Decision Ref:	2021-0373
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Rejection of claim - pre-existing condition Claim handling delays or issues Disagreement regarding Medical evidence submitted Rejection of claim - waiting periods apply
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainant incepted a health insurance policy with the Provider on **16 January 2019**. He suffered a heart attack the following day. As a result of this, the Complainant was admitted to hospital and he received certain medical treatment and he made a claim under the policy in respect of these medical expenses.

The Provider declined the claim on the basis that the signs/symptoms which caused the heart attack were *pre-existing* the policy inception and the claim was not covered due to the required policy "waiting period".

The Complainant's Case

The Complainant explains he incepted a private health insurance policy with the Provider on **16 January 2019**.

He says that following a sudden and unexpected heart attack on **17 January 2019** he underwent unforeseen medical treatment in hospital, between **21** and **23 January 2019**, and again on **4 March 2019**.

The Complainant states on **13 September 2019**, he was advised that his medical claim was rejected and a Final Response letter was issued by the Provider on **9 December 2019** rejecting the claim on the basis that the Complainant's treatment was in respect of a medical condition that had existed before the Complainant incepted the policy and the Complainant had not served the 5 year waiting period to be covered for the cost of treatment for pre-existing conditions.

The Complainant disputes that his condition was a pre-existing medical condition and he is dissatisfied with the assessment of his claim and the time taken to reach a decision. The Complainant states that he is also dissatisfied with the unprofessional and unacceptable manner in which the Provider communicated its decision.

The Complainant refers to his health conditions and states that the Provider advised that all follow-up consultations or treatment would not be covered during a 5 year waiting period. Following his heart attack on **17 January 2019**, the Complainant advises that he was transferred to hospital and prior to transferring from public (**Hospital 1**) to private care (**Hospital 2**) it was confirmed that the Complainant was not subject to any waiting periods for new medical conditions.

The Complainant submits that as he never suffered from any cardiac distress or abnormalities prior to **17 January 2019**, it was obvious to all parties that this was a new condition given its sudden onset and the Complainant's medical history. The Complainant submits that the Provider wrongfully declined his appeal.

He says that:

- he attended his GP on **16 January 2019** regarding an existing medical condition of arthritis and a stomach condition was confirmed that day;
- the examination by his GP, which included an examination of his heart, did not show any signs or symptoms of heart attack;
- he never displayed any warning signs of heart attack;
- he had a healthy lifestyle; and
- he did not have any cardiac issues or cardiac abnormalities prior to **17 January 2019**.

In its Final Response letter, the Complainant notes that the Provider relied on the admission notes received from Hospital 1. The Complainant submits:

- due to the *hearsay nature* of this report, it is unacceptable that it should be used as medical evidence;
- the report does not confirm or suggest there were prior signs or symptoms of heart attack; and
- he described prior symptoms of an unrelated stomach condition.

The Complainant submits that the Provider is trying to align his symptoms for an unrelated stomach condition, with his heart attack and that it is doing so without any appropriate medical evidence.

Further to this, the Complainant explains that an invoice was received directly from Hospital 2 on **13 September 2019** and he was required to contact the Provider to seek clarity on the matter. The Complainant says he was then advised by phone that his claim was rejected and that correspondence to this effect would be issued by post.

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The Complainant states that the means by which the sensitive information regarding the rejection of his claim was disclosed, was unacceptable and unprofessional given the sensitive nature of the information. The Complainant submits that the first communication of this information should come from the Provider, not from a third party. This caused genuine embarrassment and stress for the Complainant.

The Complainant also says that there was a lack of transparency and the withholding of information by the Provider. The Complainant states that concerns were raised over the transparency of the appeals process and on **8 November 2019,** a request was made for the release of all correspondence relating to the claim. The request was processed and the information was received on **18 November 2019**.

The Complainant says that when the file was reviewed, it was established that not all information had been released by the Provider. The Complainant says the Provider subsequently confirmed that all information had been disclosed.

The Complainant advises that it was highlighted to the Provider that a letter from the Complainant's GP dated **3 October 2019** responding to a query from the Provider, had not been disclosed. The Complainant says the Provider furnished the letter but no explanation was given. The Complainant says he requested that an explanation be given as to why it had not been initially disclosed, but no explanation was given. The Complainant submits that he has genuine belief that this was a deliberate act on the part of the Provider to withhold important information because this letter confirmed, that following an examination of the Complainant's heart on **16 January 2019**, no cardiac abnormalities were present.

The Complainant also expresses concern over the *abrupt* closure of his claim appeal. On **6 December 2019**, the Complainant says the Provider advised that no decision had been made, the claim was still being reviewed and he would have a decision before **13 December 2019**. The Complainant explains that the Provider was advised that additional information would be forwarded from the Consultant Cardiologist for review, which would further reaffirm that no signs or symptoms of heart attack were present before **17 January 2019**. The Complainant states the Provider issued a decision the next working day, closing the claim appeal, before it received this information. The Complainant believes the timing of this, was *highly questionable*.

The Complainant has set out the implications of the Provider's conduct for him in terms of his health and continued health cover. The Complainant has also made a number of *Concluding Comments*.

