An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0315
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Complaint handling (Consumer Protection Code) Maladministration
Outcome:	Partially upheld

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Second Complainant holds an international health insurance policy with a Healthcare Provider and has been living in Australia for a number of years. On **16 October 2017**, the Second Complainant was admitted to hospital in Australia and diagnosed with diverticulitis. It was recommended that the Second Complainant's diagnosis be confirmed with a colonoscopy. However, it was not possible to perform the colonoscopy during the Second Complainant's admission due to his condition. The colonoscopy was subsequently arranged through the Second Complainant's doctor. The Second Complainant made a claim under his policy for the cost of the colonoscopy. However, the cost of the colonoscopy was not admitted by the Provider as the Second Complainant did not undergo this procedure while in hospital nor was it necessary to treat his condition during his admission.

The Parties

The policy the subject of this complaint is a standalone policy. Only one person is insured under the policy, the Second Complainant. The First Complainant (his father) is not a part to the policy. He does, however, pay for the policy and, is therefore, considered the policyholder.

The Healthcare Provider undertakes all services relating to the general administration of the policy. The Healthcare Provider is *tied* to the Claims Handler, the entity responsible for the provision of services regarding claims under the policy.

The Healthcare Provider is underwritten by the Insurer/Underwriter. For the purposes of this complaint, both the Claims Handler and the Insurer/Underwriter are the Provider.

The Complainants' Case

The Complainants explain that the Second Complainant has been a customer of the Healthcare Provider for [number of years redacted] and has never made a claim. The Second Complainant has been working in Australia for the past 4 years and on **16 October 2017** became ill while at work and was taken to hospital on **17 October 2017** by air ambulance. The First Complainant contacted the Healthcare Provider *"… and a case was opened for [the Second Complainant] and I was assured that everything would be looked after."*

The Second Complainant was told he was suffering from diverticulitis but this would need to be confirmed with a colonoscopy. The Second Complainant was unable to have a colonoscopy at the time because of the level of infection in his abdomen. On **18 October 2017**, the hospital recommended that the Second Complainant undergo a colonoscopy through his doctor when his infection settled down.

The Complainants explain that on **24 October 2017**, the Second Complainant attended his GP and referred him to a consultant to arrange a colonoscopy. A colonoscopy was organised for **18 December 2017**.

The Second Complainant contacted the Provider on **6 November 2017** to enquire about payment options for the colonoscopy procedure. The Second Complainant was advised that he had already been diagnosed and the colonoscopy was classed as routine management of the condition and was not covered by the policy. The Complainants refer to a letter from the Second Complainant's consultant which confirms the colonoscopy was *'recommended to confirm that the diagnosis was of diverticulitis and that there was no underlying other bowel pathologies.'*

The First Complainant spoke to the Provider's agents in respect of its decision to decline the claim *"… but found them most unreasonable to deal with."* On **24 November 2017**, the First Complainant wrote to the CEO of the Healthcare Provider outlining his concerns about the manner in which the Second Complainant was being treated. On **26 January 2018**, it was decided by the Provider that the cost of the colonoscopy would be covered under the policy. However, the payment in respect of the procedure was not made until **28 March 2018**.

The Complainants submit that:

> *"This complaint should never have happened. [The Second Complainant] should have been entitled to a full diagnosis of his condition without dispute.*
>
> *I feel [the Healthcare Provider and the Provider] need to change their processes so this does not happen to any other sick person."*

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In resolution of this complaint, the Complainants state:

> *"It would be helpful if the [the Healthcare Provider and the Provider] all apologise to [the Second Complainant] for the manner in which they treated him.*
>
> *I feel the cost of the flight that [the Second Complainant's] girlfriend made from City 1 to City 2 should be paid.*
>
> *[The Healthcare Provider] should recognise that in situations such as [the Second Complainant's] that a colonoscopy is recognised as a diagnostics tool and not as treatment."*

The Provider's Case

The Second Complainant's Claim

The Provider explains that the Second Complainant holds an international health insurance policy. The policy is designed to provide cover if an insured is presenting with symptoms which require medically necessary treatment. The Provider explains this broadly falls between two categories: *Respond quickly to treatment* and *Are long-lasting or recurrent*. These categories comprise either acute or chronic medical conditions. These aspects of the policy are cited extensively in the Provider's submission.

The Provider received a medical report which was reviewed by its medical team. The Second Complainant's medical conditions as per the report, were deemed chronic and a letter was issued to the Second Complainant on **14 November 2017** to explain how this would affect the level of cover under the policy terms and conditions. Once a medical condition has been deemed chronic, Level 1 provides cover for the treatment of the acute episodes of a chronic condition and benefit of up to €10,000 for chronic conditions during each period of insurance.

As the Second Complainant holds Level 1 cover, the level of cover on this policy is limited to acute episodes only and does not include cover for any routine follow ups, preventative examinations or palliative treatment specific to a condition. The Provider states the Second Complainant sought pre-approval for a treatment after his medical condition had been deemed chronic. The Provider submits the treatment was considered as routine follow up and not covered under the terms of the policy.

