An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2018-0173
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Rejection of claim - pre-existing condition
Outcome:	Partially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainant, now age 66, incepted a health insurance policy with the Company on 31 March 2015, having never held private medical insurance previously.

The Complainant's Case

The Complainant submitted a claim to the Company in respect of treatment she received on 24 October 2016 in a private Hospital. This treatment is coded as Procedure 3416, that is, *"Arthroscopy, shoulder, surgical; with rotator cuff repair and decompression of subacromial space by bursectomy and/or acromioplasty"*.

The Company declined the Complainant's claim on 4 April 2017 as it determined that the treatment related to a pre-existing condition and that her GP Consultation Notes showed that the Complainant had signs and symptoms of the condition as far back as 2010. In this regard, the Company states that the terms and conditions of the Complainant's policy provide that a pre-existing condition waiting period will apply to all policyholders who take out private health insurance for the first time or who have had a break in cover for 13 consecutive weeks or more and will apply to any *"ailment, illness or condition, where, on the basis of medical advice, the signs or symptoms of that ailment, illness or condition existed at any time in the period of 6 months ending on the day on which the person became insured under the contract"*. The Company notes that given her age the relevant waiting period for the Complainant is 5 years, which will not be served until 31 March 2020.

The Complainant sets out her complaint, as follows:

> *"I had an operation in October 2016 and* [the Company] *subsequently declined cover. Their argument: It was a pre-existing condition therefore I am not covered. My argument: It was a new condition so I should be covered…*
>
> *I took out health insurance cover for the first time on 31st March 2015. After many years procrastination, a friend advised me that if I didn't take out cover before April 2015 (the introduction of lifetime community rating) then I would have to pay 60% more due to my age.*
>
> *You will see from my GP notes that I have suffered from a nagging right shoulder pain for many years, I had an x-ray in August 2012. I was advised that this was normal wear and tear experienced by many people. My GP stated in his referral letter that the pain had been ongoing for 2 years. This was incorrect as is evidenced by my GP notes…Even the first entry in 2010 refers to right shoulder pain.*
>
> *This new pain was a very different and more acute pain to the nagging ache that I had been having and only happened in the period preceding my visit to my GP in April 2016. Hence I requested the MRI. The nagging ache was still ongoing.*
>
> *My proof that this was a new condition is the radiologists report from June 2016 which states that in their expert opinion that the tear was likely to have happened between 3 and 6 months before I got the MRI in June, making it a new condition…Hence* [the Company] *should cover my medical costs"*

In addition, the Complainant also advises, as follows:

> *"My second issue with* [the Company]*: It took* [the Company] *5 and a half months to inform me of their decision to deny me cover. I had the operation in October 2016. I found out in the first week in April* [2017] *that they were declining cover. I had just renewed my policy with them starting 31st March 2017 costing me €940.* [The Company] *received the request for cover from the [Hospital] on 16th December 2016. It took until 13th March for them to request the letter of referral…This is 2 weeks before my renewal date and nearly 5 and a half months after the operation. They informed me that they were declining cover on 4th April 2017, just a few days after I had renewed and nearly 5 and a half months after the operation…*
>
> *I have not worked since the procedure so money is very tight. I will be on the state pension next March* [2018]*. If I had known they were not covered me for the procedure I would have at least had the opportunity to change provider or to use the money to pay my medical bills. It is an unacceptable delay"*.

As a result, the Complainant seeks for the Company *"to pay my medical costs associated with this operation. These include my consultant's fees, the [Hospital] and any physiotherapy cost associated with it"*. In addition, the Complainant also seeks for the renewal premium she paid to the Company on 23 March 2017 by way of cheque in the amount of €919 to be refunded. In this regard, in her email to this Office dated 25 April 2018 the Complainant's

/Cont'd…

nominated representative advises that the Complainant *"is a pensioner with very little money and would probably not have renewed with* [the Company] *had she known they would not cover her for the procedure…They informed her four days after she renewed"*.
The Complainant's complaint is that the Company wrongly or unfairly declined her health insurance claim and that it provided her with poor customer service by way of the length of time it took to assess her claim.

The Provider's Case

Company records indicate that the Complainant incepted a health insurance policy with the Company on 31 March 2015, having never held private medical insurance previously. The Complainant's complaint relates to the declinature of her claim for treatment received on 24 October 2016 in [a Hospital]. This treatment is coded as Procedure 3416, that is, *"Arthroscopy, shoulder, surgical; with rotator cuff repair and decompression of subacromial space by bursectomy and/or acromioplasty"*.

