An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0025
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Rejection of claim - treatment abroad
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The complaint concerns the Complainant's health insurance policy with the Provider.

The Complainant's Case

The Complainant submits that she suffers from a medical condition which she developed after she underwent surgery for the treatment of cancer in **2017**.

The Complainant submits that she has had to *"jump through hoops"* with the Provider for various reasons since her diagnosis. The Complainant submits that the Provider has refused to provide cover for a PET scan and it informed her that she needed to change hospitals for treatments, to one with which it had an agreement. The Complainant submits that due to GDPR, Data Protection Regulations, she has experienced difficulty in transferring the results of the diagnostic results between the hospitals.

The Complainant submits that the Provider delayed the diagnostic scans which she was due to undertake, by nine months, by continually requesting information to prove that the scans were medically necessary and by requesting that she change hospitals.

The Complainant submits that the treatment which she was receiving for her medical conditions in Ireland did not meet her needs and she continued to suffer excruciating pain. The Complainant submits that her medical consultant referred her for surgery to reduce the symptoms of the condition and that this surgery was not available in Ireland.

The Complainant submits that she was referred to a facility in the United Kingdom to undergo the surgery and the medical consultant in the United Kingdom, to whom she had been referred, stated that the surgery needed to be done as soon as possible before her condition deteriorated.

The Complainant submits that under the policy, the Provider allows a policyholder to apply for pre-approval for treatment abroad, if the treatment cannot be performed in Ireland and the cover is subject to a benefit limit of €100,000. The Complainant states that she submitted a claim to the Provider for pre-approval of the surgery in the United Kingdom and the pre-approval was declined. The Complainant states that the Provider has refused to cover the treatment being claimed as the information that she supplied in support of the claim for the surgery does not meet its criteria under the policy for the procedure to be considered a proven form of treatment for the condition.

The Complainant submits that she has supplied the Provider with *"over and above information and links for proof"* that the treatment in question is effective and she does not accept the Provider's decision. The Complainant asserts that the treatment in question is not new or experimental and it is not part of any clinical trial and she contends that the procedure in the United Kingdom is not available in Ireland and that, in these circumstances, the Provider should provide cover for the surgery. The Complainant contends that the HSE grants automatic approval for access to the surgery in question.

The Complainant asserts that the Provider is seeking too much information in its consideration of the claim for the surgery and that she has exhausted all avenues in trying to retrieve the information that has been requested by it. The Complainant states that the Provider has failed to accept the medical opinion of her two treating consultants, that in their view, the surgery is effective and medically proven in the treatment of the medical condition in question and she states that neither of her consultants will provide any additional documentation to the Provider. The Complainant submits that she expects that the Provider will refuse the appeal of the claim, as it did her initial claim application to provide cover for surgery, regardless of whether she provides it with any further information.

The Complainant submits that she went ahead with the surgery in the United Kingdom and she paid for it herself. The Complainant submits that since having the surgery, she has experienced fewer incidences of complications related to the medical condition and she submits that the benefits of the surgery have been fantastic. The Complainant states that she has supplied the Provider with recent scan results of her condition as proof that the surgery was a success to support her claim.

The Complainant submits that due to the severity of the medical condition and the complications associated with it, it would cost the Provider more to cover the ongoing hospital treatments had she not had the surgery, than for it to cover the cost of the surgery in dispute, which totalled £16,800.

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The Complainant submits that international guidelines pertaining to the treatment of the condition, state that the surgery in question should be carried out early, in the course of the disease, and that the surgery in question is performed in several countries worldwide including some countries in the European Union.

The Complainant made further submissions to this Office by email dated **30 January 2020** in response to the Provider's **13 January 2020** submissions. These further submissions largely focus on the issue of cover for her PET-CT scans. The Complainant explains that she was not aware of the conditions that applied to cover for PET-CT scans until after her first surveillance outpatient CT scan and the issue of payment only came to light when she received a bill from the hospital. She states that CT scans are covered under her policy but not for oncology surveillance and it took *"more than one call"* with the Provider to clarify this. She states that after her initial diagnosis she should have a CT scan every 3 months for the first 2 years but as these would not be fully covered and it would have cost her more for 4 CT scans in a year than a PET scan and having waited 9 months between scans for approval, only to be denied approval, this is the reason she went ahead and paid for a PET scan. The Complainant reiterates that the Provider did ask for additional medical information that the PET scan was medically necessary and that this was requested to the Hospital PETCT centre on **18 April 2018**.