Notification of the Claim

On **17 October 2017**, the First Complainant contacted the Provider by telephone in respect of the Second Complainant's attendance at hospital.

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The Provider explains that while the First Complainant was of the understanding that *'everything would be looked after'*, its agent set up a case and advised the First Complainant that a medical report from the hospital would be required to enable the Provider to understand, medically, what was happening and what the Second Complainant was being treated for. The Provider's agent also explained that given the reciprocal health arrangement between Ireland and Australia, there would likely be no cost for the hospital admission but the Provider would check and confirm this.

The Provider's agent informed the First Complainant that if there were any costs, it would try to validate the claim and pay them directly rather than the Second Complainant having to do so. The Provider submits this call related to the hospital admission and it is satisfied with what was outlined to the First Complainant. The Provider also states that any costs that may be incurred for the hospital admission would be subject to the claim being validated and a claim can only be validated when a medical report is received and reviewed.

Pre-Approval Procedure

The Provider explains that unless a person is an in-patient, all claims are usually done on a pay and claim basis through the submission of treatment details and receipts. There is a process by which an insured can seek pre-approval for a procedure and this is outlined in the policy documentation. The relevant section of the policy has been cited by the Provider.

On **5 November 2017**, the Second Complainant contacted the Provider to enquire about payment options as he had been referred to a specialist. The Provider's agent responded by outlining the usual process would be to pay and claim, or pre-authorisation. The Provider advises there is no evidence to indicate that its agent informed the Second Complainant of the pre-authorisation process verbally. However, the Provider's agent explained the process during the Second Complainant's call on **16 November 2017**.

The Complaint

The Provider states that a formal complaint was made on **16 November 2017** as the Complainants were unhappy the treatment could not be considered under the terms of the policy. The First Complainant wrote to the CEO of the Healthcare Provider who also logged a formal complaint.

The Provider advises that its email containing its Final Response letter outlined that on this particular occasion, consideration for the cost of the Second Complainant's treatment had been agreed but technically, the decision to decline cover was correct under the terms of the policy. The Provider submits this decision was reached in the interests of what was fair and reasonable given the complaint in respect of the Provider and the Healthcare Provider. The Provider adds that while the Second Complainant's medical condition had been declared chronic before the specialist treatment date, had the treatment been done at the time of admission to hospital, it would have been considered.

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Settlement of the Claim

The Provider states that it received a claim form for costs on **8 February 2018** and further information was required on **15 February 2018** regarding any amount that may have been refunded through Medicare, the Australian universal healthcare scheme. The Second Complainant confirmed on **16 February 2018** that no reimbursements were received under the scheme.

The Provider explains that Australian law provides that a person must apply to Medicare before requesting any private insurance company to respond to the costs incurred and the Provider cannot assess any claim for costs until a Medicare statement is received. This was received on **16 March 2018**. The claim was then assessed and a claim settlement issued.

A payment in the amount of €1,314.13 was instructed to be issued to the Second Complainant's nominated bank account on **28 March 2018**. The Provider outlines the settlement amount is based on the costs incurred less any benefit provided by Medicare and subject to any policy excess.

Customer Service

Responding to the Complainants' point that they found the various agents of the Provider with whom they spoke to be unreasonable to deal with, the Provider states it has reviewed the call recordings available to it and there is no evidence of anyone being unreasonable to deal with.

Flight Costs

The Provider submits that it has not received a letter from the First Complainant dated **25 June 2018**. However, the Provider received a request from the Healthcare Provider to look into the possibility for cover on flights for partners. This was investigated and a response issued to the Healthcare Provider.

The Provider points out the cost for the flight of the Second Complainant's girlfriend was received and settled.

<u>The Complaints for Adjudication</u>

The complaints are that the Provider:

1. Refused to pre-authorise cover for the Second Complainant's colonoscopy;

2. Declined a post procedure claim for a colonoscopy;

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3. Delayed in making the colonoscopy settlement payment; and

4. Refused to cover the cost of a flight for the Second Complainant's girlfriend.

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 on 2 September 2020, 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.

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 Second Complainant's illness or condition. It is the duty of this Office to establish whether, on the basis of an objective assessment of the medical evidence submitted, the Provider has adequately assessed the Second Complainant's claim and subsequently the First Complainant's claim and whether it was reasonably entitled to arrive at the decision it did following its assessment of the claim and the medical evidence submitted.

