An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2018-0169
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Rejection of claim - non-medical necessity
Outcome:	Upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

This Complaint concerns the Respondent's refusal of a portion of a claim made under the Complainant's health insurance policy.

The Complainants' Case

The Complainant was covered under a policy of health insurance with the Respondent. The Complainant required treatment in a detoxification and rehabilitation centre in March/April 2017.

The Complainant submitted her claim under the policy for the cost of treatment received. The Complainant was a patient in the rehabilitation centre for a total of 35 days, from the 3rd of March 2017 to the 7th of April 2017. However, the Respondent has only reimbursed the cost of 28 days.

The Complaint is that the Respondent has not honoured the claim in full. The Complainant is seeking payment of the cost for the 7 days' treatment received that was not paid for by the Respondent.

The Respondent's Case

The Respondent has declined to pay out for the last 7 days on the basis that it has not received evidence to show that those last 7 days were medically necessary, within the terms of the 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 Complainants were 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 15 November 2018, outlining the preliminary determination of this office in relation to the complaint. The parties were advised on that date, that certain limited submissions could then be made within a period of 15 working days, and in the absence of such submissions from either or both of the parties, within that period, a Legally Binding Decision would be issued to the parties, on the same terms as the Preliminary Decision, in order to conclude the matter.

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

Background

On the 15th of September 2016 an annual policy of health insurance was renewed with the Respondent. On the 31st of December 2016 the First Complainant was added to the policy. A letter was issued to the original policyholder confirming same, and a table of cover together with membership certificate was issued.

The Claim

On the 21st of February 2017 the Respondent received an email from a rehabilitation facility seeking confirmation that the policy would cover 28 days of treatment in the facility.

The following day the First Complainant's partner, the Second Complainant, telephoned the Respondent. It was confirmed that the rehabilitation facility was covered under the policy, although the details of the treatment to be undergone were not known at that stage.

On the 3rd of March 2017 the First Complainant was admitted to the rehabilitation facility for treatment.

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On the 20th of March 2017, the Second Complainant contacted the Respondent seeking cover for 5 weeks (35 days), as she had understood that there was cover for 28 days under the policy. The Respondent advised that it was not aware of a 28 day limit under the policy, as the policy terms provided for up to 91 days of cover over a 5 year period. Later that day, the Second Complainant told the Respondent that the facility had been advised by the Respondent that cover was in place for 28 days of treatment.

This was confirmed by the Respondent as the agreement with the facility centre. It appears that this confusion arises out of the fact that the facility sought confirmation for a 28 day course of treatment, for which cover was confirmed.

Correspondence then ensued whereby the Second Complainant sought confirmation that the further 7 days would be covered (for a total of 35 days), but the Respondent advised it had only agreed 28 days with the facility, and the policy would not cover another 7 days in the absence of being satisfied same was medically necessary, within the terms of the policy. The parties appeared to be at cross purposes whereby the Complainant believed the Respondent to be telling her that 28 days was the maximum period covered under the terms of the policy, when the Respondent was in fact saying 28 days was the maximum period for which they had been provided with evidence that the treatment was medically necessary, or that had been agreed in advance with the facility.

On the 4th of March 2017 a letter was written by a consultant psychiatrist which stated that the Complainant "*was not really able to participate in our residential programme during her first week with us, whilst we tapered down her Librium medication (i.e. one week detoxification). For this reason I [illegible] recommended that her residential programme begin on 10/3/17 and end on 7/4/17. In this way we can provide her with a full four week programme*".

Ultimately, the Complainant spent 35 days in the treatment facility, from the 3rd of March 2017 to the 7th of April 2017. The facility submitted documentation seeking payment for 35 days of treatment on the 3rd of May 2017.

The Respondent assessed the claim and has paid out for 28 days of treatment. It relies on the policy terms which require that treatment covered under the policy must be "medically necessary" within its terms. It notes that by June 2017 the Second Complainant had advised them that the reason for the further 7 days was that "*It was at this point, when* [the Complainant] *had completed Step 1 [ie the first 7 days], it became obvious to the counsellors that* [the Complainant] *had not fully grasped sections of the treatment from the first 7 days. This was not apparent at the time to either her or the counsellors/facilitators. It was therefore necessary for her to redo Step 1".*

The Respondent states that "*from our point of view it is not possible to say whether* [the Complainant] *was participating in the daily activities and group therapy or if she was staying in the unit undergoing straightforward detoxification which potentially could have been completed at home under the supervision of her GP".*

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By letter dated 23rd of June 2017, the Complainant's consultant psychiatrist responded to the declinature of the 7 days' cover in the following terms:

> "*Unforeseen clinical circumstances obliged me to recommend this patient stay with us an additional 7 days.*
> *I am the Consultant Psychiatrist in Addiction in this unit for the past 25 years.*
> *This claim has involved our staff in endless telephone calls and correspondence in relation to your refusal to settle what appears to me to be a straightforward and simple claim.*
> *I am satisfied that the clinical circumstances were complex and unforeseen and I am therefore requesting that this matter be concluded at this stage by a decision on your part to settle the claim in full.*"

Analysis

It seems that the "*extra*" 7 days arose because it was necessary for the Complainant to "*re-do*" Step 1 of the Rehabilitation Programme.