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

The Provider explains that the Complainant incepted a health insurance policy on **16 January 2019**. The Provider states that all entrants who are new to health insurance, or those who had a break in health insurance cover for more than 13 weeks, are subject to a 5 year waiting period for any pre-existing conditions. In this case, the Complainant had a break in cover of longer than 13 weeks.

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The Provider states the Complainant was made aware of the waiting periods applicable to the policy at the quote stage, and also when the policy was confirmed. The Provider also states that the Complainant's son and wife were made aware of the waiting periods again, during a number of telephone calls, as they had permission to deal with the policy on behalf of the Complainant.

The Provider states that on **18 January 2019** the Complainant's son telephoned to confirm that the Complainant's policy was in place. The Provider says the Complainant had been admitted to hospital the previous day, but this was not disclosed to the Provider during this call.

The Provider advises that on **23 January 2019** an email was sent to the Complainant's son to advise that policy documents were available to view in the Members Area. The Provider advises that the Members Area includes the Rules Booklet where the term *pre-existing condition* is defined. The Provider also sets out this definition in its Formal Response. The Provider refers to section 9 of the Rules Booklet which sets out what is not covered, in terms of waiting periods and pre-existing conditions.

The Provider refers to the advice contained in the Rules Booklet to contact the Provider in advance of treatment to confirm cover. The Provider says the Complainant attended his GP on **16 January 2019** and was admitted to Hospital 1 as a public patient on **17 January 2019**. He was then transferred to Hospital 2 on **21 January 2019**. The Provider advises it was not contacted to confirm cover prior to these admissions.

In respect of the telephone conversation with the Complainant on **25 January 2019**, the Provider advises that this took place after the Complainant's discharge from hospital and before a second admission on **4 March 2019**. During this call, the Provider says the Complainant was advised that because he had a break from insurance cover, he would be subject to waiting periods, before he would be covered for any pre-existing condition.

During the calls with the various parties in **January 2019**, the Provider states the Complainant, his son and wife were advised that the Complainant would be covered immediately for any new condition, whereas any pre-existing condition would not be covered for 5 years.

The Provider states that to confirm cover, it requires the hospital name, consultant's name and the procedure code. The Provider states that during communications between **15** and **25 January 2019**, there was no reference by the parties to either the public or private hospital admissions. The Provider explains that as per page 7 of the Rules Booklet, the Provider's medical advisors decide, based on all the medical notes available, whether or not a condition is a pre-existing condition.

The Provider cites a passage from a referral letter from the Registrar in Hospital 1 to the Consultant Cardiologist in Hospital 2 and it says the symptoms, which fit the description of a pre-existing condition, were deemed by its medical advisors to be symptoms of Ischaemic Heart Disease/Coronary Heart Disease and not gastric issues.

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The Provider submits that the documented symptoms were ongoing for at least a year prior to the Complainant joining the Provider on **16 January 2019**. Therefore, it maintains that the claim was correctly rejected under the 5 year pre-existing condition waiting period rule.

The Provider advises that all medical information submitted by the Complainant's doctors was reviewed. The Provider says as per the general notes on **21 January 2019** from the Complainant's GP to the Consultant Cardiologist, "cardiac chest pain red flags" were discussed at the **16 January 2019** consultation. The **21 January 2019** referral also advises that on **17 January 2019**, the Complainant attended the emergency department with severe chest pain where his troponin levels were *progressively rising*.

The Provider explains that when heart muscles are damaged, troponin is sent into the bloodstream. As heart damage increases, greater amounts of troponin are released into the blood and high levels of troponin in the blood may indicate you are having or recently had a heart attack. The Provider states that an urgent angiogram was requested by the GP in the referral letter.

The Provider states the Complainant's epigastric pain and belching symptoms mirror the symptoms noted on the referral letter from Registrar in Hospital 1 sent to the Consultant Cardiologist in Hospital 2 which are documented as having been ongoing for a least a year prior to the Complainant joining the Provider. The Provider advises that its external medical advisors have deemed these symptoms to be of Ischaemic Heart Disease/Coronary Heart Disease.

On **16 July 2019**, the Provider states it received a report from the Complainant's GP with the following symptoms noted: "epigastric pain, chest pain and belching" (though this is disputed by the Complainant).

The Provider says that it was noted that these symptoms had been ongoing for three days prior to **21 January 2019**. However, this timeframe is at odds with both (i) the GP notes from the **16 January 2019** consultation and (ii) the more detailed referral from the Registrar to the Consultant Cardiologist in Hospital 2 where the symptoms were documented as having been ongoing for at least a year prior to the policy inception.

The Provider states that on **21 January 2019**, the Consultant Cardiologist recorded troponin levels as rising from 99 to 210. These notes also state that this condition started on **16 January 2019**, the day the Complainant's policy began. The Provider says that this is at odds with the Registrar's notes from Hospital 1, which documented the symptoms as ongoing for up to a year.

The Provider advises that at the initial assessment stage, based on the clinical information documented by the Complainant's medical team, its medical advisors determined that the signs and symptoms which prompted the hospital admissions, were present prior to the Complainant joining the Provider.

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A further independent review of the case was carried out following receipt of the Complainant's appeal request on **16 September 2019**. The Provider advises that this was reviewed by its external Medical Advisor Board, to ensure a fair and equitable outcome. The Provider has cited a number of passages from this report stating that the overriding medical evidence supports the case as being one of a pre-existing condition, as defined in the Rules Booklet.