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Table of Benefits

The benefits under the policy are set out in the *Table of Benefits*. This table is in respect of Level 1 cover which is the cover maintained by the Second Complainant. The following benefits are provided under the policy:

> *"Chronic medical conditions for acute episodes only for each chronic medical condition* *€10,000*
>
> *…*
>
> *Transportation costs of the insured person in the case of an emergency medical transfer or evacuation* *Full Cover*
>
> *…*
>
> *Return trip for one adult to travel to the location where the insured person is hospitalised* *€955"*

The Policy

Section 2 of the policy contains certain information regarding pre-authorisation:

> *"**Direct Settlement** – If We pre-authorise Your treatment, this means that We will normally settle all Eligible Costs directly with the Hospital or Physician subject to the terms of Your policy. … In order for Us to arrange Direct Settlement We need to pre-authorise Your treatment first. …*
>
> *You must contact Us for pre-authorisation within 14 days of learning that Medical Treatment has been scheduled, if Your Medical Treatment is scheduled within 14 days You must contact Us immediately. If You do not meet these conditions You will be responsible for bearing 25% of the Eligible Costs."*

Section 4 of the policy contains a number of definitions:

> *"**Acute***
>
> *A Medical Condition of rapid onset resulting in severe pain or symptoms which is of brief duration that it likely to respond quickly to Medical Treatment.*
>
> *…*

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Chronic Medical Condition

A Medical Condition which has two or more of the following characteristics:

- *It has no known recognised cure*
- *It continues indefinitely*
- *It has come back*
- *It is permanent*
- *Requires Palliative Treatment*
- *Requires long-term monitoring, consultations, check-ups, examinations or tests*
- *You need to be rehabilitated or specially trained to cope with it.*

Chronic Medical Condition – Acute Episode

An event or incident of rapid onset resulting in severe pain or symptoms which is of a brief duration that it likely to respond quickly to Medical Treatment to stabilise a Chronic Medical Condition.

…

Emergency Medical Transfer or Evacuation

Medically necessary expenses of an emergency transportation where approved by Our 24 Hour Customer Service Centre and medical care during such transportation to move an Insured Person who is suffering from a Critical Medical Condition to the nearest suitable Hospital which may not necessarily be in the Insured Person's Country of Residence.

Medical Condition

Any disease or illness … not otherwise excluded in this Policy.

Medical Treatment

The provision of recognised medical and surgical procedures and healthcare services which are administered on the order of and under the direction of a Physician for the purposes of curing a Medical Condition, Bodily Injury or Illness or to provide relief of a Chronic Medical Condition.

…

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Palliative Treatment

Treatment where the primary purpose is only to offer temporary relief of symptoms rather than to cure the Medical Condition causing the symptoms."

Section 5 of the policy details what is, and what is not, covered under the policy. Section 5(2)(k) states:

"Chronic Medical Conditions – Where a Medical Condition is deemed to be Chronic, the maximum benefit We will pay for all and any Medical Treatment covered by this Policy for each Chronic Medical Condition is limited to:

- *The Acute episodes of a Chronic Medical Condition on Level 1*
- *The Acute episodes of a Chronic Medical Condition including routine management and Palliative Treatment on Levels 2 and 3."*

Section 6 of the policy deals with travel and states at subparagraph (b):

"If the Insured Person does not have an accompanying adult, then We will pay the reasonable travelling costs of a return trip by first class rail or economy/tourist class air fare for one adult to travel to the location where the Insured Person is hospitalised."

The Second Complainant's Claim

On **17 October 2017**, the First Complainant telephoned the Provider to advise that the Second Complainant had been admitted to hospital in Australia. The First Complainant stated that, as far as he knew, the Second Complainant had an abscess on his intestine. The First Complainant advised the Provider's agent he had a query from the Second Complainant regarding the policy checking if there was anything the Provider needed to know in advance of anything happening in the hospital where the Second Complainant was admitted. The First Complainant also advised the Provider's agent that the Second Complainant had been taken to hospital by air ambulance.

The Provider's agent explained that he would *get a case open* but there was not much he could do due to the time difference but would pass the case to night's team. When the night's team arrived, the First Complainant was advised, they would contact the hospital, find out where the Second Complainant was and request a medical report. The Provider's agent also mentioned the reciprocal health arrangement between Ireland and Australia and that there should not be any cost for the hospital admission but this would be double checked. The Provider's agent explained that if there was any cost, the Provider would try and validate the claim and pay those costs directly.

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One of the Provider's agents telephoned the Second Complainant on **18 October 2017** and advised him that an *assistance case* had been set up for him. The Provider's agent explained to the Second Complainant it would request medical reports from the hospital for the purpose of claim validation. The Provider's agent also advised that the Second Complainant might be entitled to the cost of his treatment under the reciprocal health agreement. The Second Complainant expressed the view that in terms of his air transfer between hospitals, there was a grey area under the reciprocal health agreement and that's why he contacted the Provider. The Provider's agent indicated this was unlikely to be a problem. The conversation continued with the Provider's agent outlining that it would validate the Second Complainant's claim and the claim would be covered if validated. The Second Complainant was also informed that if the costs were not covered by the reciprocal health agreement, it would need to know the costs incurred.

The Provider's agent followed up with the Second Complainant on **23 October 2017** in respect of medical reports. The Second Complainant advised the Provider's agent that he would be attending his GP the next day. The Provider's agent advised the Second Complainant there would be no costs for the hospitals as they were covered under the reciprocal health agreement.

