An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0263
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Rejection of claim - pre-existing condition
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainant incepted a health insurance policy with the Provider on **24 December 2017**.

The Complainant's Case

The Complainant attended her GP on **25 May 2018** and received a pneumococcus vaccination but says she had a bad reaction to this shot, resulting in persistent pain in her left shoulder.

The Complainant says her GP then diagnosed her with a left shoulder joint injury on **11 June 2018** and referred her for an ultrasound. The Complainant had the ultrasound on **10 July 2018** and the results showed her to have a frozen shoulder. The GP referred the Complainant to a Consultant Orthopaedic Surgeon for further treatment.

The Complainant says that on **31 August 2018** the Consultant Orthopaedic Surgeon diagnosed her with a torn rotator cuff and she had treatments on her left shoulder on 31 August and 26 November 2018 and 1 March and 22 March 2019.

In **May 2019**, the Provider declined the ensuing claims in respect of the cost of these treatments on the basis that the symptoms for which the Complainant received treatment, were present prior to her taking out her health insurance cover with the Provider on 24 December 2017, and therefore her claims in relation to those hospital admissions were subject to the 5 year "pre-existing condition" waiting period.

On **22 July 2019** the Complainant wrote to the Provider, as follows:

> *"On Friday 25th May, 2018 during a routine visit to my GP she suggested I have the pneumonia shot as I had reached the age of 65. I had a very bad reaction to it which resulted in my not being able to move my arm. I returned to her on Monday 28th May and she prescribed Tramadol for the pain The next day I departed for my annual holiday to Spain and when I returned on 11th June* [2018] *I again visited my GP as pain was still persistent.*
>
> *She arranged for me to have an ultra sound…and I attended there on 10th July, 2018. The results showed a frozen shoulder so she wrote a referral on 22nd August for me to see* [a Consultant Orthopaedic Surgeon]*…and my first appointment with him was 31st August, 2018 when he confirmed it was a torn rotator cuff.*
>
> *My appeal is based on the fact that the diagnosis and treatment didn't commence until 31st August, 2018 and therefore should not be classified as a pre-existing condition"*.

On **21 August 2019** following its review, the Provider wrote to the Complainant to advise that it was standing over its decision to decline her claims.

The Complainant sets out her complaint in the Complaint Form she completed, as follows:

> *"This* [shoulder pain] *was most definitely not consistent and ongoing prior to commencement of cover. Following the results of the initial x-ray, I made an 'off the cuff' remark to my GP that "this would explain why I've had sporadic pain following gardening or heavy lifting". My* [GP] *has since confirmed that I never consulted her prior to the pneumonia show. How can* [the Provider] *say this was a pre-existing condition when it was only diagnosed on 31.08.18 by* [the Consultant Orthopaedic Surgeon]*?"*

In this regard, the Complainant notes that the GP letter dated **23 August 2019** states that:

> *"The first time* [the Complainant] *presented with, and was diagnosed with a (L) shoulder* ***joint*** *injury was on 11th June 2018. Just prior to this she had had a pneumococcus vaccine which caused pain in her (L) deltoid, a muscle injury"*

The Complainant submits that this GP letter confirms that the shoulder injury is not a pre-existing condition and that she had never consulted her doctor with any pain in her shoulder prior to having the pneumococcus vaccine on 25 May 2018.

/Cont'd…

In addition, the Complainant notes that the Consultant Orthopaedic Surgeon's letter dated **7 April 2021** states that:

> *"*[The Complainant] *had some symptoms as indicated by her general practitioner for some time. However, it was following a Pneumococcal vaccine into the left deltoid by her GP three months prior to her attendance with me in August 2018 that she developed acute symptoms in her shoulder that eventually required referral for diagnosis. The diagnosis was an acute rotator cuff arthropathy.*
>
> *I have no doubt that she had some low-grade degenerative symptoms in her shoulder previously but that was a background to her acute problem, which required the treatment".*

As a result, the Complainant seeks for the Provider to admit her health insurance claims and in this regard, when she submitted her Complaint Form to this Office, she submitted as follows:

> *"I would like* [the Provider] *to honour the claims submitted…in the sums of €1,281 and €650 respectively, and also that I may continue to receive treatment for my shoulder"*

The Complainant's complaint is that the Provider wrongly or unfairly declined her health insurance claim.