The Provider's Final Response letter was issued on **6 December 2019**. The Provider acknowledges receiving letters from the Complainant's GP written on **18 December 2019** and **30 January 2020**. The Provider states that these letters were reviewed, the first of which states that the Complainant was treated for gastric symptoms on **16 January 2019** and the second of which provided no new clinical evidence that changed the rejection status of the claim.

The Provider advises that it received additional correspondence from the Registrar, the Complainant's GP and the Consultant Cardiologist on **19 June 2020** and all correspondence was reviewed by its medical advisors. The Provider states that as no new clinical information was contained in this correspondence, the original decision to reject the claim based on the pre-existing nature of the symptoms, remained unchanged.

Referring in particular to the letter from the Consultant Cardiologist, the Provider states that to satisfy the definition of pre-existing condition, it is sufficient that the Complainant had symptoms of coronary artery disease, even if he did not have a diagnosis.

The Provider advises that onset dates are established, based on clinical notes taken in real time, and not based on letters written after the fact.

The Provider acknowledges that due to human error, the letter of **3 October 2019** from the Complainant's GP was omitted from the medical notes provided to the Complainant on **15 November 2019**. On **8 November 2019**, the Provider says it received a request for the information on file in respect of the appeal. The appeals team responded on **11 November 2019** acknowledging the request and advised they were in the process of gathering the information. The Provider says this information was provided on **15 November 2019**.

The Complainant's son contacted the appeals team on **19 November 2019** noting that certain information was missing. The appeals team advised the Complainant's son on **28 November 2019** that they were not aware of any missing information and that they would be happy to review the request again. The Provider advises that on **28 November 2019,** the Complainant's son requested a copy of the letter dated **3 October 2019**. The Provider says the appeals team carried out a full review and established that this letter had been omitted. The Provider states this letter was reviewed by its medical advisors, however, it contained no new clinical information. The Provider advises that once an appeal is received, a full review of the claim and the accompanying clinical notes is undertaken by the appeals team. This team is separate from the original assessment team, to ensure a fair and equitable outcome. The Provider explains that additional clinical information may be sought and a review may be conducted by the Provider's Medical Advisor Board, or an external group of international medical advisors.

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In terms of the Complainant's position regarding the lack of transparency during the appeals process, the Provider refers to section 10.9 of the ***Consumer Protection Code 2012*** (the **Code**), stating the appeal was opened as requested on **16 September 2019** and an acknowledgement was sent on that date. The Complainant was provided with a direct contact number for a member of the claims appeals team and an email address, should he have any queries. An update letter on the status of the appeal issued every 20 working days and once a decision was made, following a thorough investigation, the Provider says a Final Response letter issued to him.

The Provider advises that during the course of the appeal, the Complainant's son contacted the appeals team via email on a number of occasions (i) to verity if information had been received, (ii) requesting medical information and (iii) requesting a specific date in which the appeal would be finalised. The Provider says each request was responded to and the status of the appeal was advised. In this regard, the Provider refers to correspondence between the parties between **16 October 2019** and **13 December 2019**.

In response to the contention that the Complainant was informed of his unpaid claim by the treating hospital, the Provider advises that claims are assessed on an ongoing basis and, once a month, claims are set for payment or rejection. Once this monthly process is complete, all claimants and providers are informed of the outcome of the claim.

In this case, the Provider says the two claims were rejected on **10 September 2019** and on **11 September 2019**, a statement of claim was sent to the Complainant's Members Area and Hospital 2. The Provider advises that it has no control once a hospital is advised of a claim rejection, as to how soon they would contact the Complainant for payment. This is part of the particular hospital's internal process.

The Provider states that as the Complainant had a communication preference of surface post, a postal statement of claim was prepared and these were sent on the Provider's behalf by a third-party on **19 September 2019**. The Provider submits that its conduct in this regard is in line with the claim notification requirement of the Code.

The Complaint for Adjudication

The complaint is that the Provider failed in its obligations to the Complainant, insofar as it:

1. wrongfully and/or unreasonably declined the Complainant's claims for policy benefits;

2. failed to communicate its decision to decline the claims to the Complainant; and

3. failed to conduct a proper appeal in respect of the Complainant's claims.

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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 **15 February 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. Following the consideration of numerous additional submissions from the parties, the final determination of this office is set out below.

It is important to emphasise that, for the purpose of assessing this complaint, it is not the role of this Office to comment on or form an opinion as to the nature or severity of the Complainant's symptoms, condition or diagnosis. It is the function of this Office to establish whether, on the basis of an objective assessment of the medical evidence, the Provider adequately assessed the Complainant's claim for the cost of treatment, in early 2019, and whether it was reasonably entitled to arrive at the decision it did to decline that claim, following its assessment of that medical evidence.

I am satisfied that this approach is in accordance with the views of the High Court in *Baskaran v. FSPO* [2016/149MCA], where the Court confirmed at paragraph 70, that:

> *"The function of the* [Financial Services and Pensions Ombudsman] *in considering the…complaint was, in general terms, to assess whether or not* [the Provider] *acted reasonably, properly and lawfully in declining the claim of the Appellant"*.