The Second Complainant queried the costs going forward to which the Provider's agent responded that the Provider should be contacted after the GP visit and updated as to what was required going forward. The Second Complainant then asked if the Provider would be covering the future costs. The Provider's agent replied by advising that the treatment/costs would have to be assessed by its medical department and that medical reports and a report from the Second Complainant's GP would also be required.

During a telephone conversation on **2 November 2017**, the Second Complainant informed the Provider that he had recently been to see his GP and he was referred to a specialist who he would be attending in two weeks. The Provider's agent advised the Second Complainant that he would need pre-authorisation of this attendance/procedure. The Provider's agent enquired if the Second Complainant had any medical reports from his GP and the like. The Second Complainant stated that he received one from the hospital but was away with work and would not be able to forward it until his return to City 1. It was agreed that the Second Complainant could scan and email the report to the Provider. The Provider's agent also asked that the Second Complainant provide some details regarding the specialist he would be attending.

The Second Complainant forwarded medical reports to the Provider by email dated **5 November 2017** and explained that he had been to see his GP on **24 October 2017** who referred him to a specialist. The Second Complainant enquired about payment options regarding this referral.

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The Provider wrote to the Second Complainant on **14 November 2017** as follows:

> *"We refer to the above and the review of the medical information received relating to your medical condition Diverticulitis. Our Medical Team has deemed the condition to be a chronic medical condition under the terms and conditions of your … policy.*
>
> *We wish to confirm that your … policy defines a* ***"Chronic Medical Condition"*** *as follows;*
>
> *…*
>
> *Our Medical Team has confirmed that your condition meets three of the above set of criteria. Therefore, your condition has deemed to be a chronic medical condition in line with your policy terms and conditions.*
>
> *The characteristics it meets are as follows:*
>
> - *It continues indefinitely*
> - *It is permanent*
> - *Requires long-term monitoring, consultations, check-ups, examinations or tests*
>
> *In accordance with the terms and conditions of your … policy, where a medical condition is deemed to be chronic, the maximum benefit we will pay for any medical treatment for each chronic medical condition is limited to EUR 10,000 per insured year.*
>
> *Under your policy Terms and Conditions you are covered for* ***acute*** *episodes of a Chronic Medical Condition.*
>
> *An acute episode of a chronic medical condition is defined as the following under your policy terms and conditions:*
>
> *…*
>
> *Therefore, all expenses incurred for treatment of acute episodes in respect of Diverticulitis will be limited to EUR 10,000 per insured year, as outlined in the policy schedule."*

The Healthcare Provider wrote to the Second Complainant on **16 November 2017** to inform him that his claim for the colonoscopy would not be covered by the policy:

> *"Upon review of the medical information received the colonoscopy you are scheduled to have on 18/12/2017 would be classed as a routine management of your condition and would not fall into the definition of an acute episode. We therefore are unable to cover any costs relating to this procedure."*

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The Second Complainant contacted the Provider by telephone on **16 November 2017** in response to the above email expressing the view that the Provider had done its best to get out of paying for the claim. The Provider's agent advised the Second Complainant that certain costs had been paid for. However, the Second Complainant stated this was under the reciprocal health arrangement. The Second Complainant informed the Provider's agent that he was advised the costs of his treatment would be covered under the policy. The Provider' agent then logged a complaint on behalf of the Second Complainant.

Later the same day, the First Complainant contacted the Provider stating that his son was quiet upset at the way he was being treated. The First Complainant stated that the colonoscopy was not routine management but was required to properly diagnose the Second Complainant. The Provider's agent stated the diagnosis was given in **October 2017**. The Provider's agent advised the case was passed to its nurses for review and the colonoscopy was not deemed to be acute. The Second Complainant had Level 1 cover which only covered acute episodes. The First Complainant wished to speak to someone else regarding the claim. The Provider's agent advised the First Complainant that the Second Complainant's claim/medical condition could not be discussed as the consent of the Second Complainant was required.

One of the Provider's agents contacted the First Complainant on **17 November 2017**, during this conversation, the First Complainant was advised that the Second Complainant would need to give full third party authorisation to allow the Provider to discuss his case with the First Complainant. The First Complainant stated the Second Complainant's consultant considered the colonoscopy necessary to confirm the Second Complainant's diagnosis. The Provider's agent advised that based on the information available, the colonoscopy does not come within the policy. The Provider's agent explained to the First Complainant that the medical information had been examined by its panel of doctors and nurses. The Provider's agent then advised the First Complainant that it could not discuss the case with the First Complainant.

The Healthcare Provider wrote to the Second Complainant again on **17 November 2017** following an earlier telephone conversation with the First Complainant requesting that the medical information sought in respect of the Second Complainant's consultant be furnished as soon as possible.