The Provider's Case

Provider records indicate that the Complainant telephoned the Provider on **24 November 2017** to obtain a health insurance quote and confirmed during this call that she had not held health insurance in Ireland previously, though she had held private heath insurance in England but that was *"many years ago"*.

The Provider notes from the recording of this telephone call that the Sales Advisor then explained to the Complainant:

> *"… with any policy, we will cover you immediately for any new health conditions, so that would be any illness that start after you join or accidents. They're all covered from day one. You wouldn't be covered for any existing health conditions for the first 5 years of cover"*.

The Sales Advisor also explained to the Complainant that a pre-existing condition is:

> *"… anything you've had signs of symptoms of in the 6 months before you join so even if there has been not treatment for it, if symptoms are there it would be considered a pre-existing condition. Just to give you a bit more information on that, the way we would determine that is if you go to hospital for any reason after the policy is in place, the consultant will say the onset date of the problem was such and such a date"*.

/Cont'd…

The Provider notes that the Complainant agreed to incept her health insurance policy on that date, however she telephoned the Provider again on 6 December 2017 and it was agreed to change the policy start date from 24 November 2017 to 24 December 2017 for direct debit reasons. The Provider posted the policy documentation to the Complainant on 7 December 2017, including the General Rules policy booklet, which sets out the terms and conditions of the health insurance policy in full.

The Provider says that its records indicate that the first time the Complainant contacted the Provider regarding shoulder issues was when she telephoned on **17 July 2018**. The Provider notes from the recording of this telephone call that the Complainant advised:

> *"I have been to the doctor and I've had an ultrasound and I have a frozen shoulder, five tendons affected. I'm just wondering am I covered now to see a specialist on that?"*

The Customer Service Advisor then advised the Complainant that:

> *" … If your symptoms are found to be pre-existing before you joined us, you will not have any cover for this procedure for 5 years"*.

The Provider confirms that it later received 5 claims from the Hospital in relation to the Complainant's shoulder issues, as follows:

Claim ID	Date of treatment	Type of treatment	Total Billed to Provider	Total Paid by Provider
xxxx441	31/08/2018	Day-case/Out-patient surgical	€318	€0
xxxx747	26/11/2018	Day-case/Out-patient surgical	€321	€0
xxxx476	21/12/2018	MRI	€195	€195
xxxx056	01/03/2019	Day-case/Out-patient surgical	€321	0
xxxx115	22/03/2019	Day-case/Out-patient surgical	€321	€0

The Provider says that Claim IDs xxxx441, xxxx747, xxxx056 and xxxx115 were for day-case treatments. Day-case treatments are treatments where, for medical reasons, the person has to be admitted into a hospital and occupy a bed in that hospital during the day, but not overnight, for treatment which would be accepted generally by the medical profession in Ireland as day-case treatment, as opposed to out-patient treatment. The Provider says it rejected these claims in full, as day-case treatments are subject to the pre-existing condition waiting period.

/Cont'd…

Claim ID xxxx476 was for a thoracic spine MRI. An MRI is considered an everyday medical expense. Everyday medical expenses, also referred to as out-patient expenses, are fees and charges for hospitals and consultants for nonsurgical treatment, for which there is no waiting period, for example, GP visits, consultant visits, physiotherapy etc. The Provider admitted this claim in full on a direct settlement basis with the Hospital, in accordance with its Schedule of Benefits.

