Decision Ref: 2021-0518

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

This complaint concerns a health insurance policy.

The Complainant's Case

The Complainant has been a customer of the Provider since in or about **2016**. He had changed his policy in **2019** and states that he increased his level of cover and maintained continuity of insurance.

The Complainant underwent sinus surgery in **2019** in a private hospital. The Complainant had tissue and polyps removed from his sinuses during this surgery. The Complainant contends that the cause of the issue requiring the procedure was something he had never suffered from before and claims that this is supported by his medical professional.

The Complainant asserts that the Provider denied his claim stating that the illness requiring the procedure was pre-existing and/or as a result of an injury incurred in the Complainant's teenage years.

The Complainant made further submissions to this Office on **14 December 2020** stating that the Provider's response failed to address the fact that the polyps were not a pre-existing condition and *"communication with regard to the procedure being covered fully at another third party hospital under current insurance at the time/options"*.

The Complainant made further submissions dated **18 December 2020** wherein he stated that *"the fact remains. Nasal polyps were not a pre-existing condition"*.
The Complainant made further submissions dated **12 January 2021** stating that the Provider continues *"to unilaterally job-lot my nasal polyps with a pre-existing sinus condition"*. He states that the sinus condition and the polyps are *"distinctly two separate conditions"* and reiterates that his nasal polyps were not pre-existing. The Complainant attached a medical report from his consultant dated **24 October 2019** in this regard.

The Complainant made further submissions to this Office dated **31 January 2021**. He stated therein that the examination that found no polyps did not take place after the fact and the records show that he was examined in **2018** and the consultant's registrar *"did not document any evidence of nasal polyposis"*. Again, the Complainant reiterates that nasal polyposis is a distinctly separate condition to sinusitis. The Complainant also reiterates that he should have been informed by the Provider that he was fully covered in another third party hospital.

The Complainant wants the Provider to pay his claim in the sum of €2,675.32.

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

By way of Final Response Letter dated **05 December 2019**, the Provider wrote to the Complainant stating that his claim was declined. The Provider stated that the claim was declined as the information provided by the Complainant indicated that the nasal symptoms which prompted his referral for surgery were present prior to the Complainant increasing his benefits on **1 January 2018** to include cover for the private hospital where the surgery took place. The Provider stated that as the Complainant was serving a two-year upgrade waiting period. It states that his claim was assessed in accordance with his previous scheme of insurance which does not provide cover for the private hospital the Complainant attended.

The Final Response Letter notes that the Provider further considered the claim following the appeal lodged by the Complainant in respect of the declination of his claim.

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The Provider notes the following in its Final Response Letter:

- On **28 October 2016**, the Complainant consulted with his GP and his GP noted that he suffers with *"recurrent sinus trouble"*;
- On **2 December 2016**, the Complainant consulted with his GP in relation to sinus congestion and blockage.
- On **1 December 2017**, the Complainant consulted with his GP and the GP noted that the Complainant had *"nasal obstruction sinus congestion"* and upon examination that the Complainant had *"septal deviation"* from an old injury.
- On **1 December 2017**, the Complainant's GP referred him to a specialist who documented that the Complainant had an old football injury to his nose incurred at aged 17 and has had *"septal deviation since"*. The specialist also documented that the Complainant *"always has nasal blockage"*, has a *"tendency to sinus infections"* and *"mouth breathes due to nasal obstruction"*.
- On **1 January 2018**, the Complainant increased its benefits to include cover for a particular private hospital. When benefits are increased, there is a two-year upgrade waiting period before you can avail of the increased benefits.
- On **24 April 2018**, the Complainant consulted with the registrar to the specialist and his GP documented that he would undergo a CT scan of the sinuses for assessment of his symptoms.
- On **15 February 2019**, the GP notes documented that the Complainant had not received an appointment for the sinus CT and would consider going privately for same. These notes document that the Complainant presented with *"some fatigue likely related to chronic sinus issues"*.
- On **23 February 2019**, the Complainant underwent a sinus CT scan, following which he was re-referred to the consultant.
- On **14 March 2019**, a letter from the consultant to the GP documented that the Complainant was seen by the consultant due to *"chronic bilateral nasal obstruction and pain across the nasal bridge, postnasal drip and hyposmia"*. The consultant noted that he had listed the Complainant for *"endroscopic sinus surgery and nasal polypectomy"*.
- On **02 May 2019**, the Complainant underwent the above surgery at the private hospital which he had extended his benefits to cover.

The Provider stated that based on the information provided by the Complainant for review, its medical advisors have concluded that the nasal symptoms which prompted referral and surgery were consistent and ongoing prior to the Complainant increasing his

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benefits on **1 January 2018**. Therefore, the Provider stated that the upgrade waiting period of two years applied and it was unable to cover the treatment undertaken.

