An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0523
Sector:	Insurance
Product / Service:	Payment Protection
Conduct(s) complained of:	Rejection of claim - pre-existing condition Disagreement regarding Medical evidence submitted
Outcome:	Partially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The complaint concerns a claim under a Payment Protection Policy that the Complainant holds with the Provider.

The Complainant's Case

The Complainant submits that she underwent a successful total hip replacement in **Spring 2017**. The Complainant states that five weeks following the hip surgery she had a fall on the same side of the body as her operation and that following the fall, she was diagnosed with muscle atrophy.

The Complainant states that she sent a claim to the Provider pertaining to the muscle atrophy condition and the Provider refused to admit the claim on the basis that the muscle atrophy is linked to a pre-existing hip condition.

The Complainant submits that she appealed the decision not to admit the claim and the Provider has maintained its position on the matter.

The Provider wrote to the Complainant on **4 October 2019** to confirm its decision that it was unable to admit the claim. The Provider submits that its decision is based on its conclusion that as the Complainant had developed symptoms of muscle atrophy following

the surgery for the pre-existing hip condition, the muscle atrophy condition is linked to the total hip replacement and is therefore excluded from cover under the policy.

The Complainant rejects the Provider's position that the muscle atrophy condition is linked to the pre-existing hip condition. The Complainant submits that the muscle atrophy condition is a new unrelated condition.

The Complainant submits that there was a gap of time between her hip surgery and the fall and as a result of the fall she was diagnosed with muscle atrophy. The Complainant submits that her treating consultant orthopaedic surgeon referred her for an MRI following the fall. The Complainant submits that the orthopaedic surgeon has confirmed in a letter that "*it is far more likely that her abductor deficit occurred as a result of a fall than any pre operative issue*" and that this along with the results of the MRI are confirmation that the muscle atrophy condition is a new unrelated condition.

In a correspondence dated **14 August 2020** the Complainant advised that she had not returned to work. The Complainant states that when she had her hip operation she was told she would be out for 3 plus months. The Complainant questions how she could return to work in between each condition if it was just her total hip replacement. The Complainant states she would have returned to work after the three months, but as it was, she had no strength in her right leg and had to walk any distance with a walking stick, due to her muscle atrophy.

In her submission dated **5 April 2021** the Complainant says the injury she received was a new injury, and that she will have a limp for the rest of her life due to her muscle wastage from the fall she had.

The Complainant wants the Provider to admit the claim for the Muscle Atrophy condition.

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

The terms and conditions of the policy that the Provider is relying on in its denial of the claim, state:

> *"We will not pay any Accident or Sickness benefits if Your Accident or Sickness results from:*
> - *any Pre-Existing Medical Condition;"*

It is the Provider's position that the primary condition is pre-existing which is a specific policy exclusion. The Provider says the Complainant has advised that she does not wish to claim for the hip condition as she acknowledges this is pre-existing. The Provider however states that in order for the Complainant to claim for a new condition, she would have needed to have returned to work between each condition. The Provider states that if the Complainant did not return to work after her hip replacement then she was still signed off as unfit to work and therefore, not working at the time she requested to claim for a new condition.

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As regards the Complainant's MRI and how the results of the MRI impacted on the claim, the Provider states that the results following the Complainant's MRI have been taken into account during the assessment process. The Provider says the results do not furnish it with suitable information that would make the Provider reconsider its original decision. The Provider says there is no definitive information within the MRI results that show the primary condition that the Complainant is suffering from, is due to her post operative fall.

The Provider states that whilst it acknowledges that the Complainant has experienced a setback in recovery due to her post operative fall, the Provider still has no confirmation from the medical professionals involved, that the primary condition that is preventing her from working has changed. The Provider therefore says it has used the medical information that it has received and asserts that the primary condition that is preventing the Complainant from working is her Total Hip Replacement.

As regards the medical report from the Complainant's consultant orthopaedic surgeon and its consideration by the Provider, the Provider says the medical report has been taken into account during the assessment of the claim. The Provider says the medical report advises that the Complainant had complained of a limp and had been experiencing pains that have been ongoing, but had worsened as time went on. The Provider's position is that there is no evidence that the pain that the Complainant was suffering from was solely due to her fall.

The Provider states that the condition that the Complainant is wishing to claim for is pre-existing. The Provider says whilst it understands that the Complainant sustained a fall post her operation, the medical information suggests that it is all linked to her Hip Replacement. The Provider submits that the medical professionals involved in this specific claim have not confirmed that the pain and current reason for being signed as unfit to work, is solely due to the Complainant's fall.