The Company received a telephone call on 1 September 2016 to confirm cover prior to Procedure 3416 taking place and it is satisfied that all information provided by the Agent during this call was correct, although the Company notes that it was disclosed at a later date that it was not the Complainant herself who made this telephone call but rather her nominated representative, Ms S. O'M. In this regard, the Agent confirmed with Ms S. O'M. that the Complainant had no private health insurance prior to March 2015 and advised that, should Procedure 3416 be in respect of a pre-existing condition, there would be no cover until the industry-standard waiting period for pre-existing conditions had been served. The Agent did advise that this was a 10 year waiting period, however the Company notes that changes in the regulations meant that this waiting period had decreased to 5 years when the Complainant renewed her policy in March 2016 and that this change was set out in her renewal policy documentation. Ms S. O'M. stated that the upcoming procedure was not a pre-existing condition and the Agent advised that it is for the treating consultant to note such on the claim form. The Agent confirmed that the procedure is covered subject to a €150 excess and that once the claim was received it would be assessed to confirm that all applicable waiting periods have been served. Ms S. O'M. then queried the definition of a new condition and was advised by the Agent that it would be any condition that began after 31 March 2015, when the Complainant first obtained private health insurance cover.

The Company subsequently received a claim from the [Hospital] on 15 December 2016 in respect of treatment the Complainant received there on 24 October 2016, that is, Procedure 3416, listed as *"Arthroscopy, shoulder, surgical; with rotator cuff repair and decompression of subacromial space by bursectomy and/or acromioplasty"*. Having assessed this claim, the Company determined that the treatment the Complainant had received was in respect of a pre-existing condition and that she had not completed all of the applicable policy waiting periods.

As part of its assessment of her claim, the Company requested details of the Complainant's previous insurance details as the claim form received from the treating consultant detailed that the procedure in question was carried out for *"rotator cuff degeneration"* with symptoms present for a year. As the Complainant confirmed that she had no previous

/Cont'd…

private medical insurance, the Company requested the Complainant's GP referral letter to the treating consultant. This referral letter was received on 22 March 2017 and stated that the Complainant had been suffering with symptoms for two years prior to her being referred for treatment. The Company was thus satisfied that the treatment the Complainant received on 24 October 2016 related to a pre-existing condition and that she was still serving the industry-standard 5 year waiting period for pre-existing conditions. As a result, the Company issued claim declinature notifications to the Complainant, her treating consultant and the [Hospital] on 4 April 2017.

The Complainant appealed this declinature on 12 June 2017 and submitted to the Company her GP notes as well as an MRI report relating to a scan dated 19 June 2016. The Company notes that there was an addendum to this original MRI report that was requested by the Complainant and was dated 29 May 2017 and which contradicts the original MRI report. The Company's medical advisors, based on all the evidence received, do not agree with the information included in this addendum. The details of the claim along with all supporting medical information was sent to the Company's medical advisors to review, who again determined that the procedure carried out was in relation to the same condition that the Complainant had been aware of since 2010. In this regard, the Company notes that the terms and conditions of the Complainant's policy provides that *"*[Company] *medical advisors will decide whether your claim relates to a pre-existing condition. Their decision is final"*.

The Company advised the Complainant on 10 July 2017 that the decision to decline her claim remained as her GP Consultation Notes showed that the Complainant had signs and symptoms of the condition as far back as 2010. In this regard, the terms and conditions of the Complainant's policy provides that a pre-existing condition waiting period will apply to all policyholders who take out private health insurance for the first time or who have had a break in cover for 13 consecutive weeks or more and will apply to any *"ailment, illness or condition, where, on the basis of medical advice, the signs or symptoms of that ailment, illness or condition existed at any time in the period of 6 months ending on the day on which the person became insured under the contract"*.

The Company notes that the private health insurance system in Ireland is based on four core principles, all of which are necessary in order for the system to operate effectively, These core principles are open enrolment, community rating, lifetime cover and minimum benefits, and are all set out within the Health Insurance Act, 1994 as amended. Community rating means that with limited exceptions all persons who purchase the same health insurance plan do this at the same price regardless of age, sex or health status. As such, no underwriting criteria are applied specifically targeted to any individual and no health data is collected when a person purchases health insurance as this is not necessary in order to establish price. In addition to which, under the principle of open enrolment (again with limited exceptions), a health insurer must provide insurance cover to all who seek it. Hence, in order for a community rated market to function properly and remain affordable waiting periods are prescribed under law, to avoid persons only purchasing health insurance once they develop a sickness or illness.