The Second Complainant contacted a separate department within the Provider on **17 November 2017**, referring to the Provider's decision regarding the colonoscopy and outlining his position on the matter. The Second Complainant advised this agent he had been told previously that the costs of his claim were not going to be a problem and the colonoscopy was going to be covered. The agent contacted by the Second Complainant only dealt with acute medical emergencies and it was explained to the Second Complainant that he would need to speak to the Provider's claims department. The Second Complainant indicated there was a disagreement as to the interpretation of the policy. The Provider's agent advised the Second Complainant to get a letter from his doctor to confirm his position.

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The Consultant's Letter

The Second Complainant submitted a letter from his colorectal surgeon dated **20 November 2017** on **22 November 2017**. This letter states:

> *"This letter is regarding [the Second Complainant] who has had his first admission to hospital with a diagnosis of acute diverticulitis while he was working in [location]. The discharge summary provided by the [hospital] has noted a CT abdomen performed at the time (17/10/17) of sigmoid diverticulitis with surrounding inflammatory mass. [The Second Complainant] has not previously had a colonoscopy, particularly given his age, a colonoscopy has been recommended to confirm that the diagnosis was of diverticulitis, and that there is no underlying other bowel pathology such as a malignancy. …"*

The Provider reviewed this letter and responded to the Second Complainant on **23 November 2017**:

> *"The report has been reviewed and I can confirm that our decision on cover for the colonoscopy remains in place.*
>
> *This reports states that a diagnosis of diverticulitis has been given and that a scope is recommended to also rule out any malignancy. As discussed previously, this would not be considered an acute episode of a chronic medical condition and we remain unable to authorise such expenses."*

The Second Complainant contacted the Provider on **23 November 2017** having received the above email. The Second Complainant expressed the view that the report recorded his diagnosis as a *suspected diagnosis*. The Provider's agent stated the report indicated that diverticulitis was the diagnosis actually received.

Letter to Healthcare Provider's CEO

The First Complainant wrote to the CEO of the Healthcare Provider on **24 November 2017** outlining the Complainants' position and appealing to this individual to make representations to the Provider to allow the Second Complainant's claim. This letter states, in part, as follows:

> *"On the 16/11/2017 [the Second Complainant] became ill at work and was taken to … hospital in [location]. On the 17/10/2017 … he was taken by air ambulance to the [hospital]. At the time I contacted [the Healthcare Provider] and a case was opened for [the Second Complainant] and I was assured that everything would be looked after.*

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In the hospital [the Second Complainant] was told that he was suffering from diverticulitis but that this would need to be confirmed with a colonoscopy which he was unable to have in the hospital because of the level of swelling in his abdomen. He was given antibiotics and told to arrange a colonoscopy through his doctor when the infection settled down. …

On the 24th of Oct [the Second Complainant] went to visit his GP who referred him to a consultant in [City 1] in order to organise his colonoscopy. The colonoscopy was organised for 18th of December. On the 6th [of] Nov [the Second Complainant] was told by [the Provider] that he would have to claim the cost back through [the Provider]. [The Second Complainant] then contacted [the Provider] for to find out payment options for the colonoscopy procedure.

… This is not routine maintenance of [the Second Complainant's] condition it is part of the diagnosis procedure. As you can see from the attached [the Second Complainant's] consultant has written a letter to emphasise that the colonoscopy is 'recommended to confirm that the diagnosis was of diverticulitis and that there is no underlying other bowel pathologies'. …"

Internal Correspondence

An internal email written by one of the Provider's managers and dated **10 January 2018**, appears to outline the Provider's rational regarding the Second Complainant's claim:

*"The question still remains: is a colonoscopy the **only** procedure that would confirm this medical condition? From looking online, it appears … this condition can be diagnosed by CT scan or blood tests as well.*

I am not sure if the previous medical report was review by [agent] … whereby it clearly indicates a previous diagnosis of diverticulitis given in May 2017 by CT and was treated with PO Abx … So to me, the client was previously diagnosed with this condition in May 2017 and was treated for same.

*I feel that the chronic application was made correctly based on all of the medical information received at that point, and cover limited to acute episodes only. As such, treatment must be due to **rapid onset** resulting in **severe pain or symptoms** which is of **brief duration** that is **likely to respond quickly to** medical treatment.*

*The client was discharged on 20/10/2017and the colonoscopy scheduled for Mid December … In view of the policy definition above, I do not feel the colonoscopy was to **treat** the acute episode (he had this treatment in October during admission) and that the colonoscopy would be considered a routine follow up from the exacerbation to rule out any malignancies (again routine/preventative). Generally, a colonoscopy is considered diagnostic and is not actual treatment for a medical condition.*

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The medical information further confirms this condition as diagnosed by CT in May 2017 for which the client had treatment (5 months prior to the admission of the acute episode).