The Provider can confirm that its notes indicate that the Hospital checked its internal Provider healthcare verification system on **31 August 2018**, **1 December 2018** and **1 March 2018**, prior to the Complainant's admissions, and each time the system noted:

> *"Waiting Periods may apply for this member, please contact* [the Provider]. *(Note: The additional cover waiting period of 2 years may apply)"*.

The Provider says that the Hospital did not contact it, to check cover for the Complainant.

The Provider says that the medical records relied upon to assess these health insurance claims were (i) the referral letter from the Complainant's GP to the Consultant Orthopaedic Surgeon dated **18 July 2018**, and (ii) the response from the Consultant Orthopaedic Surgeon to the GP dated **31 August 2018**.

The Provider notes that the initial referral letter from the Complainant's GP to the Consultant Orthopaedic Surgeon dated 18 July 2018 states:

> *"*[The Complainant] *has had L shoulder pain for 18/12+, getting worse despite a chiropractor and acupuncture. Movement is limited"*.

The Provider says that *"18/12+"* in medical terms means 18 months and that 18 months prior to 18 July 2018, the date of the referral letter, is 18 January 2017; however, the Complainant did not take out her health insurance policy until 24 December 2017.

The Provider notes that the response from the Consultant Orthopaedic Surgeon to the Complainant's GP dated 31 August 2018 states:

> *"*[The Complainant] *has pain in her left shoulder which is probably progressive over the past 12 months"*.

The Provider says that 12 months prior to 31 August 2018, the date of the response letter, is 31 August 2017; however the Complainant did not take out her health insurance policy until 24 December 2017.

The Provider says that according to both of these clinical letters, the Complainant's symptoms of left shoulder pain were ongoing for approximately 12-18 months prior to 18 July 2018. As she incepted her health insurance policy with it on 24 December 2017, the Provider says that the symptoms, as documented in these clinical letters, pre-existed the Complainant taking out her health insurance cover with the Provider.

/Cont'd…

The Provider assesses claims based on the clinical information available. This information is recorded in real time by the medical practitioners involved in the case, as per the guide to Professional Conduct and Ethics for Registered Medical Practitioners 2019, as compiled by the Medical Council of Ireland. Practitioners have a duty of care to ensure that their records are accurate and up to date and the Provider says it is reasonable for it to be able to rely on these records, when assessing claims.

The Provider accepts that it has not received any clinical notes from consultations or clinical letters advising that the Complainant consulted with a doctor prior to May 2018 regarding her left shoulder pain. However, in accordance with the terms and conditions of the Complainant's health insurance policy, a pre-existing condition is based on when the signs or symptoms of an ailment, illness or injury first occurred, rather than the date of diagnosis or the date a patient first consults with their doctor.

The Provider notes from the medical file received that the Complainant's GP made a consultation note on **11 June 2018**, as follows:

> *"Unable to use (L) shoulder fully for a while, worse after injection* - [written annotation states: *"Pneumoccus vaccine into (l) deltoid"*]*"*.

The Provider says this consultation note documents that the Complainant's symptoms got worse <u>after</u> the injection, not that the symptoms were caused by the injection. In that regard, the Provider says that there is no conclusive evidence that the pneumococcus vaccine is the root cause of the Complainant's shoulder issues.

In addition, the Provider notes that in his letter dated **7 April 2021**, the Consultant Orthopaedic Surgeon states:

> *"*[The Complainant] *had some symptoms as indicated by her general practitioner for some time. However, it was following a Pneumococcal vaccine into the left deltoid by her GP three months prior to her attendance with me in August 2018 that she developed acute symptoms in her shoulder that eventually required referral for diagnosis. The diagnosis was an acute rotator cuff arthropathy.*
>
> *I have no doubt that she had some low-grade degenerative symptoms in her shoulder previously but that was a background to her acute problem, which required the treatment".*

The Provider says that although the Complainant's symptoms may have been mild before she took out her health insurance policy with it in December 2017 and were then exacerbated after, nonetheless the symptoms were still present before she took out her insurance cover and the claims were in respect of treatment relating to the continuation and progression of the same symptoms.