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The Policy Booklet

I note that the ***General Rules*** of the Complainant's policy are contained in the Policy Booklet. These are the rules of the scheme that the Provider makes available to its insured.

A *Pre-existing condition* is defined on page 5 as follows:

> *"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; or*
>
> *c) the day **you** changed **your scheme** and gained additional cover/**benefits**.*
>
> ***Please note that our medical advisors will determine whether a condition is a pre-existing condition. Their decision is final.****"*

Section 9 of the Rules sets out ***What is not covered under the scheme***:

> *"We will not pay benefits for the following*
>
> *(a) **Treatment** which a person requires during any waiting period that may apply to the **treatment** under their scheme. All waiting periods commence on a person's **membership start date** or the date of the change to their **policy/scheme**.*
>
> *Waiting periods which apply*
>
> - *the initial waiting period – this applies to any **treatment** that a person may require*
> - *the **pre-existing condition** waiting period – this only applies to **treatment** which a person requires for a **pre-existing condition***
> - *…*
>
> *…*
>
> *The pre-existing condition waiting period is*
>
> - *the first five **years** of membership*
>
> *…"*

Medical Evidence

- The notes from the Complainant's GP visit on **16 January 2019** state as follows:

  "drug prescription

  Omeprazole Actavis 20 mg gastro-resistant capsules, 1 caps daily (1 x 35 caps)

  gastritis / gord/ see rx . r/v prn."

- In a letter to the Provider dated **17 October 2019**, the GP explained that the notes of the consultation on 16 January 2019:

  "… were very brief as we were dealing with a busy surgery on the day."

- The *General Referral Form* completed by the Complainant's GP dated **21 January 2019** states:

  "… Attended our surgery on 16/01/2019 with epigastric pain, belching. Symptoms aggravated by food intake, worse when lying down, Some abdo distension. Nil typical cardiac symptoms at that time. Started on PPI and advised re cardiac chest pain red flags. Severe pain on Thursday and attended ED. Seen after – 5 hours and serial ECGs – NAD troponins – progressive rise. …"

- The Registrar and a Medical Intern in Hospital 1 appear to have written two apparently identical referrals to the Consultant Cardiologist in Hospital 2 dated **21 January** and **18 January 2019** respectively, noting that:

  "I wish to refer this [xx] *year old gentleman who presented to [Hospital 1] with atypical chest pain for consideration of inpatient angiogram …*

  [The Complainant] was admitted to [Hospital 1] under medical consultant … on 17/01/2019 for a 5-6 minute episode of chest pain. [The Complainant] described the pain as a burning sensation in his throat and central chest. He rated the pain as 8/10 but was subsequently relieved by belching. This episode of chest pain did not radiate to the jaw or left arm and was not associated with shortness of breath, diaphoresis, palpitations, nausea or vomiting. [The Complainant] mentions he has had this sort of pain in the past but it has been relieved by belching or Gaviscon. He does, however, describe reproducible chest discomfort on exertion.

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[The Complainant] describes himself as a fit and healthy man and used to walk 5-6 miles a day, however, in the past year he mentions that now he feels this burning pain in his throat after walking a couple of hundred yards and feels the need to belch.

This has subsequently limited his physical activity. These episodes are never associated with palpitations, shortness of breath, diaphoresis or nausea. …"

- The notes from the Complainant's admission to Hospital 2 dated **21 January 2019** have been provided by the parties. The handwritten notes state:

  "[The Complainant] was referred from [Hospital 1] as he had chest pain typical on 17/1/19 and ST depression on V5 & V6 + troponin [rising] 99 – 210.

  Condition started on 16/Jan/2019 while he was doing exercise – walking had central chest pain relieved by rest, was for 5 mins then next day on 17/Jan/2019 at 11:30pm while watching TV had severe central chest tightness for 10 min. Not radiating not associated with swelling or SoB or LoC or nausea or vomiting. Pt scored pain as 9/10. P had no PMHx or similar condition. Pt not smoker.

  Pt believed that pain relieved by belching but he has no epigastric pain or heart pain an Gi symptoms …"

I note that the Provider wrote to the Complainant's GP on **4 June 2019** asking certain questions in respect of the Complainant's hospital admission on **4 March 2019**. In response, the GP confirmed the Complainant first consulted him on **21 January 2019** with symptoms of epigastric pain, chest pain and belching and these symptoms had presented 3 days prior to their consultation.

The Complainant's son was advised during a telephone conversation on **16 September 2019** that the Complainant's claims were rejected. It appears that written correspondence to this effect was issued to the Complainant on **19 September 2019**. It also seems that although these details had already been made available by the Provider in the "Members Area", the Complainant's preference was for communications by way of surface post, and the letter in question did not issue until some days later.

<u>The Appeal</u>

An appeal was opened in respect of the Complainant's claim during a telephone call with the Complainant's son on **16 September 2019**. Thereafter, in response to a letter from the Provider, the Complainant's GP wrote to the Provider on **3 October 2019**, explaining:

"[The Complainant] attended our surgery on the 16th of January 2019 complaining of (in my opinion) typical of symptoms for a progressive gastritis – he had epigastric discomfort and belching, worse post food ingestion and when lying down.

There was NO chest pain and no compromised cardiac contractility/output symptoms.