…

*I do appreciate the client's father advising he needed the colonoscopy as it could not be completed during the admission due to the level of inflammation and that this was to be completed 6 weeks afterwards. However, based on the medical reports received, client was diagnosed already back in May 2017, so the colonoscopy due in December cannot be considered diagnostic to confirm the diagnosis, and I would consider the colonoscopy to be routine/preventative (**routine** as it was normal to have this 6 weeks after such an inflammation and **preventative** as it was intended to rule out any malignancies). …"*

Final Response Letter

In its Final Response letter dated **26 January 2018**, the Provider informed the Second Complainant that his complaint was being upheld and his claim for the colonoscopy allowed:

"As discussed when we spoke on 19 January 2018, your particular case was referred to our colleagues in [the Healthcare Provider]. Although this treatment is not technically covered by the policy as a result of the total review of your circumstances it has been agreed that we will cover the cost of this colonoscopy for this incident only.

Can I please request that you submit the invoice for the colonoscopy by email …

I apologise that this decision has taken longer than we had originally hoped when we began the investigation into your case and I hope that the agreement to settle the claim has resolved your complaint. Based on the review of your complaint I will be upholding your complaint into the service that you received. …"

Settlement of Colonoscopy Claim

The Second Complainant responded to the Final Response letter on **8 February 2018** with the requested invoices. The Provider responded on **15 February 2018** requesting Medicare statements to confirm the amounts reimbursed to the Second Complainant and details of the Second Complainant's Australian bank account. The Second Complainant replied on **16 February 2018** advising:

"I have not received any reimbursement for any of the invoices submitted, medicare does not cover this procedure.

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My bank details are as follows."

A telephone conversation took place after this email on **16 February 2018** during which the Provider's agent advised the Second Complainant that his SWIFT code was also required to process payment. The Provider's agent also highlighted that the Second Complainant did not submit a Medicare statement. The Second Complainant advised that he did not claim anything under Medicare. The Provider's agent advised the Second Complainant that it had to assess the claim under the terms of the policy. At this point, the Second Complainant expressed the view that he was being *treated like dirt*. The Provider's agent stated that it was trying to verify the claim and the Second Complainant was required to provide a Medicare statement. The Provider's agent noted that a Medicare number was on the invoices submitted by the Second Complainant. The Second Complainant indicated that while the Medicare number was on the invoices, it does not mean the cost would be covered under Medicare. The Provider's agent advised the Second Complainant that it would still need to verify this.

The Second Complainant emailed the Provider on **16 March 2018** explaining that:

> *"I finally got to the medicare office today with my invoices, i was unaware they would cover anything. They have paid me on what they can cover. I have attached the gap benefit information form.*

The Provider responded on the same day acknowledging the email and advised that the information provided had been placed in line for review. The Second Complainant emailed the Provider on **25 March 2018** requesting an update on his claim. The Provider wrote to the Second Complainant on **28 March 2018** enclosing a benefit statement and explained the sum of €1,314.13 would be paid in full and final settlement of the claim within 5 working days to the Second Complainant's nominated bank account.

The Flight Claim

The First Complainant wrote to the Healthcare Provider on **25 June 2018** seeking to make a claim for the flight costs incurred by the Second Complainant's girlfriend when she travelled to the hospital in which he was being treated in City 2. The relevant part of this letter states:

> *"… [The Second Complainant's] girlfriend travelled from City 1 to City 2 on the 17/10.2017 to be with him when he was hospitalised. I understand from reading [the Second Complainant's] policy that the cost of this flight should be covered. I have mentioned this to her and as a result of the way [the Second Complainant] was treated she is of the opinion that [the Provider] would find a reason not to pay this cost and she is not prepared to endure this annoyance.*

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> *I would be grateful if you would let me know if [the Second Complainant's] girlfriend is entitled to the cost of this return flight. If this is the case can you please give me some assurance that if she submits a valid return flight receipt for that flight that it will be processed without undue hassel."*

The Healthcare Provider contacted the Provider in respect of the First Complainant's claim for the flight costs by email dated **4 July 2018**. In a further email of the same date, the Provider's agent made the following observation in respect of the First Complainant's letter:

> *"… there has been no claim submitted for the flights as of yet and [the First Complainant] will not submit these details until he knows if a benefit will be allowed."*

The Healthcare Provider wrote to the First Complainant on **25 July 2018**, advising:

> *"I would like to confirm that our underwriters have confirmed the cost of [the Second Complainant's] girlfriend's flights can be considered under the Rules: Terms and Conditions of cover once we can validate the medical evacuation required for [the Second Complainant].*
>
> *In order for us to validate the evacuation we will require the medical report confirming that the medical treatment [the Second Complainant] needed was unavailable where he was originally located and this in turn necessitated the evacuation to City 2. …*
>
> *In addition, the booking invoice for the flight in which [the Second Complainant's] girlfriend paid for will also need to be submitted …*
>
> *I have enclosed a claim form for you to submit your claim … we have agreed to review as priority upon receipt of the relevant details."*

A claim form was completed and signed by the First Complainant on **8 September 2018** and submitted under cover of letter of the same date. The Provider responded on **21 September 2018** requesting bank account details for payment of the claim. The Provider wrote to the Second Complainant on **12 October 2018** enclosing a benefit statement and explained the sum of €197.76 would be paid in full and final settlement of the claim within 5 working days to the Second Complainant's nominated bank account.