The Company notes that the Complainant does not agree with the decision of the Company's medical advisors that the procedure she underwent on 24 October 2016 relates

/Cont'd…

to a condition which existed prior to her taking out private health insurance for the first time in March 2015. In this regard, the Complainant contends that her claim is valid and that the procedure carried out was not in any way related to her historical shoulder pain which dates back to 2010 but instead related to a newly occurring condition, a *"new…and more acute pain"* in April 2016 in the same shoulder that was no more than 6 months old at the time of the MRI on 19 June 2016. In addition, the Complainant advises that at no point prior to her taking out private health insurance was the possibility of shoulder surgery ever mentioned to her by her GP. However, the Company notes that the medical information it received when reviewed in its entirety shows that the Complainant was suffering from *"rotator cuff degeneration"*, as detailed in the claim form, which in itself means that the condition had become progressively worse over time.

Whilst the Company is aware that there was no need for surgical intervention prior to the inception of the Complainant's health insurance policy, the same condition did become worse and require surgery at a later date and therefore the condition is defined as a pre-existing condition.

The Company notes that the Complainant incepted her health insurance policy with the Company on 31 March 2015 by taking out the policy with one of its Sales Agents over the telephone. On the original sales call on 24 February 2015 the Complainant confirmed that she was then currently taking anti-inflammatories for her shoulder. The Agent advised the Complainant that her health insurance policy that she was at that time seeking to incept would not provide cover if she required surgery on her shoulder and reminded her that she held a medical card. The Company notes that during this telephone call the Complainant acknowledged that, in line with the industry-standard waiting periods for pre-existing conditions, she would be unable to claim for any treatment for her right shoulder for 10 years until she is age 72, given that she was then aged 62. The Company posted the Complainant the terms and conditions of her policy on 1 April 2015, which set out the pre-existing waiting periods to be served. Following legislative changes in April 2015, the waiting period for pre-existing conditions which the Complainant is currently serving was reduced from 10 years to 5 years at her policy renewal date in 2016.

The Company states that it remains satisfied from the medical evidence before it that the treatment the Complainant received on 24 October 2016 relates to a condition that she had signs and symptoms of as far back as 2010 and thus is a pre-existing condition to which a policy waiting period of 5 years applies. Accordingly, the Company is satisfied that it declined the Complainant's claim in accordance with the terms and conditions of her health insurance policy.

The Company notes that the Complainant also addresses the amount of time it took for the Company to decline the claim. In this regard, the Company received the claim from the [Hospital] on 15 December 2016 and wrote to the Complainant on 19 December 2016 requesting her previous insurance details. The claim was put on hold to await the receipt of the required documentation. The Company notes that the Complainant's nominated representative, Ms S. O'M. contacted its claims department on 22 December 2016 to confirm that the Complainant had not previously held insurance, however the Complainant's claim remained in the pended state. The Company did not review the claim

/Cont'd…

again until 13 March 2017, at which point it requested the GP referral letter to the consultant. Having received this referral letter on 22 March 2017 and then assessing all the medical information received, the Company declined the Complainant's claim by way of correspondence dated 4 April 2017.

In addition, the Complainant also addresses the fact that the declinature notifications issued on 4 April 2017 *"just a few days after* [she] *had renewed"* her policy. In this regard, the Company received the Complainant's GP referral letter, which informed the Company's decision to decline the Complainant's claim, on 22 March 2017 and the Complainant's premium payment by cheque on 23 March 2017, however each item was processed independently by two different administration departments.

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 12 October 2018, 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.

In the absence of additional submissions from the parties, my final determination is set out below.

The complaint at hand is, in essence, that the Company wrongly or unfairly declined the Complainant's health insurance claim and that it provided her with poor customer service by way of the length of time it took to assess her claim.

In this regard, the Complainant incepted a health insurance policy with the Company on 31 March 2015, having never held private medical insurance previously. The Complainant later

/Cont'd…

submitted a claim to the Company in respect of treatment she received on 24 October 2016. This treatment is coded as Procedure 3416, that is, *"Arthroscopy, shoulder, surgical; with rotator cuff repair and decompression of subacromial space by bursectomy and/or acromioplasty"*.