The Complainant made further submissions to this Office by email dated **3 February 2020**. In these submissions the Complainant submits information from a patient in the USA who successfully received benefit for the surgery that the Complainant received and/or had the denial decision by an insurance provider overturned. The Complainant also submitted an article from the International Society of Lymphology concerning the surgical procedure she underwent and documentation from an insurance company in the US which provides benefit for the surgery.

The Complainant made further submissions to this Office by email dated **21 February 2020**. In these submissions the Complainant states that the issue she has is that she *"cannot understand why there is no agreement in place for CT cover for surveillance with [a particular hospital] for CT scans"*. She states that this makes *"no logistical sense as a customer OR patient"*.

Ultimately, the Complainant wants the Provider to compensate her for her treatment expenses relating to her treatment abroad (£16,800) and full compensation for her PET/CT scans which took place in Ireland.

The Provider's Case

The Provider made submissions to this Office dated **13 January 2020**. In these submissions it states that it received the treatment abroad application from the Complainant on **11 October 2018** and this was for an assessment and potential treatment in the UK.

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The Provider states that this application for treatment abroad was rejected on **18 October 2018** in accordance with Rule 6(c)(26)(ii) of the Provider's Rules-Terms and Conditions as assessment, investigations or diagnostic procedures are excluded from benefit. The Provider states in its submissions to this Office that *"at this point is was not clear what treatment would be carried out and from the information we received at the time it appeared that* [the Complainant] *would be receiving outpatient treatment under local anaesthetic. The proposed treatment therefore did not appear to be a treatment that* [the Provider] *provide benefit for in Ireland"*.

The Provider states that it received an appeal of its decision to decline benefit for treatment abroad on **12 November 2018** as the Complainant was proceeding to surgery. The Provider states that this information was referred to its panel of medical advisors who requested additional information. The Provider states that this requested information was not provided and based on all of the information submitted the application was rejected as the proposed treatment was not considered a proven form of treatment. The Provider issued a Final Response letter in this regard dated **18 January 2019** wherein it states that in order to consider a treatment abroad to be a proven form of treatment the Provider requires that:

> *"(i) There is reliable evidence that the procedure has been the subject of well-controlled studies with meaningful endpoints, which have determined its safety and efficacy compared with standard treatments.*
>
> *(ii) There is reliable evidence that the consensus amongst experts regarding the procedure is that further studies or clinical trials are not necessary to determine its safety or its effectiveness as compared with standard treatments.*
>
> *(iii) Long term outcomes are available, defined as 5 year follow-up, unless there are exceptional extenuating circumstances related to specific well-defined population groups for whom there is no other reasonable alternative form of treatment otherwise available".*

In its Final Response Letter, the Provider states that with regards to (i) above, *"the consultant has provided details of a randomised controlled trial which compared the treatment with no treatment. This would not be consistent with a trial comparing the treatment with standard treatments. Therefore this trial alone would not meet the criteria as detailed above."*

In relation to (ii) above the Provider notes that the [health authority abroad redacted] states that the procedure [procedure redacted] is experimental and is not in widespread use and a large US insurance company similarly found that surgical techniques including the procedure was investigational (unproven) and more studies were needed to see how it worked over the long term. The Provider noted that the Complainant's consultant in the UK had indicated the procedure is still available in Wales however the Provider states that it was initiated in Wales for a trial period of 2 years and then extended for a further 3 years to evaluate the benefit of the procedure and it is not generally available elsewhere on the [health authority abroad redacted].

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The Provider also states that it has been supplied with chapters of a book entitled *"Best Practice for the management of lymphoedema"* (2nd Edition) which states that *"further work needs to be undertaken to effectively define indications for such surgery"*. The Provider notes that the UK consultant has indicated that the procedure is available in the USA, however, the Provider states that while some surgeons are performing the surgery, the biggest US Insurer states that they consider the surgery *"experimental and investigational….because the long-term effectiveness of this procedure has not been established by peer-review medical literature"*.