He was on Methotrexeate and has also been on steroids recently, alongside other meds for unrelated medical condition – which, in my view contributed to the gastritis symptoms. We did discuss cardiac chest pain specific red flags on the day and I sent him home with a PPI prescription.

I was then called after a few days and informed [the Complainant] had presented to the Emergency Department with different sudden onset symptoms suggestive or cardiac chest pain and had a positive diagnosis of NSTEMI …"

The following month, by letter dated **22 November 2019**, the Complainant's GP wrote to the Provider as follows:

"This is clarify [the Complainant's] attendance on 16/01/2019 with me. …

[The Complainant] came in complaining of "gas" sensation to throat and bloating stomach – sensation relieved by belching. He has had the similar symptoms since 1978, worse with fresh bread, tomatoes, bananas … He also recalls drinking cold water helped relieve the symptoms.

He then asked me at that stage "Could this be reflux?" and I answered that it was the most likely explanation for his symptoms.

I went on to clinically examine his heart – by auscultating the 4 points, and I was satisfied that this part of the examination was normal. I also examined the abdomen – [the Complainant] does not recall this being tender, but I remember a slight reaction present and I proceeded to state that "Your heart is probably better than mine" and went on to prescribe anti-acids for him …

I was called a few days later by his wife, from the hospital and discussing the symptoms and presentation to hospital, I recall being surprised by the turn of events and telling [the Complainant's] wife that this development was unexpected and a different thing to his earlier presentation. …"

This was followed by a number of further letters from the Complainant's GP dated **18 December 2019**, **30 January 2020** and **10 June 2020**. The Complainant's son also forwarded a letter from the Consultant Cardiologist to the Provider dated **26 November 2019**. This letter states:

"In relation to [the Complainant's] claim I am attaching his referral from [Hospital 1] to me on the day of his admission for angiography and subsequent PCI following and (sic) acute admission for myocardial infraction.

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You can see that [the Complainant] has previously experienced a burning sensation in his throat which was relieved by belching and Gaviscon. This issue was being treated as gastritis and the patient was attributing this sensation with gastritis rather than any cardiac issue.

To the best of my knowledge no physician referred him on for cardiac assessment prior to this admission to [Hospital 1] on 17.01.2019 and there was no previous indication of cardiac problems. His sensation of burning in the throat was relieved by belching and Gaviscon and it would be fair to assume the patient was unaware there was anything more sinister than gastritis causing this.

He was limiting his exercise due to the discomfort of a burning sensation in his throat so exertional chest pain would be difficult for a patient to interpret in isolation. On giving his history to [doctor] (the registrar to the admitting consultant physician … in [Hospital 1]) the patient's instinct would have been to "put two and two together" and he describes to [doctor] as having felt this type of pain before, but this sensation was never associated with palpitations or shortness of breath.

At no point does the patient mention he sought further investigation of this sensation from either physician or a cardiologist as he was under the impression that it was gastritis and not cardiac. His first assessment from a cardiac point of view was the admission in January and given that up to that point both his GP and himself were interpreting this issue as gastritis I do not believe you can possibly assess that he had a pre-existing condition or in any way sought to mislead his insurance. …"

An *Expert Clinical Advisor Report* dated **25 November 2019** was prepared on behalf of the Provider by its external advisors, which states:

"… Currently [xx]*-year old male patient with coronary artery disease that has been treated invasively according to the enclosed documentation and the above summary of events since 16th of January 2019.*

Requests/Questions:

Requested Services:

1. *Based on the provided documentation, when is the earliest date on which the patient presented with signs and/or symptoms of chest pain?*

   On page 2 of the enclosed documentation the patient is cited as having had stable angina when exercising "in the past year" (that is 2018). <u>He described in detail "reproducible chest discomfort on exertion".</u>

   The general physician (page 27 of the enclosed documentation) interpreted the symptoms as gastritis and write that there were <u>no cardiac symptoms at that time which in the light of later events and better history taking (page 2) was proven to be wrong.</u> The physician clearly missed the diagnosis of stable

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angina pectoris. However, whether this was an avoidable mistake or not is difficult to say because there is no documentation on how the history had been taken by the doctor nor how it was given by the patient.

In the following notes the misinterpretation of gastric pain in repeated.

[underlining added for emphasis]

2. *Please provide an approximate time frame during which it is likely the patient would have first experienced symptoms related to chest pain?*

   The patient himself, according to doctors documentation, has given "in the past year" (that is 2018) as the time frame for symptoms of stable angina.

3. *Can [the Medical Advisors] please advise based on the attached medical notes and medical opinion if the symptoms the member first presented to his GP with, which led to his eventual admission and procedures were present prior to joining [the Provider] on the 16th January 2019 i.e. did the symptoms persist and manifest and lead to the eventual diagnosis and treatment?* ***Yes***

   see above

   Whether the patient was aware of the cardiac nature of his symptoms or not, cannot be said. The GP who was treating him for "gastritis" was either not asking the right questions or simply failing to make the right diagnosis. It is not clear for me whether the patient had attended his GP before the 16th of January because of these symptoms or whether it had been the first time. Again, the history on page 2 (one year of stable angina) and the impressing risk profile of the patient, point directly towards the diagnosis of coronary artery disease.