The Company declined the Complainant's claim on 4 April 2017 as it determined that the treatment related to a pre-existing condition and that her GP Consultation Notes showed that the Complainant had signs and symptoms of the condition as far back as 2010. In this regard, the terms and conditions of the Complainant's policy provide that a pre-existing condition waiting period will apply to all policyholders who take out private health insurance for the first time or who have had a break in cover for 13 consecutive weeks or more and will apply to any *"ailment, illness or condition, where, on the basis of medical advice, the signs or symptoms of that ailment, illness or condition existed at any time in the period of 6 months ending on the day on which the person became insured under the contract"*.

The Company notes that given her age the relevant waiting period for the Complainant is 5 years, which will not be served until 31 March 2020.

The Complainant does not agree with the decision of the Company's medical advisors that the procedure she underwent on 24 October 2016 relates to a condition which existed prior to her taking out private health insurance for the first time in March 2015. In this regard, the Complainant contends that her claim is valid and that the procedure carried out was not in any way related to her historical shoulder pain which dates back to 2010 but instead related to a newly occurring condition, a *"new… and more acute pain"* in April 2016 in the same shoulder that was no more than 6 months old at the time of the MRI on 19 June 2016.

In addition, the Complainant advises that at no point prior to her taking out private health insurance was the possibility of shoulder surgery ever mentioned to her by her GP.

In this regard, the Complainant emailed the Company on 28 July 2017, as follows:

> *"You will see from my GP records that I have had a problem with my right shoulder for several years. I had an x-ray in a few years back and was told that it was just normal wear and tear that happens a lot of people as they get older. Surgery was never suggested to me as even a possibility. The pain, as you can see from my records, continued but was always the same pain. Early in 2016 I experienced a very severe pain in my shoulder. This pain was over and above the ongoing pain. My work is physical in nature and could well explain the tear. I visited my GP in April 2016 and requested an MRI because I knew that the pain was very different to the other ongoing chronic pain I had been experiencing. It is at the consultant with* [G.H.] *that surgery was suggested for the first time. You will see from the radiologists report that the radiologist believed the tear to be between 3-6 months at the time of the MRI"*.

Health insurance 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. I note that the Company wrote to the Complainant on 30 March 2016 confirming the renewal of her health insurance policy from

/Cont'd…

31 March 2016. Section 3, 'Exclusions from Your Cover', of the enclosed Membership Handbook (March 2016) provides at pg. 22, as follows:

> *"We do not cover the following…*
>
> - *Any costs incurred whilst a waiting period applies"*.

Section 6, 'Waiting Periods', of this Membership Handbook provides at pg. 25, as follows:

> *"**Pre-existing condition waiting periods***
>
> *Where you make a claim which relates to a pre-existing condition, a pre-existing condition waiting period will apply. A pre-existing condition is an ailment, illness or condition, the signs or symptoms of which existed at any time in the six months before you took out health insurance for the first time or before you took out health insurance after your health insurance had lapsed for 13 weeks or more.*
>
> *You will not be covered for a pre-existing condition during your pre-existing condition waiting period. Our medical advisers will decide whether your claim relates to a pre-existing condition. Their decision is final …*
>
> *The table below sets out the pre-existing condition waiting periods applied by* [the Company]*. These waiting periods will apply from the date you took out health insurance for the first time (with* [the Company] *or another insurer), or from the date you took out health insurance ((with* [the Company] *or another insurer) after your health insurance had lapsed for 13 weeks or more"*.

I note that the 'Pre-Existing Condition Waiting Periods' table then confirms that there is a 5 year waiting period for those policyholders age 55 or over in respect of, among other things, all In-Patient Benefits.