The Provider states that all of the forgoing indicates that there is not reliable evidence that the consensus amongst experts regarding the procedure is that further studies or clinical trials are not necessary to determine its safety or its effectiveness as compared with standard treatments.

In relation to (iii) above, the Provider states that information relating to 5 year follow-up data does not exist and therefore this criteria has not been fulfilled.

The Provider stated in its Final Response Letter that it had not been provided with the exact details of the surgery to be performed and details of the medical report from the consultant abroad detailing the necessity of the treatment and that the [Medical Practice] has indicated to the Provider by email dated **3 January 2019** that it cannot furnish the Provider with the information that it requested.

The Provider states in its submissions dated **13 January 2020** that it *"cannot comment on HSE cover for this treatment"* and it only provides benefit for treatment abroad subject to a specified criteria which were not fulfilled in respect of the Complainant.

In relation to the issue of benefit for the PET-CT scans, the Provider states in its submissions dated **13 January 2020** that benefit for these scans is available subject to the following criteria as outlined at section4 (16) of the Terms and Conditions:

- Prior Approval; and
- The patient is referred for a PET-CT scan by a consultant; and
- The PET-CT scan is carried out in a PET-CT Centre covered by your plan and as specified in the directory of out-patient scan centres; and
- The PET-CT scan is carried out for one of the clinical indications as specified by the Provider to all consultants.

The Provider states that in order to review the PET scan application to establish if the clinical indication was satisfied it requested additional information from the Consultant Plastic Surgeon in **June 2018** and this was not received. Following the Complainant's appeal, the Provider states that it wrote to the consultant plastic surgeon again seeking this information and pointing out that in exceptional circumstances and when agreed by the Provider's medical director, benefit will be provided for uncovered oncology indications when recommended by the multi-disciplinary team and when all other relevant investigations have failed to resolve management issues.

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The Provider states that at this stage it received confirmation from the consultant plastic surgeon that the Complainant had proceeded to have the PET scan at her own expense as he had suggested that she undergo a CT TAP in the first instances and should that show any discrepancy, he would apply again for a PET scan. The Provider states that the consultant plastic surgeon informed it that the case was then reviewed at MDT and a further PET scan was not required. The Provider states that based on this information, the clinical indication for the PET scan was not satisfied and no benefit was payable in respect of the scan under the terms and conditions of the Complainant's contract.

The Provider states that it did not inform the Complainant that in order for her to receive cover for diagnostic scans pertaining to the cancer diagnosis that she would need to change hospitals. It submits copies of web chat conversations in support of this contention.

The Provider also states that it did not ask the Complainant to provide evidence that the PET scan was medically necessary rather it sought additional information from her to establish if the specified clinical indications were met, namely clarification if this is a case of (a) local recurrence of melanoma or (b) metastatic disease and if resection is being considered.

The Provider states that following an appeal from the Complainant in **August 2018** it requested the information again from the consultant plastic surgeon and sought details of any MDT meeting as outlined in medical decision of **22 August 2018**. The Provider states that the information provided by the consultant plastic surgeon confirmed that the clinical indication for the PET scan was not satisfied and therefore no benefit was payable in accordance with the terms of the contract.

The Provider made further submissions to this Office on **18 February 2020** wherein it clarified the position regarding the PET scans. The Provider stated that it approved the Complainant's PET scan in **May 2017** as the clinical indications for the scan were satisfied but it did not approve the PET scan in **2018** as the clinical indications were not satisfied. The Provider also states that the Complainant attended a Hospital for CT scans that is not an approved centre for direct payment oncology CT scans in accordance with its rules. Furthermore, the Provider states that the clinical indication for the CT scan was not satisfied and therefore the CT scan was not eligible for direct payment. Therefore, the Provider states that the Complainant must pay for the CT scans upfront and claim benefit back under the day-to-day element of her plan, which entitles her to 50% of the cost incurred of the scans subject to a €125 excess.

The Provider made further submissions to this Office dated **10 March 2020** wherein it explained that there is no agreement in place for direct pay oncology CT scans in the particular Hospital as it is *"unable to enter into contracts with public hospitals."* It states that it will raise the issue regarding the availability of CT centres in public hospitals with its product and business division with a view to reviewing the issues raised by the Complainant but cannot guarantee if any changes will be made.