The Provider asserts that it did not reject the Complainant's claim because of a broken nose, rather it rejected the claim based on the two year additional cover waiting period for pre-existing conditions. The Provider states that since **2016**, the Complainant has had a history of slowly worsening chronic sinus inflammatory disease which eventually led to development of overt nasal polyposis. Due to this, the Complainant underwent functional endoscopy surgery in **May 2019** which the Provider states is a type of surgery used to treat chronic or recurrent sinus infections or to remove polyps from the nose. The Provider states that the development of nasal polyps was an expression of the Complainant's underlying symptom and furthermore that the surgery was not only to remove the polyps but also to restore sinus functionality leading to healing of the chronic inflammatory condition. The Provider also states that a review carried out by independent medical review specialists has also deemed this procedure to relate to a pre-existing condition dating back to **2016**.

The Provider states that it is of the view that the condition which required surgery was pre-existing based on its medical advisors' opinion. It also stated that the other third party hospital referenced by the Complainant was also subject to the same 2-year upgrade rule as applicable to the hospital where the Complainant had the surgery.

The Provider made further submissions dated **5 January 2021** wherein it stated that *"nasal polyps is just an expression of the underlying condition. The surgery was not only to remove the polyps but also to restore the sinus functionality leading to healing of the chronic inflammatory condition. The Complainant has since **2016** a history of slowly worsening chronic sinus"*.

The Provider made further submissions dated **21 January 2021** wherein it states that the consultant's report submitted by the Complainant and dated **24 October 2019** was previously reviewed by the Provider's medical advisors but it was written after the fact and the Provider's medical advisors only assess claims based on clinical notes which were written in real time.

<u>The Complaint for Adjudication</u>

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The complaint is that the Provider wrongfully failed to admit and pay the Complainant's claim on his health insurance policy.

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 11 November 2021, outlining my preliminary determination 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, within the period permitted, I set out below my final determination.

I note that the Complainant originally incepted a health insurance policy with the Provider on **6 January 2016**. The Complainant had this policy from **6 January 2016** to **31 March 2017** and then switched policy from **1 April 2017** to **31 December 2017** before switching policy again from **1 January 2018** to his current policy.

The policy switch made by the Complainant on **1 January 2018** included cover for private hospitals. I note that section 8 of the policy rules states that:

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> *"A person's additional cover waiting period…shall be the first two years following their membership start date"*

This means that the Complainant would not be covered in private hospitals for any pre-existing conditions for a period of two years from the date of upgrade.

I note that the Complainant filled out the Provider's online cover checker and entered the onset date of his symptoms as **1 January 2018**. Cover was confirmed for the Complainant for his procedure on this basis. I note that the Provider has furnished documentary evidence that the two year waiting period warning appears when using the online checker to confirm cover for a procedure.

Based on the foregoing, I accept that the requirement of a waiting period was made clear to the Complainant both in his policy document and at the time he checked his proposed procedure cover online.

I note that the Complainant is adamant that his development of nasal polyps is separate from his ongoing nasal problems and that the Provider disputes that, asserting that the Complainant's medical history (outlined in the Provider's response above) show that since **2016**, he has had a history of slowly worsening chronic sinus inflammatory disease which eventually led to development of overt nasal polyposis. In this regard I note that on **24 November 2020**, further to this complaint being made, the Provider engaged a medical review company to review the medical circumstances of the Complainant's complaint. This review stated that *"due to the CT finding in **February 2019** (mucoperisteal thickening) the client had, in my opinion, a long standing chronic sinus problem. Development of nasal polyps is just an expression of the underlying condition. The surgery was not only addressed to remove the polyps but also to restore sinus functionality leading to healing of the chronic inflammatory condition. It is therefore likely that the client had chronic sinus problems before **1/1/18** even thought the polyps were not overt until sometime between **February 2018** and **May 2019**"*.

Based on the medical history of the Complainant and based on the findings of the further medical review commissioned by the Provider, I accept that it was not unreasonable for the Provider to decline the Complainant's claim on the basis that the records and advice received indicated that the nasal polyps were a result of the Complainant's chronic nasal problems, rather than being a separate condition.

In respect of the issue raised by the Complainant concerning his coverage at another hospital, I note that during a phone conversation between the Complainant and a representative of the Provider (**Call 306293F003- date uncertain**) there was a conversation

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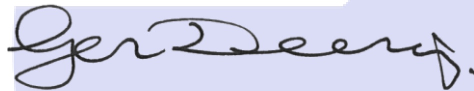
as to which hospitals in Dublin the Complainant was covered for his procedure and that three hospitals were mentioned. I note that the representative of the Provider supplied the information concerning coverage to the Complainant on the basis that the Complainant told her during the phone conversation that the issue he was suffering from had just recently arisen.

For the reasons set out in this Decision, I accept that the Provider was entitled to decline the Complainant's claim and accordingly, I do not uphold this complaint.

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.



GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

15 December 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

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(b) ensures compliance with the Data Protection Regulation and the Data Protection Act 2018.