/Cont'd…

The Provider notes that the Consultant Orthopaedic Surgeon advises that these symptoms were the onset of the Complainant's more acute issue. The Provider cannot comment on the Complainant's opinion that the vaccine led to these acute symptoms. Regardless of the vaccination, the Provider notes that the Consultant Orthopaedic Surgeon has confirmed that the Complainant's low-grade degenerative symptoms were present as indicated by her GP. The symptoms indicated by the Complainant's GP, as per the referral letter was 18 months prior to 18 July 2018, that is, January 2017.

The Provider believes that the Complainant's shoulder issue was a condition that existed prior to her taking out her health insurance cover with it in December 2017. A pre-existing condition is based on when the signs or symptoms of an ailment, illness or injury occurred, rather than the date of diagnosis or the date a patient consults their doctor. The Provider notes that the Complainant's pre-existing condition waiting period will be served on **24 December 2022.**

The Provider is satisfied that it declined the Complainant's claims in accordance with the terms and conditions of her health insurance policy.

The Complaint for Adjudication

The complaint is that the Provider wrongly or unfairly declined the Complainant's health insurance claim.

Decision

During the investigation of this complaint by this Office, the Provider was requested to supply its written response to the complaint and to supply all relevant documents and information. The Provider responded in writing to the complaint and supplied a number of items in evidence. The Complainant was given the opportunity to see the Provider's response and the evidence supplied by the Provider. A full exchange of documentation and evidence took place between the parties.

In arriving at my Legally Binding Decision I have carefully considered the evidence and submissions put forward by the parties to the complaint. Having reviewed and considered the submissions made by the parties to this complaint, I am satisfied that the submissions and evidence furnished did not disclose a conflict of fact such as would require the holding of an Oral Hearing to resolve any such conflict. I am also satisfied that the submissions and evidence furnished were sufficient to enable a Legally Binding Decision to be made in this complaint without the necessity for holding an Oral Hearing.

A Preliminary Decision was issued to the parties on **8 July 2021**, 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.

/Cont'd…

In the absence of additional submissions from the parties, within the period permitted, the final determination of this office is set out below.

I note that the Complainant's health insurance policy with the Provider was incepted on **24 December 2017**. Some five months later on **25 May 2018**, I note that she attended her GP and received a pneumococcus vaccination. She says that she had a bad reaction to this shot, resulting in persistent pain in her left shoulder.

The Complainant says on **11 June 2018** her GP then diagnosed her with a left shoulder joint injury and referred her for an ultrasound and then to a Consultant Orthopaedic Surgeon. On **31 August 2018** the Consultant Orthopaedic Surgeon diagnosed the Complainant with a torn rotator cuff and she had treatments on her left shoulder on 31 August and 26 November 2018 and 1 March and 22 March 2019.

I note that the Provider declined the ensuing claims as it concluded from the medical evidence received that because the Complainant had been complaining of a sore shoulder since early 2017, prior to taking out her health insurance policy with the Provider on 24 December 2017, that the shoulder injury related to a pre-existing condition and that accordingly, the treatment being claimed for had taken place, within the 5 year waiting period to be served, to be covered for pre-existing conditions.

The Complainant's health insurance policy, like all insurance policies, does not provide cover for every eventuality. Rather the cover is subject to the terms, conditions, endorsements and exclusions set out in the policy documentation, as well as the level of cover provided by the policy itself. It is an industry wide standard that waiting periods apply to health insurance policies in relation to pre-existing conditions, i.e. where the medical condition or the symptoms of the medical condition were present prior to the commencement of cover (or prior to a change in the level of cover).