The nature of treatment that is "*Medically Necessary*" under the policy is, ultimately, decided by the Respondent's medical advisors.

"*Medically Necessary*" is defined at Page 27 of the policy as follows:-

> *"Medical care which is prescribed by a consultant, GP, dentist, oral surgeon or periodontist and which, in the opinion of our medical advisors, is generally accepted as appropriate with regard to good standards of medical practice and:-*
>
> *(i) is consistent with the member's symptoms or diagnosis or treatment;*
> *(ii) is necessary for such a diagnosis or treatment;*
> *(iii) is not provided primarily for the convenience of the member, the medical facility or healthcare provider or at the request of the member;*
> *is furnished at the most appropriate level, which can be safely and effectively provided to the member;*
> *(iv) is for procedures and investigations that are medically proven and appropriate;*
> *(v) does not include extended convalescence or palliative care."*

The Respondent's position is that it is not satisfied that the first 7 days were medically necessary, as it is unsure whether or not the First Complainant was participating in group therapy or whether she was involved in a detoxification element during those first 7 days which could have been carried out at home under the supervision of her general practitioner.

In my opinion, this stance ignores the manner in which events unfolded, and the particular nature of the treatment that was undergone. I don't believe that it is appropriate for the Respondent to decline cover because it is not possible for it to establish the precise level of

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participation by the First Complainant in group therapy and group activities during the first 7 days. In my opinion, such a stance purports to offer an overly strict interpretation of the policy terms, which is devoid of any recognition of the nature of the treatment being undergone. There is no indication in the evidence that the treatment centre staff somehow considered that the Complainant ought to be discharged for any portion of that first 7 days, or that they believed it was not necessary for her to be in the facility during those 7 days. Even the Respondent itself suggests that it is *"unsure*" whether an out-patient option would have been appropriate for the Complainant to achieve a certain level of detoxification *"under the supervision of her GP"*.

Addiction treatment and rehabilitation by its very nature can be unpredictable, even accepting that certain programmes follow strict timelines. The Respondent's characterisation of the detoxification portion as being possibly "*straightforward*", is somewhat unfortunate in my view and fails to recognise the very individual presentation of the patient requiring the treatment. In this instance, the medical evidence indicates that although the programme commenced on 3 March, the required progress had not been achieved by the First Complainant within the first week and the medical practitioners felt it appropriate to re-commence the programme again on 10 March. The letter from the Complainant's Consultant Psychiatrist of June 2017 makes it clear that it was the unforeseen clinical circumstances which obliged him to recommend that the Complainant stay an additional 7 days. Bearing in mind his opinion in that regard, as the expert in the field, and indeed, taking into account that the Respondent's own policy definition of "*medically necessary*" acknowledges the regard to be had to "*good standards of medical practice*", I take the view that I should accept that this additional 7 days of treatment was considered to be medically necessary by her medical advisers, and should likewise have been accepted by the Respondent as "*medically necessary*" at that time, taking into account the First Complainant's individual situation and the level of progress which was required to enable the balance of the Rehabilitation Programme to remain relevant to her.

I consider it appropriate to accept that it was for this reason that the practitioner on the ground deemed it necessary for the Complainant to "start over" after week one. The facility's final bill confirms she was under its care for 35 days.

The policy provides for 91 days of psychiatric treatment per 5 years. Whilst the original approval from the Provider was for cover for a programme for 28 days, I do not accept that the additional 7 days in question should not be covered, simply because the additional 7 day period was not foreseen at the outset. The additional 7 days does not bring the treatment beyond the maximum of 91 days in a 5 year period and, consequently, I take the view that it would be unreasonable, if not unconscionable to permit the Respondent to refuse cover for the additional 7 days claimed.

On the basis of the correspondence from the Complainant's consultant psychiatrist, I am satisfied that the 35 day stay was medically necessary for the First Complainant within the policy terms, and even in the absence of evidence that the said period of 7 days was strictly speaking "medically necessary", within the meaning of the terms and conditions of the policy, I would be minded in any event to uphold this complaint on the basis outlined at ***Section 60(2)(c)*** that the conduct of the Respondent Provider, whilst in accordance with a

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law or established practice or regulatory standard, was nevertheless unreasonable, unjust, oppressive or improperly discriminatory in its application to the Complainant.

Accordingly, for the reasons outlined above, I consider it appropriate to uphold this complaint.

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Conclusion

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

- Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to rectify the conduct complained of by discharging the remaining outstanding payment to the Treatment Centre and, in addition, by making a compensatory payment to the First Complainant in the sum of €350, to an account of the Complainant's choosing, within a period of 35 days of the nomination of account details by the Complainant to the Provider. I also direct that interest is to be paid by the Provider on the said compensatory payment, at the rate referred to in ***Section 22*** of the ***Courts Act 1981***, if the amount is not paid to the said account, within that period.

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

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
DIRECTOR OF INVESTIGATION, ADJUDICATION
AND LEGAL SERVICES

6 December 2018

Pursuant to *Section 62* of the *Financial Services and Pensions Ombudsman Act 2017*, the Financial Services and Pensions Ombudsman will publish legally binding decisions in relation to complaints concerning financial service providers in such a manner that—

(a) ensures that—

(i) a complainant shall not be identified by name, address or otherwise,
(ii) a provider shall not be identified by name or address,
and

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