   Has the patient attended his GP for these symptoms before January 16th, 2019?"

[underlining added for emphasis]

In an email from the Consultant Cardiologist dated **26 November 2019**, she states that:

"… I have gone through his notes extensively and there is no suggestion or history of coronary artery disease prior to his presentation on 17.01.2019. …"

The Provider wrote to the Complainant in respect of his appeal on **6 December 2019**.

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The letter of **6 December 2019** states:

> *"… These claims were declined based on the advice of our Medical Advisors who determined that the condition and symptoms, which prompted the above admissions, were present prior to the inception of your [Provider] policy on 16 January 2019.*
> *Consequently, your claims were not eligible for benefit in line with the pre-existing condition waiting period.*
> *…*
>
> ***Appeal***
>
> *Following receipt of your appeal the circumstances surrounding the rejection of the above claims had been further reviewed, in association with additional clinical information. In order to establish the onset date of your condition symptoms and to ensure a fair and equitable outcome, the information provided for review had been independently assessed by our external Medical Advisory Board.*
>
> ***Background***
> *…*
> ***Review of Documentation and Medical Records***
>
> - *The documented evidence, which was made available to us, clearly demonstrates that the condition of Ischaemic Heart Disease/Coronary Heart Disease and the associated signs and symptoms you presented to [Hospital 1] with on 17 January 2019 were present prior to joining [the Provider].*
> - *This determination was established based on the detail of your presenting symptoms and relevant clinical history in the medical record provided by your treating physician at that time … in his letter dated 21 January 2019. The letter documents the following ' … '*
> - *On the 17 January 2019, the day after joining [the Provider], you were admitted to [Hospital 1]. We note during this admission that referrals were made by [the Registrar] and by your GP … on the 21 January 2019 to a Consultant Cardiologist in [Hospital 2], detailing the findings of your investigations which further led to your cardiac diagnosis and subsequent surgery.*
>
> *In conclusion, following a peer-to-peer review by a Cardiovascular Disease and Internal Medicine Consultant of all the clinical information secured, it is their reasonable medical opinion that the pre-existing condition of Ischaemic Heart Disease/Coronary Heart Disease had evolved prior to your date of joining. It has also been established that the symptoms, which you described and presented with on the 16 and 17 January 2019, and subsequently investigated, confirmed the diagnosis of Ischaemic Heart Disease/Coronary Heart Disease, which had manifested prior to joining [the Provider].*

/Cont'd…

Therefore, taking the recommendations of our Medical Advisory Board into consideration, we are unable to consider your claim for treatment …"

In an email dated **14 June 2020**, from the Complainant's original GP to the Complainant's son, the GP states that:

"… I have spoken with [the Complainant's current GP] and I understand a letter was going to be issued confirming there was no presentation with any cardiac signs or symptoms before the event resulting in admission.

If I recall correctly, I wrote at least 1 letter underlying my opinion as to there not being any cardiac symptoms or findings during my examination. I stand by that letter.

I will also state that I was not contacted in relation to the attached reports for my opinion by [the Provider] or the doctor who wrote the reports at any time."

An *Expert Clinical Advisor Report* dated **29 June 2020** and prepared for the Provider states that:

"Patient Clinical Information
…
Currently [xx]-*year old male patient with coronary artery disease that has been treated invasively according to the enclosed documentation and the above summary of events since 16th January 2019.*

Requests/Questions:

Requested Services:

The additional documentation does not clarify the information that is given in a letter in the original documentation …. The symptoms are described that retrospectively appear to be atypical angina during exertion: '… in the past year … feels this burning pain in his throat after walking a couple of hundred yards…'.

He was not treated for these complaints as heart related and the assessment as atypical angina is a retrospective one. The patient was not aware of the fact that this was atypical angina pectoris. Chest pain as the question is, he has (sic) not have.

There is no rule for when a patient is likely to experience chest pain when having coronary artery disease. The variability is just too big and the correlation between the objective findings and the subjective symptoms is too bad.

/Cont'd…

> ***See Rationale***
>
> *See above. Even if we understand the patient's symptoms 'in the past year' before admission as atypical angina and first sign of coronary artery disease, this is a retrospective assessment that neither the patient nor his physicians were aware of."*

Analysis

The Complainant's claims for the cost of medical treatment were declined by the Provider and his appeal was rejected, on the basis that his admission to hospital in **January 2019** and subsequent associated treatments and procedures were for the purpose of treating what was a heart condition, that pre-existed his cover with the Provider.

I note that the Complainant's policy contains rule regarding a 5 year waiting period to be covered for the cost of treatment for any *pre-existing condition.* In that regard, policy benefits will not be paid for treatment received during that 5 year period, in respect of such conditions. That 5 year waiting period must first be served by the member of the scheme.

The policy also defines the term *pre-existing condition*. As can be seen, this definition does not require a policyholder to have an existing diagnosis, to have a name put on their symptoms, to have received treatment or to have been assessed for a particular identified condition, in order for a condition to be considered "*pre-existing*" within the meaning of the policy. Neither does it matter how sudden or unforeseen the condition was, or that a diagnosis was only made after the policy was incepted.