Post Complaint Correspondence

The Provider wrote to the Complainants on **29 November 2018** with the following apology:

> *"I am sorry that you were compelled to put your concerns in writing to the CEO of [the Healthcare Provider] …*

/Cont'd…

We endeavour to provide all information to our members in a concise and transparent manner, we are sincerely sorry that this has not been the case in this instance. We would like to take this opportunity to apologise for the upset and distress this caused to the entire family. We have highlighted your customer journey with the Claims Manager to ensure there is always a comprehensive explanation in claims decisions, and a better process for any case that warrants additional review or reassessment.

We are sorry for the delay in finalising the payment of the claim and would like to thank [the Second Complainant] for his continued pro-active approach, ensuring all the information was furnished to progress and finalise the claim.

We acknowledge there were additional aspects to the claim following the admission, in particular to costs incurred by [the Second Complainant's] girlfriend in arranging a flight to be with [the Second Complainant] during his hospitalisation. This query was referred to us from [the Healthcare Provider] for consideration on 5 July 2018. We are sorry for any perceived delay in handling this aspect of the claim and I would again like to thank [the Second Complainant] for his input in ensuring the claim settlement was expedited.

As both a valued member of [the Provider] and [the Healthcare Provider] we acknowledge the distress and concerns any illness can create and we are sorry you did not feel adequately supported from the service you received. …"

The First and Second Complaints

The Second Complainant was admitted to hospital on **16 October 2017**. The First Complainant contacted the Provider by telephone to advise the Provider of the admission and a case was opened by the Provider. The Second Complainant was diagnosed with diverticulitis and in **December 2017** underwent a colonoscopy. The Second Complainant sought to make a claim under the policy in respect of the colonoscopy. I note the costs associated with his hospital admissions were covered under the reciprocal health agreement. The Provider declined the claim on the grounds that the colonoscopy was considered routine management of the Second Complainant's condition and did not come within the definition of an acute episode.

It appears medical reports from the hospital at which the Second Complainant received treatment have not been furnished nor have any reports from the Second Complainant's GP. However, a copy of a letter from the Second Complainant's consultant has been provided. Notwithstanding this, it is not disputed that all of this information was available to the Provider when assessing the Second Complainant's claim.

The Second Complainant has Level 1 cover. As per the *Table of Benefits*, the Second Complainant is covered for *Chronic medical conditions for acute episodes only*.

/Cont'd…

This is further defined in section 2 of the policy as:

> *"**Chronic Medical Condition – Acute Episode***
>
> *An event or incident of rapid onset resulting in severe pain or symptoms which is of a brief duration that it likely to respond quickly to Medical Treatment to stabilise a Chronic Medical Condition."*

Section 5(2)(k) states:

> *"Chronic Medical Conditions – Where a Medical Condition is deemed to be Chronic, the maximum benefit We will pay for all and any Medical Treatment covered by this Policy for each Chronic Medical Condition is limited to:*
>
> - *The Acute episodes of a Chronic Medical Condition on Level 1*
> - *The Acute episodes of a Chronic Medical Condition including routine management and Palliative Treatment on Levels 2 and 3."*

The letter prepared by the Second Complainant's consultant states:

> *"… The discharge summary provided by the [hospital] has noted a CT abdomen performed at the time (17/10/17) of sigmoid diverticulitis with surrounding inflammatory mass.*
>
> *[The Second Complainant] has not previously had a colonoscopy, particularly given his age, a colonoscopy has been recommended to confirm that the diagnosis was of diverticulitis, and that there is no underlying other bowel pathology such as a malignancy. …"*

Further to this, there is also evidence to suggest the Second Complainant had been diagnosed with diverticulitis in **May 2017**.

As the Second Complainant has Level 1 cover, he is only insured in respect of acute episodes. While at hospital, he was unable to undergo a colonoscopy due to the level of infection in his abdomen but was nonetheless treated for his condition. The treatment covered under the policy in respect of acute episodes is medical treatment to stabilise a chronic medical condition. I accept that at the time of the Second Complainant's admission to hospital, he received treatment for his acute episode.

The purpose for which the Second Complainant attended the colonoscopy was to confirm the diagnosis of diverticulitis. The letter prepared by the Second Complainant's consultant states the colonoscopy was *"…to confirm that the diagnosis was of diverticulitis, and that there is no underlying other bowel pathology such as a malignancy."*

/Cont'd…

Given the very clear statement by the Second Complainant's consultant, I am surprised at the comment by one of the Provider's managers that:

> "*The question still remains: is the colonoscopy the **only** procedure that would confirm this medical condition? From looking on line it appears … this condition can be diagnosed by CT scan or blood tests as well".*

I find it difficult to understand the rationale for this manager "*looking on line*" to establish if the treatment/tests required by a medical consultant are somehow appropriate.