The Provider states that since the final response letter was sent to the Complainant, the Provider has received further medical information that advises the Muscle Atrophy may have been caused by the Complainant's fall. The Provider says however, as it has not received any confirmation that the primary condition that the Complainant is suffering from is not her Total Hip Replacement, then it is not in a position to overturn its decision.

The Provider submits that additionally, it has not been furnished with confirmation that the Complainant returned to work in between each condition. The Provider states that in order to claim for a new condition (which the Complainant wishes to do), the Complainant would have needed to return to work in between the conditions and provide evidence of this which to date has not been furnished.

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Evidence

Policy Provisions

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When can You claim for Accident or Sickness Benefit?
*If **You** are unable to **Work** because of an **Accident** or **Sickness** for at least 30 consecutive days, **We** will pay **Your Credit Union** one **Monthly Benefit**. **We** will continue to pay one **Monthly Benefit** in respect of each complete and continuous 30 day period **You** are unable to **Work** because of an **Accident** or **Sickness** until the first of the following occurs:*
*• **You** cease to be unable to **Work** due to an **Accident** or **Sickness**;*
*• **You** fail to provide **Us** with proof of an **Accident** or **Sickness**;*
*• **We** have paid a maximum of 24 **Monthly Benefits** in respect of any one event of **Accident** or **Sickness**;*
*• The policy **End Date**.*
*Periods of **Accident** or **Sickness** separated by less than 3 months will be treated as one continuous period of **Accident** or **Sickness**.*

*If **We** have paid the maximum number of **Monthly Benefits**, **You** must return to **Work** for a continuous period of 6 months before **You** are entitled to make another claim for a related condition or 1 month for an unrelated condition.*

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When can You not claim for Accident or Sickness Benefit?
***We** will not pay any **Accident** or **Sickness** benefits if **Your Accident or Sickness** results from:*
*• any **Pre-Existing Medical Condition**;*
*• any **Chronic Condition** which is existing or which **You** knew about at the **Commencement Date**. This includes where **You** were exhibiting the symptoms whether specifically diagnosed or not or for which **You** were receiving medical treatment or advice during the 12 months preceding the **Commencement Date**;*

Page 4 Section 12 – Meaning of Words/Definitions
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Pre-Existing Medical Condition
A medical condition, injury, illness, disease, sickness or related condition and/or associated symptoms, whether diagnosed or not, which exist prior to the start date of the policy either:

*(i) for which **You** received treatment in the 12 months up to and including the **Commencement Date**, or*

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*(ii) which **You** were aware of, or in **Our** opinion **You** should have been aware of, during the 12 months up to and including the **Commencement Date**.*
*Unless **You** have been symptom free and not consulted a **Doctor** or received treatment in the 12 months preceding the claim.*

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Sickness
*A medical condition or disease, after it is diagnosed and confirmed by **Your Doctor** and occurring whilst **You** are in **Work**, which stops **You** doing **Your Work** or any **Work** that **Your** experience, education or training may reasonably qualify **You** to do.*

Work / Working / Worked
Permanent gainful Employment or Self Employment paying the correct Pay Related Social Insurance (PRSI) contributions in Ireland or National Insurance (NI) contributions in the UK".

The Complaint for Adjudication

The Complaint is that the Provider has wrongly and/or unfairly refused to admit the Complainant's claim for a muscle atrophy condition.

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 **23 November 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

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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, the final determination of this office is set out below.

Analysis

The evidence shows that the Complainant submitted a claim to the Provider in July 2019. The claim for benefit was in respect of two medical conditions - Total Hip Replacement and Muscle Atrophy. Both medical conditions were set out on the one Claim Form dated **29 July 2019**. The Total Hip Replacement was carried out in April 2018 (the Complainant being in hospital from **16 April** to **19 April 2018**).

The claim in respect Total Hip Replacement was refused by the Provider by way of letter dated **29 August 2019**, on the grounds that the medical condition requiring the Total Hip Replacement was considered to be pre-existing.

The Complainant accepted that the medical condition requiring the Total Hip Replacement was a pre-existing medical condition, but disputed that the Muscle Atrophy was a pre-existing medical condition. The Complainant states that the Muscle Atrophy resulted from a fall 5 weeks after the Total Hip Replacement.