Instead, the policy definition of "*pre-existing*" is met, if:

> "*the **signs or symptoms** of that ailment, illness or condition **existed** at any time in the period of 6 months immediately preceding"* the policy inception date.
>
> [My emphasis]

This policy definition of *pre-existing condition* is clearly set out to the policyholder, within the scheme rules of the policy which the Provider makes available, which I have quoted from above at page 9. Indeed, this information is readily available to the public, as this "*pre-existing condition*" rule (which requires that a wating period is served by the scheme member, before being covered for that pre-existing condition) is an industry standard, implemented by all providers of private medical health insurance in Ireland.

I do not accept in that regard the Complainant's contention that this is a "*loophole*". The policy definition does not require the Complainant or his medical advisors to have been aware of the import of, or of the potential diagnosis from, the signs or symptoms exhibited by the Complainant. Instead, all that is required for the definition to be met, is that the signs or symptoms ***existed*** before cover was incepted.

/Cont'd…

I accept in that regard that notwithstanding his experience over the previous year, of ongoing burning pain in his throat when walking a couple of hundred yards, that the Complainant may have been unaware that the symptoms he was experiencing were of a cardiac nature. It seems that it was only on 17 January 2019, whilst watching TV, that he then realised that in fact he required immediate medical attention.

The Provider has referred to the information it relied on in considering the Complainant's claim and appeal. This includes the Complainant's GP records, referrals, admission notes, correspondence received from his treating physicians and certain medical reports.

Having considered the correspondence prepared by the Complainant's GP and by his Consultant Cardiologist, I am conscious that this correspondence does not refer to or acknowledge the very specific policy definition of "*pre-existing condition*". Neither do the authors of this correspondence demonstrate that their opinions are based on, or take into account, the policy definition of "*pre-existing condition*".

This correspondence appears to me to offer the particular individual's opinion of the Complainant's condition and symptoms, but without any apparent appreciation or consideration of the specific policy definition of a "*pre-existing condition*", which is relevant to the level of cover available to the Complainant, under his policy with the Provider.

It is important to note that it is of no relevance that the Complainant had not received a diagnosis for his symptoms on 16 January 2019, i.e. that no name or title had been suggested for his symptoms. Neither is it relevant that his General Practitioner did not recognise his symptoms as anything other than potential gastritis, or that the GP it seems, failed to consider potential cardiac issues to be relevant to those symptoms.

What is relevant is that the existing symptoms experienced by the Complainant before the policy inception, which it is suggested were gastric symptoms, were in fact the symptoms of a condition for which the Complainant then very shortly after policy inception, required medical treatment. I am satisfied that this is what the Provider was entitled to take account of, in determining that the medical treatment which the Complainant underwent, was for a "*pre-existing condition*" within the meaning of the policy terms and conditions. I accept that the Provider was entitled to form the opinion that the treatment the Complainant underwent in January 2021, was not for a "new" condition.

The Complainant had submitted evidence and made extensive submissions to support his opinion that his heart condition was not a "*pre-existing condition*". However, having considered the evidence and the Provider's assessment of the Complainant's claims and subsequent appeal, I am satisfied the Provider adequately assessed both the claims and the appeal. Further to this, I am satisfied that I should accept that the Provider was reasonably entitled to decline the claims and the Complainant's subsequent appeal.

/Cont'd…

The Complainant takes the view that the *Expert Clinical Advisor Report* dated **25 November 2019** was "absurd" to offer the opinion that:

> *"The physician clearly missed the diagnosis of stable angina pectoris. However, whether this was an avoidable mistake or not is difficult to say because there is no documentation on how the history had been taken by the doctor nor how it was given by the patient.*

I am satisfied that this was a reasonable conclusion for the Provider's expert to come to, given the medical evidence from the Registrar and from a Medical Intern in Hospital 1, who both wrote identical referrals to the Consultant Cardiologist in Hospital 2 dated **21 January** and **18 January 2019** respectively, noting amongst other things that:

> *in the past year he mentions that now he feels this burning pain in his throat after walking a couple of hundred yards and feels the need to belch.*

I do not accept the Complainant's suggestion that the authors of this "*retrospective*" report have a conflict of interest, in confirming their medical motes at the time of the Complainant's referral. In my opinion (i) the Complainant's own doctors, (ii) the medical professionals who treated the Complainant, and (iii) any medical professionals instructed by the Provider are capable of each offering their professional opinion, whether they were instructed by the Complainant or by the Provider. I also accept the Provider's comment that the review it instructed was conducted by a global provider of quality independent medical reviews.

I do not accept the Complainant's comment that the Provider has "*manipulated*" the Complainant's medical history. I note that, more recently in 2021, the Complainant was diagnosed with a hiatus hernia, which is the cause of ongoing symptoms. This does not however alter my opinion that in 2019, the Provider was entitled to take the view that the medical treatment undergone by the Complainant, was for a condition the symptoms of which pre-existed the inception of his medical cover with the Provider on 16 January 2019.

Turning to the manner in which the Provider notified the Complainant of its decision regarding his claim, the Provider advises that the claims were rejected on **10** and **11 September 2019**, and that statements of claim were sent to the Members Area and to Hospital 2. The Provider advises these were posted to the Complainant by a third-party on its behalf, on **19 September 2019**. While a copy of this correspondence has not been made available, it is not disputed by the Complainant that the letter dated **19 September 2019** was received.