Recordings of calls have been provided in evidence. I note that prior to incepting her health insurance policy with the Company, the Complainant telephoned the Company on 24 February 2015 to enquire about the different levels of cover available. During this telephone call the Complainant advised that she was then aged 62 and had no health insurance but did have a medical card. I also note that the Agent advised the Complainant of the applicable waiting periods in respect of pre-existing conditions, as follows:

> Agent: *If you have a pre-existing condition, something you have before you take up health insurance, you must wait 10 years before you can use the health insurance policy, ok?*
>
> Complainant: *And what sort of condition would that be now?*
>
> Agent: *That could be anything…*

/Cont'd…

Complainant: *Ok, and at the moment now I have to take anti-inflammatories, I have a shoulder that's, em,* [indecipherable] *nerve or something…*

Agent: *If you had to have surgery, let's say, on that shoulder, like your private health insurance wouldn't pay for it because it's already there before you've taken out the health care insurance -*

Complainant: *Alright. Grand … with my shoulder now I have to wait 10 years until I'm 72?*

Agent: *Yeah*

Complainant: *OK, grand …*

Agent: *Now a consultant will decide…whether it's a new condition or it's been there beforehand*

Furthermore, the Complainant's nominated representative, Ms S. O'M., telephoned the Company on 1 September 2016, although I note from the recording of this telephone call that Ms S.O'M. presented herself during this telephone call as the Complainant herself.

Ms S. O'M. was checking if cover was available in respect of Procedure Code 3416:

Agent: *Now this particular policy started on the 31st March of last year, 2015. Did you have health insurance before that?*

Ms S. O'M.: *No*

Agent: *Ok, so that's just one thing to make you aware of first of all that if this is a pre-existing condition then you wouldn't be covered because you would be serving a 10 year waiting period for pre-existing conditions*

Ms S. O'M.: *It's not a pre-existing condition.*

Agent: *Ok, that's no problem. So your consultant will notify those details on the claim form …*

Once we receive the claim it will be assessed in conjunction with the medical information that we received just to confirm that all of your waiting periods have been served. The consultant will just note all of the medical criteria on the claim form to state that it is a new condition and you just pay the excess of €150 on the day

Ms S. O'M.: *Like what's the definition of a new condition?*

Agent: *So, your policy started on 31st March 2015 so a new condition will be any condition that has started after that date.*

/Cont'd…

Ms S. O'M.: *Alright. Ok.*

As a result, I accept that the Company provided the Complainant with appropriate notice, both in writing by way of her policy documentation and by telephone, that waiting periods would apply to any claim in respect of treatment relating to any pre-existing condition and, I also accept that what would be considered a pre-existing condition was explained to her. However, what was not explained to the Complainant was that it was the [Company] Medical Advisors that would decide whether the claim related to a pre-existing condition.

In the telephone call of 24 February 2015, the Company's agent states "*now a consultant will decide… whether it's a new condition or it's been there before*". This is clearly in conflict with the policy which states that it is the [Company] Medical Advisors that will decide if it is a pre-existing condition and it further states that their decision is final. This is a critical piece of information which should have been brought to the Complainant's attention as this was how the matter was in fact ultimately decided.

That said, the main issue to be decided is whether the treatment the Complainant received on 24 October 2016, that is, Procedure 3416, that is, *"Arthroscopy, shoulder, surgical; with rotator cuff repair and decompression of subacromial space by bursectomy and/or acromioplasty"*, was in respect of a pre-existing condition, that is, one that existed prior to her incepting her health insurance policy with the Company on 31 March 2015.

In this regard, I note from the documentary evidence from me that the Complainant's GP Consultation Notes records, among other things, the following entries:

"03/02/2010 *discomfort r shoulder – tendon a-c jt – refer physio*

03/07/2012 *R sh pain, x 3yrs, no imp w physio, gen work.*
O/E good rom active, res elev and ext rot painful

IMP; SUPRA and INFRASPINATUS TENDONOPATHY.

28/08/2012 *28 AUG 12:-* [x-ray image]
RIGHT SHOULDER – STH INF

13/09/2012 *rt shoulder degenerative changes – Adcortyl*

31/01/2013 *In RTA y'day – some restriction of movt – 60 deg rt and left – mild spasm and tenderness, shoulder ok …*

27/01/2015 *…shoulder pain, adv arcoxia prn only, getting chiro, adv consider ac."*

I note that the Complainant's GP referred the Complainant to a consultant by correspondence dated 29 June 2016, as follows:

/Cont'd…

"I would appreciate if you could see this 64-yer old lady with a tear torn supraspinatus.

*She had been complaining of right shoulder pain **for almost two years**. She has been treated with anti-inflammatories, chiropractic and acupuncture etc.*

On examination on 19.4.16 she had reduced elevation, I thought a positive scarf sign. Evidence of impingement. I will enclose a copy of the MRI report and she will bring along the disk which shows torn supraspinatus. She is otherwise generally well".

