiated and that the insurer would be evading the underlying function of the policy by insisting on strict adherence to the contractual definition."

3. A copy of the report was provided to the insurer. The insurer discussed the matter with their re-insurer's Chief Medical Officer who in turn concurred with the independent medical consultant's opinion.

4. The insurer settled the claim in respect of the cancer benefit.

*Names have been changed

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(Sharecall) 086 010 3236
(T) +27 21 657 5000
(F) +27 21 674 0951
(E) info@ombud.co.za
Third Floor, Sunclare Building, 21 Dreyer Street, Claremont, Cape Town, 7700
Private Bag X45, Claremont, Cape Town, 7735
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