It is noted that by way of letter dated **4 October 2019** the Provider remained of the position that the claim for either medical condition was not covered. In this letter the Provider advised:

> *"Upon review of the medical records provided, I note that following your operation for a right total hip replacement, you had developed Muscle Atrophy.*
>
> *From the information provided, I note that you have exhibited symptoms of Muscle Atrophy since your hip replacement. Therefore, it is reasonable for us to conclude that your symptoms are linked to your previous total hip replacement.*
>
> *Due to your hip condition being pre-existing, we are unable to consider a claim for your Muscle Atrophy and have upheld our decision to decline your claim".*

In the above letter the Provider shows no acceptance that the two conditions had two different onset dates, or that the muscle atrophy resulted from a fall, some time after the hip replacement.

In the Complainant's appeal of the Provider's decision, she submitted medical evidence that indicated that the fall brought on the Muscle Atrophy condition.

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I note that the Provider argues that a return to work was required before a second claim, (the Provider considered the Muscle Atrophy was a second claim) could be assessed. I accept that the Provider was not correct in this argument, in that the Policy only has a return to work requirement if the Provider had paid the maximum Monthly Benefits. The Complainant received no claim payment. Both medical conditions being claimed for, at the same time.

I note that the Policy does state that: *"Periods of **Accident** or **Sickness** separated by less than 3 months will be treated as one continuous period of **Accident** or **Sickness"***. I accept that the Complainant's Muscle Atrophy would more appropriately be considered to be a continuous period of accident or sickness, in accordance with this provision.

The Provider also refers to a requirement for the Complainant to be physically in work when the Muscle Atrophy condition manifested itself. I accept that the Provider is also not correct in its view in this regard. The particular Policy wording states that a "Sickness" is:

> ***"A medical condition or disease, after it is diagnosed and confirmed by Your Doctor and occurring whilst You are in Work, which stops You doing Your Work or any Work that Your experience, education or training may reasonably qualify You to do"***

The policy definition for "Work" is as follows:

> ***"Work / Working / Worked***
> *Permanent gainful Employment or Self Employment paying the correct Pay Related Social Insurance (PRSI) contributions in Ireland or National Insurance (NI) contributions in the UK".*

The Complainant was merely on leave from "Work", and her employment status had not otherwise changed. I accept that the fall which is stated to have caused the Muscle Atrophy occurred when the Complainant was in work, that is, in employment.
The Provider also refers to the primary condition being the condition requiring the Total Hip Replacement, and that nowhere was the Muscle Atrophy mentioned as the primary condition preventing the Complainant from working.

In the above regard I note that the Provider had asked the Complainant's GP the following question, in its letter of **2 August 2019**:

> "*If your patient has more than one medical condition, please advise whether each medical condition on its own would prevent your patient from working. Please also state the primary medical condition".*

The Complainant's GP did not give an answer for this question, and I note that the Provider did not follow up with the GP on this question. This is particularly relevant as the second medical condition was being relied upon by the Complainant, in her appeal. I also note that the Provider did not specifically seek clarification from the Complainant's Consultant

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Orthopaedic Surgeon as to the primary medical condition. While the Provider has referred to the "primary condition" a number of times, I note that other than in the report for completion by the GP (dated **2 August 2019**), this term is not used anywhere in the policy documentation.

I accept that the medical condition requiring the Total Hip Replacement was a pre-existing medical condition, and I note that the Complainant also accepts that position. However, what has not been further queried or clarified by the Provider is whether the Muscle Atrophy is, or could be, the medical condition preventing the Complainant from working. I note that the Complainant's Consultant Orthopaedic Surgeon has stated in a letter dated **6 December 2019** that "*it is far more likely that her abductor deficit occurred as a result of a fall than any pre operative issue*". That said, I accept that there is a difficulty for both parties to prove or disprove that the Muscle Atrophy medical condition met or does not meet the policy criteria for cover. I accept that further enquiry by the Provider was necessary in the circumstances where the Complainant was relying on the Muscle Atrophy alone in respect of the claim.

While I accept that arriving a definitive "primary condition" was difficult, given the interconnectedness of both conditions, I believe the Provider's efforts to do so were deficient and unreasonable in that it should have made further and more detailed consideration of the claim.

For the reasons set out above, I partially uphold the complaint and direct the Provider to pay a sum of €2,000 (two thousand euro) compensation for the inconvenience caused to the Complainant.

Conclusion

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

- Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to make a compensatory payment to the Complainant in the sum of €2,000, to a account of the Complainant's choosing, within a period of 35 days of the nomination of account details by the Complainant to the Provider. I also direct that interest is to be paid by the Provider on the said compensatory payment, at the rate referred to in ***Section 22*** of the ***Courts Act 1981***, if the amount is not paid to the said account, within that period.

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

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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.

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FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

16 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
(b) ensures compliance with the Data Protection Regulation and the Data Protection Act 2018.