[Emphasis added]

The treating consultant completed Part 2 of the Hospital Claim Form on 24 October 2016 and advised, as follows:

"Reason for admission (admitting diagnosis):

a. *Primary: **Rotator cuff degeneration/tearing Right shoulder***

b. *Secondary: **Subacromial impingement**"*

I note the contents of the MRI Report in respect of the Complainant's right shoulder dated 19 June 2016 and approved by the Consultant Radiologist on 22 June 2016, as follows:

"The acromion process is hooked (type 3). There is also degenerative change in the AC joint with inferior osteophytosis resulting in further narrowing of the subacromial space. There is a complete tear of the supraspinatus tendon, with tendon retraction of approximately 1.5cm. There is fluid tracking into the subacromial space from the glenohumeral joint.

There is a tendinopathy of the subscapularis tendon. However the subscapularis and infraspinatus tendons are intact. The long head of biceps tendon is intact.

Normal glenohumeral joint alignment and the articular cartilage is generally well preserved. There is no marrow oedema in the scapula or proximal right humerus. Unremarkable periarticular soft tissues.

Opinion: Feature of severe shoulder impingement with narrowed subacromial space and complete tear of the supraspinatus tendon with tendon retraction".

I also note the contents of the Addendum Report to this MRI Report dated 29 May 2017 and approved by the Consultant Radiologist on 1 June 2017, as follows:

"Further review of the images has been requested. While there is supraspinatus tendon retraction, there is good preservation of muscle bulk with minimal or no supraspinatus muscle atrophy. This suggests a recent tear, most likely within the preceding 3 -6 months".

/Cont'd…

In addition, I note the undated Report from the Company's Medical Director, as follows:

> *"*[The Complainant] *has reported symptoms of right shoulder pain and discomfort to her GP in February 2010. At that time she was noted to have tenderness of the acromioclavicular joint (the bony tip of the shoulder). Later that year, her GP notes right shoulder pain again and comments that this has been present for 3 years. At this time a clinical impression of supra- and infraspinatus tendonopathy (inflammation of the tendons of two muscles that move the shoulder; these tendons form part of the rotator cuff around the shoulder joint). Her symptoms were sufficient for referral to the [Hospital] for an x-ray of the shoulder, and it would appear from the notes that degenerative changes were noted on the x-ray at that time. Degenerative changes are never normal; in many cases they may be painless and of no significance, but where pain is present, degenerative changes imply the presence of pathology in the area identified.*
>
> *In January 2015,* [the Complainant] *complained to her GP of shoulder pain, as she did in April 2016. At that time she was referred for specialist opinion.*
>
> *She subsequently went on to have a rotator cuff repair. This was declined on the basis that both signs and symptoms had been present since 2012.*
>
> [The Complainant] *suggests that this is a new condition. However rupture or tears of the rotator cuff occur either as a result of significant trauma or as a result of attrition from repeated impingement from the overlying bone. In* [the Complainant's] *case her MRI demonstrates the presence of osteophytes (effectively like stalactites of bone growing on the under surface of her acromioclavicular joint). Again these do not grow overnight but develop over a long period of time. The MRI identifies the tear in the rotator cuff and the severe impingement – the impingement would be most likely the source of the repeated trauma to the rotator cuff.*
>
> *I note that the radiologist commented that the periarticular tissues (the muscle tendon surrounding the joint) were unremarkable (i.e. no signs of recent injury such as oedema or swelling in the tissues).*
>
> *I also note the unusual addendum to this MRI added almost one year after the study where the radiologist "suggests" a recent tear, inferring this from the absence of muscle atrophy and good preservation of muscle bulk. This clinical impression is at most a surmised impression – muscle atrophy where it is present would indicate a longer history, but its absence does not indicate a short history. If the patient has been physically active, muscle atrophy will not be present and patients can certainly have strong musculature even with long established tears. In addition, this addendum appears to contradict the original report in that in an acute/recent tear, oedema of the tissues would not be an expected finding – this possibility is clearly rejected in the original report.*

/Cont'd…

> *The Mayo Clinic outlines that "Rotator cuff disease may be the result of either a substantial injury to the shoulder or to progressive degeneration or wear and tear of the tendon tissue. Repetitive overhead activity, heavy lifting over a prolonged period of time, and the development of bone spurs in the bones around the shoulder may irritate or damage the tendon".*
>
> [The Complainant] *had degenerative disease identified in her shoulder in 2012 and she had symptoms since that period. I think it is beyond doubt that* [the Complainant] *had clinical significant shoulder disease since that period and that therefore the condition can be justifiably considered a pre-existing condition"*.