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The Complaints for Adjudication

The complaint for adjudication is that the Provider incorrectly/wrongfully declined to cover the treatment undertaken by the Complainant in the United Kingdom and wrongfully refused to cover the cost of the Complainant's scans in **2018**.

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 8 January 2021 outlining my 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, within the period permitted, the final determination of this office is set out below.

I have carefully considered the terms & conditions of the Complainant's policy that are applicable to the assessment and payment of the claim in question.

In relation to the Complainant's treatment abroad, I note section 6(c)(26)(v) of the terms and conditions which states that benefit is not payable for *"new not proven forms of surgical procedures"* and section 7(k) which states that benefits are not covered for *"experimental…treatments"*. Essentially, the Provider requires that any treatment provided for outside of Ireland be a proven form of treatment and I am satisfied that it is reasonable and fair for the Provider to stipulate this.

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I note that in order to consider a treatment abroad to be a proven form of treatment the Provider requires that:

> *"(i) There is reliable evidence that the procedure has been the subject of well-controlled studies with meaningful endpoints, which have determined its safety and efficacy compared with standard treatments.*
>
> *(ii) There is reliable evidence that the consensus amongst experts regarding the procedure is that further studies or clinical trials are not necessary to determine its safety or its effectiveness as compared with standard treatments.*
>
> *(iii) Long term outcomes are available, defined as 5 year follow-up, unless there are exceptional extenuating circumstances related to specific well-defined population groups for whom there is no other reasonable alternative form of treatment otherwise available".*

I note from the submissions of the parties that information in respect of (i) and (iii) simply does not exist for the treatment which the Complainant underwent. In respect of (ii), I accept that the Complainant has provided information that the treatment is provided in some areas of the USA and the UK, in Japan, in Italy and in Sweden.

However, I also must take into account the submissions from the Provider that the treatment is not in widespread use and that even in a number of the countries where it is being performed (USA and the UK) its adoption is not universal or even necessarily predominant. The Complainant has also submitted a number of useful articles and patient testimonies in furtherance of her complaint and again, these demonstrate that while the procedure can lead to significant benefits for patients, they also demonstrate that there is not a consensus amongst medical experts regarding the procedure. I am particularly guided the extract cited by the Provider from *"Best Practice for the management of lymphoedema"* (2nd Edition) which states that *"further work needs to be undertaken to effectively define indications for such surgery"*.

Accordingly, I accept that the Provider arrived at its decision to reject the Complainant's claim for treatment abroad in a reasonable and just manner and was therefore entitled, under the terms and conditions of the policy, to refuse to compensate the Complainant for the treatment she received in the UK.

In respect of the PET/CT scans issue, I note that section 4(16) of the Provider's terms and conditions states that the following is necessary for cover:

> *"Prior Approval; and*
> *The patient is referred for a PET-CT scan by a consultant; and*
> *The PET-CT scan is carried out in a PET-CT Centre covered by your plan and as specified in the directory of out-patient scan centres; and*
> *The PET-CT scan is carried out for one of the clinical indications as specified by the Provider to all consultants."*

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While I am sympathetic and understanding to the Complainant's rationale as outlined in her submissions dated **30 January 2020** to this Office for undertaking and paying for her scans in the manner in which she did, the evidence submitted by the parties shows clearly that the Complainant did not get prior approval for the 2018 PET scan, was not referred by a consultant for the PET scan and did not have the PET scan carried out at one of the Provider's specified centres. The audio and webchat evidence submitted by the parties demonstrates that on **30 January 2018** and **4 April 2018** the Provider's representatives clearly explained to the Complainant the differences between the CT scans and PET scans in terms of cover and how to claim for the various scans. The Provider's representative on the audio call of **4 April 2018** also advised that there was only one direct billing scan facility in the city in question. I note that the evidence does not support the contention that the representative of the Provider recommended that the Complainant change hospital. Therefore, I accept that the Provider is entitled to refuse the Complainant's claim for the **2018** PET scan and furthermore, that the Complainant was given the correct information concerning the scans, the cost of the scans, the location the scans could be obtained and the methods of making a claim in respect of the scans.

For the reasons outlined in this Decision, 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.

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FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

2 February 2021

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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.