However, I note following this, the Provider did in fact admit the claim and pay for the colonoscopy.

The Complainants have stated that assurances were given by the Provider and/or its agents that the costs of the Second Complainant's treatment and colonoscopy would be covered by the policy. Having reviewed the evidence in this complaint, in particular the telephone call recordings, there is no evidence of such assurances being given. On the contrary, both Complainants were advised that the claim would have to be validated and assessed under the terms of the policy.

Additionally, I am satisfied that during each of the telephone conversations with the Complainants, the Provider's agents spoke to and dealt with the Complainants in a professional and courteous manner.

The Third Complaint

The Provider advised the Second Complainant in its Final Response letter dated **26 January 2018** that it would cover the cost of the colonoscopy and requested that the Second Complainant forward the relevant invoices. The Second Complainant did so on **8 February 2018**. The Provider then requested the Second Complainant's bank details and a Medicare statement on **15 February 2018**. Following this, on **16 February 2018**, the Provider advised the Second Complainant of the need for a Medicare statement. However, the Second Complainant did not believe any costs were recoverable under Medicare. About 4 weeks later, on **16 March 2018**, the Second Complainant advised the Provider that he was in fact able to recover some of his colonoscopy costs under Medicare and furnished a statement to the Provider. The Provider responded on the same day advising that the information provided had been placed in line for review. A follow up email was sent by the Second Complainant on **25 March 2018**. The settlement payment issued on **28 March 2018**.

Taking the foregoing into consideration, I do not accept that there was any delay on the part of the Provider in making the settlement payment. Once the Medicare statement was received by the Provider, which I accept was a reasonable requirement on the part of the Provider, the settlement payment issued within approximately 7 working days.

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The Fourth Complaint

The evidence indicates the First Complainant made an enquiry on **25 June 2018** in respect of claiming for the costs of the Second Complainant's girlfriend's flight. The Provider advised the First Complainant that these costs could be considered once the claim was validated. A claim form was completed on **8 September 2018** by the First Complainant. The Provider responded on **21 September 2018** requesting bank account details for payment of the claim. The Provider wrote to the Second Complainant on **12 October 2018** enclosing a benefit statement and explained the sum of €197.76 would be paid in full and final settlement of the claim within 5 working days to the Second Complainant's nominated bank account.

While the Complainants maintain that the Provider refused to cover the cost of a flight for the Second Complainant's girlfriend, there is no evidence to support this statement. Once the claim form was submitted, there was nothing to suggest that the Provider would not admit the claim or query any aspect of the claim.

The Provider's Response to this Complaint

This Office wrote to the Provider by letter dated **8 March 2019** enclosing a Summary of Complaint and a Schedule of Questions, and requested a response within 20 working days. This letter requested that the Provider respond to the complaint and reminded the Provider of its obligations under the ***Financial Services and Pensions Ombudsman Act 2017***.

A response was not received to this letter and two reminder letters were issued to the Provider on **2 May 2019** and **27 May 2019**. A generic and standard form email response was received on **27 May 2019**.

An email was received from one of the Provider's complaints handers on **30 May 2019** stating *"I apologise that this file request is outstanding, I will be on annual leave from today until the 10 June 2019 and will endeavour to have the file with you within that week."* Notwithstanding this, a further email was received from the same complaints handler on **5 June 2019** advising that she would be out of office until **2 January 2019** (six months earlier) and that *"I will reply to emails on my return alternatively you can forward your query to complainants@[Provider].com."*

This Office corresponded with all parties to the complaint on **17 June 2019**. This Office emailed the complaints handler and two emails addresses for the Provider on **25 July 2019** referring to the email of **30 May 2019** and requesting an update as to the status of the Provider's response to the Summary of Complaint. An email was received from the claims handler on **25 July 2019** advising that *"I am now out of the office until the 05 August."* A separate email was received from another of the Provider's claims handlers on **25 July 2019** indicating that she would be in a position to assist and requested this Office to *"… clarify exactly what you require."* This was despite the fact that the Summary of Complaint issued to the Provider over four months earlier, had set out 16 specific questions requiring a response and identified 7 items of evidence required under the Schedule of Evidence to be supplied.

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The responses received to the correspondence issued by this Office were wholly inadequate and demonstrate that the Provider unreasonably delayed in responding to this complaint. It is disappointing that the Provider's responses to this complaint essentially comprised either general standard form replies or out of office emails for a period of 5 months until the end of **July 2019**.

While I welcome the fact that the Provider did eventually pay for the colonoscopy and apologise to the Complainants, I believe some form of compensation was required for the inconvenience suffered by the Complainants in the handling of their claim and complaint.

For this reason, I partially uphold this complaint and direct the Provider to pay a sum of €500 in compensation.

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), (f) 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 make a compensatory payment to the Complainants in the sum of €500, to an account of the Complainants' choosing, within a period of 35 days of the nomination of account details by the Complainants 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.

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

23 September 2020

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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.