Having considered all the information supplied in evidence, I accept that it was reasonable for the Company to conclude that the treatment the Complainant received on 26 October 2016 was in relation to a condition that she had shown signs and symptoms of as far back as 2010 and which is degenerative in nature, eventually leading to the need for the treatment received. Accordingly, I accept that the Company declined the Complainant's claim in accordance with the terms and conditions of her policy.

However, I believe the Company must bear some responsibility for not informing the Complainant prior to having the procedure carried out that it would be its Medical Advisors and not her consultant who would determine whether or not it was a pre-existing condition. This is a very important piece of information that the Complainant required in deciding whether or not to proceed with the procedure.

With regard to the second element of the Complainant's complaint, that the Company provided the Complainant with poor customer service by way of the length of time it took to assess her claim, the Complainant states *"It took* [the Company] *5 and a half months to inform me of their decision to deny me cover. I had the operation in October 2016. I found out in the first week in April* [2017] *that they were declining cover"*.

I note from the documentation before me that the Company received the claim from the [Hospital] on 15 December 2016 and then wrote to the Complainant on 19 December 2016 requesting her previous health insurance details. The Company then put the Complainant's claim on hold, awaiting receipt of this information. The Complainant's nominated representative, Ms S. O'M. telephoned the Company on 22 December 2016 to confirm that the Complainant had not previously held health insurance.

Despite having received the information that it had sought at that time, in its correspondence to this Office dated 10 May 2018 the Company advises that the Complainant's claim then *"remained in the pended state"* and that it did not review the claim again until 13 March 2017, at which point it requested the GP referral letter to the consultant. Having received this referral letter on 22 March 2017 and then assessing all the medical information received, the Company declined the Complainant's claim by way of correspondence dated 4 April 2017.

In this regard, in her email to this Office dated 22 May 2018, the Complainant's nominated representative, Ms S. O'M. submits that *"the question still remains why* [the Company] *took*

/Cont'd…

nearly 4 months to decline [the Complainant] *cover from when the hospital requested payment in the middle of December"*. I am disappointed that the Company has not taken the opportunity to explain why the Complainant's claim remained in what it terms *"the pended state"* for nearly three months from 22 December 2016 until 13 March 2017. Nor has it offered an apology for the delay. I am satisfied that this period of inaction during the claims assessment process constitutes poor customer service.

Finally, the Complainant notes that the Company declined her claim on 4 April 2017 *"just a few days after* [she] *had renewed"* her policy. In this regard, I note from the documentation before me that the Company received the Complainant's GP referral letter, which informed the Company's decision to decline the Complainant's claim in the first instance, on 22 March 2017 and the Complainant's premium payment by cheque the day after, on 23 March 2017. I accept the Company position that each item was processed independently by two different administration departments and there is no evidence before me to support the Complainant's suggestion that the Company waited until she had renewed her policy to decline her claim.

I also note that in her email to this Office on 25 April 2018 the Complainant's nominated representative advises that the Complainant *"is a pensioner with very little money and would probably not have renewed with* [the Company] *had she known they would not cover her for the procedure…They informed her four days after she renewed"*. It was a matter for the Complainant herself as to whether or not she renewed her health insurance policy with the Company. If she had chosen not to renew her policy in March 2017, this would not have impacted on any outstanding claim she had under the policy.

For the reasons outlined above relating in particular to the information given to the Complainant about how her claim would be assessed and the delay in assessing her claim without providing a valid reason, I partially uphold this complaint and direct the Provider to pay a sum of €1,000 to the Complainant.

Conclusion

My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is partially upheld, on the grounds prescribed in ***Section 60(2) (b), (f) and (g).***

Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to make a compensatory payment to the Complainant in the sum of €1,000, to an account of the Complainant's choosing, within a period of 35 days of the nomination of account details by the Complainant to the provider. I also direct that interest is to be paid by the Provider on the said compensatory payment, at the rate referred to in ***Section 22*** of the ***Courts Act 1981***, if the amount is not paid to the said account, within that period.

The Provider is also required to comply with ***Section 60(8)(b)*** of the ***Financial Services and Pensions Ombudsman Act 2017.***

/Cont'd…

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.

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

9 November 2018

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.