It appears from the documentation submitted by the parties that the first indication to the Complainant of the Provider's decision to decline the claims, was an invoice from Hospital 2 dated **13 September 2019**. During a telephone conversation with the Complainant's son on **16 September 2019**, the Complainant's son indicated that an invoice had been received from Hospital 2 that morning and he was contacting the Provider, in essence, to find out what the invoice related to. It was during this conversation that the Complainant's son was advised that the claims had been declined.

/Cont'd…

The Provider's letter of **19 September 2019** issued within 6/7 business days after its decision to decline the claims. Section 7.16 of the Consumer Protection Code states that the Provider must inform the Complainant of the outcome of its assessment of a claim in writing within 10 business days of the completion of its assessment. While it was upsetting to the Complainant that he received an invoice from Hospital 2, before being informed by the Provider of the rejection of his claim, I am not satisfied that the Provider's conduct in respect of the manner in which the claims decision was communicated to the Complainant was unreasonable.

That said, I believe that the Provider should look to ensure that when a policyholder has a preference for postal communications, that any information made available by way of the Members Area, is also communicated to the policyholder by post, with the minimum of delay.

The Complainant submits that the Provider failed to conduct a proper appeal in respect of his claims, citing a lack of transparency, poor communication, absences of explanations, a failure to properly consider the evidence, and abruptly closing the appeal. The appeal was logged during a telephone conversation with the Complainant's son on **16 September 2019**.

I note that this appeal was acknowledged by the Provider by letter dated **16 September 2019** which advised that the appeal was being investigated, provided contact details for the Provider and identified the relevant Appeals Administrator. This was followed by a number of emails, letters and telephone conversations with the Complainant/the Complainant's son regarding the progress and status of the appeal between **September** and **December 2019**.

A request was made by the Complainant for a copy of all information held by the Provider in respect of the Complainant's claims on **8 November 2019**. This was later furnished by the Provider. The Complainant's son then identified that a letter from the Complainant's GP dated **3 October 2019** had not been included in the information provided, and by email dated **29 November 2019** he requested an explanation for this. In response to this email, while not necessarily providing a reason for its omission (which the Provider states above was due to human error) the Provider advised that this letter was being reviewed by its medical advisors.

It is disappointing that the Provider did not provide a reason as to why this letter had been omitted from the documentation furnished to the Complainant, though this appears to have been a single and isolated incident. I do not accept that this means that the letter was not considered by the Provider as part of the appeal; the letter was in the Provider's possession, so it is simply a case of it not having been originally included in the documentation forwarded to the Complainant as part of his request. I also note that as part of the appeal, the Provider sought certain medical records from the Complainant's GP on **2** and **16 October 2019**.

Having considered at length the evidence made available by the parties , I do not accept the Complainant's suggestion that the Provider failed to conduct a proper appeal in respect of his claims.

/Cont'd…

I note in that regard that additional information was sought by the Provider, further information was provided by the Complainant and an *Expert Clinical Advisor Report* was requested for the purpose of addressing that appeal. Separately, additional information was made available by the Complainant after the Provider's decision on the appeal, and a further *Expert Clinical Advisor Report* was commissioned by the Provider in **June 2020**.

More recently, in offering comments to this office, the Provider indicated that although it was satisfied that the Complainant's claims had been correctly rejected based on the information received, nevertheless:

> *"If the Complainant has **new** clinical information which has not been submitted previously we would be happy to have this reviewed by our internal medical advisors and by external advisors, if necessary."*

I am conscious that in response to this communication in April 2021, the Complainant went to the trouble of submitting a gastroscopy report and supporting letter from his general practitioner, and the Complainant made additional submissions regarding the nature of the symptoms he had experienced in the period up to 16 January 2019, as distinct from the symptoms which gave rise to his need for medical attention on the night of 17 January 2019.

I note that by way of response to the submission the Provider then advised that it:

> *"assesses claims based on the clinical information presented with a claim during the assessment and appeals stages. This information is recorded by the medical professionals involved with the case in real-time and as such [the Provider] are entitled to rely on this information when assessing claims."*

It is disappointing in those circumstances that the Provider led the Complainant to believe that it was open to him to submit "**new**" clinical information which had not been submitted previously, when in fact it was giving the Complainant the opportunity to submit any medical evidence that was contemporaneous to the events of and leading up to January 2019. One can understand the confusion caused to the Complainant in that regard.

Whilst this is regrettable, nevertheless, insofar as the substantive complaint against the Provider is concerned, that it unreasonably declined the Complainant's claims, failed to communicate its decision to decline the claims to the Complainant and failed to conduct a proper appeal in respect of the Complainant's claims, taking all of the evidence available into consideration, I do not consider it appropriate to find that there was wrongdoing by the Provider and accordingly, there is no aspect of this complaint which can 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.

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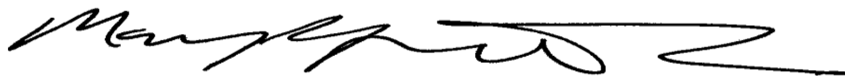
The above Decision is legally binding on the parties, subject only to an appeal to the High Court not later than 35 days after the date of notification of this Decision.



MARYROSE MCGOVERN
DEPUTY FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

19 October 2021

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.