Section 2, **'Policy Definitions'**, at pg. 5 of the applicable General Rules Policy Booklet defines a 'Pre-existing condition', as follows:

> *"**Pre-existing condition***
>
> *Pre-existing conditions: An 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 immediately preceding:*
>
> *a) The day you took out a Health insurance contract for the first time; or*
>
> *b) the day you took out a Health insurance contract again after your previous Health insurance contract had lapsed for 13 weeks or more.*
>
> ***Please note that our medical advisors will determine whether a condition is a Pre-Existing condition. Their declaration is final**".*
>
> [Underlining added for emphasis]

/Cont'd…

Section 9, '**What is not covered under the scheme'**, at pg. 11 of this Policy Booklet states:

> *"**The pre-existing condition waiting period is***
>
> - *the first five years of membership"*.

In addition, the '**Important information to note'** section at pg. 46 of the Policy Booklet states:

> *"**Waiting Periods** …*
>
> *How long before you can claim for any disease, illness or injury which began or the symptoms of which began before a membership started?*
>
> *5 years for all age groups".*

I note from the documentary evidence before me that the Complainant's GP made the following consultation note on the Complainant's medical file on 11 June 2018:

> *"Unable to use (L) shoulder fully for a while, worse after injection - Pneumoccus vaccine into (l) deltoid"*.
>
> [underlining added for emphasis]

I note that in her initial referral letter to the Consultant Orthopaedic Surgeon dated 18 July 2018, the Complainant's GP states:

> *"*[The Complainant] *has had L shoulder pain for 18/12+, getting worse despite a chiropractor and acupuncture. Movement is limited.* [Ultrasound] *shows lots of tendinopathy"*.
>
> [underlining added for emphasis]

In addition, I note that in his letter to the Complainant's GP dated 31 August 2018, the Consultant Orthopaedic Surgeon states:

> *"…* [The Complainant] *is right-handed and is now retired. She has pain in her left shoulder which is probably progressive over the past 12 months. She has had some sleep disturbance. She cannot lie on it and has difficulty lifting and elevating. On clinical examination today, she has 90 degrees of abduction and she has good rotation. However, she has pain on elevation. She has positive cuff signs. I note the findings on her MRI, which seems to suggest significant tendinopathy. I have injected her shoulders today and I will see her in three week's time for further injection"*.
>
> [underlining added for emphasis]

/Cont'd…

Having examined in detail the documentation before me, I am of the opinion that it was reasonable for the Provider to conclude from the medical evidence it obtained, and which I have cited from above, that the symptoms which the Complainant received treatment for, on 31 August and 26 November 2018 and 1 March and 22 March 2019, were present prior to the Complainant taking out her health insurance cover with the Provider on 24 December 2017, and therefore her claims in relation to the treatment she received on those dates were subject to the 5 year pre-existing condition waiting period, in accordance with the health insurance policy terms and conditions. As the Complainant had not served a 5 year period required by the policy, at the time of her claims, I am satisfied that the Provider was entitled to decline the claims in accordance with the terms and conditions of her health insurance policy.

I note that the Complainant has indicated as follows:-

> "*My appeal is based on the fact that the diagnosis and treatment didn't commence until 31st August, 2018 and therefore should not be classified as a pre-existing condition."*

It is important for the Complainant to understand however, that the date of diagnosis of the condition and the dates of the treatment received, are not relevant to the definitive of "*pre-existing condition*" within the meaning of the policy. The policy definition confirms that a pre-existing condition is an ailment 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 6 months immediately preceding the inception of the policy.

Whilst in December 2017, the Complainant may not yet have received a diagnosis of her condition, I am satisfied on the evidence available that the Provider was entitled to conclude that there were symptoms of this condition in the period leading up to the inception of the policy and, consequently, the Complainant's medical issue was a "*pre-existing condition*" within the meaning of the policy.

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

Conclusion

My Decision, pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017*** is that this complaint is rejected.

The above Decision is legally binding on the parties, subject only to an appeal to the High Court not later than 35 days after the date of notification of this Decision.

MARYROSE MCGOVERN
Deputy Financial Services and Pensions Ombudsman

30 July 2021

/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.