An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0029
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Disagreement regarding Medical evidence submitted Complaint handling (Consumer Protection Code)
Outcome:	Upheld

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The complaint concerns the Complainant's health insurance policy.

The Complainant's Case

The Complainant has a health insurance policy with the Provider incepted on **20 July 2017**.

The Complainant states that she attended a private hospital on **15 March 2018**, following which she was charged €170 for an MRI scan and €548 for overnight admission. The Complainant has submitted a letter from her Consultant stating that the Complainant *"underwent an MRI scan which did not show significant neural compression however it was deemed appropriate to admit her because of significant back pain and tingling in her legs and feet."* The Complainant's Consultant further states that *"the emergency consultant felt that she needed admission for observation overnight"*. The Consultant concludes his letter by stating his opinion that it was *"unfair that* [the Provider has] *made this decision and I request that it is reversed"* and states that *"there were clinical indications for admission in my opinion and in the opinion of the rather experienced emergency room consultant"*.

The Complainant states that she has received three letters from the Provider stating that she was ineligible for cover for overnight admission, as well as four letters from the private hospital requesting payment.

The Complainant submits that she is dissatisfied that the Provider has *"made a decision based on no clinical observation of me at the time, and this calls into question the professional reputation of the* [the Complainant's Consultant]*"*.
The Complainant contends that she *"required overnight admission for observation based upon the symptoms I presented with"*, and that she expects the Provider to cover the cost of her health care.

Ultimately, the Complainant wants the Provider to pay the cost of the claim, totalling €718, as well as her solicitor costs, totalling €100.

The Provider's Case

The Provider submits that it declined the Complainant's claim under her policy as it is not required to make a payment in respect of in-patient services if it determines that the health services provided to the insured could have been provided as day-patient services or out-patient services. The Provider states, in its Final Response Letter dated **5 July 2019**, that it relies on Regulation 6(1) of the Health Insurance Act, 1994 (Minimum Benefit) Regulations, 1996, and the Scheme Rules Clause 8(j) in this regard.

Regulation 6(1) of the Health Insurance Act, 1994 (Minimum Benefit) Regulations, 1996 states:

> *"A registered undertaking shall not be required to make the prescribed minimum payments specified in sub-paragraphs (1), (2), (3) or (6) of paragraph 1 of Schedule A in respect of in-patient services if, on receipt of appropriate medical advice, the undertaking determines that the health services provided to the insured person could have been provided as day-patient services or out-patient services rather than in-patient services…"*

Clause 8(j) of the Scheme Rules states:

> *"We do not have to pay benefits for in-patient treatment provided by a hospital if we are of the reasonable opinion, based on appropriate medical advice, that the treatment could have been received as day-case treatment or out-patient treatment. We also do not have to pay benefits for day-case treatment if we are of the reasonable opinion, based on appropriate medical advice, that the treatment could have been received as out-patient treatment. However, we will pay benefits for such treatment as follows:*
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> - *If you received in-patient treatment or day-case treatment and we determine that the treatment could have been received as out-patient treatment, we may treat such treatment as out-patient treatment for the purpose of paying benefits".*

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The Provider states that the Complainant received an MRI on **15 March 2018** and states that as the MRI did not indicate an acute cause, *"it was considered that* [the Complainant] *could have been discharged home thereafter and followed up on an outpatient basis"*.

The Provider also references a report from its external medical personnel and Orthopaedic Surgeon which stated that:

> *"As the patient presented with symptoms as* (sic) *incontinence in combination with back pain and radiculopathy, cauda equina has to be suspected which is potentially dangerous. In order to exclude this diagnosis, MRI should be performed. This was performed the same day as admittance and hence it did not demonstrate any cauda equina, the patient could be discharged after the MRI".*

The Provider also submits that *"after the performed MRI, no examination or treatment was performed which had to be done as an in-patient. Therefore, no indication for being admitted and staying at the hospital for one night has been presented".*

The Provider made further submissions to this Office dated **20 March 2020**. In these submissions the Provider states that it declined the Complainant's claim on the basis of Regulation 6(1) of the Health Insurance Act, 1994 (Minimum Benefit) Regulations and Clause 8(j) of the Scheme Rules.

In response to a query raised by this Office concerning the failure of the Provider to reimburse the Complainant for her MRI scan, the Provider stated that the schedule of benefits states that:

> *"Physician and hospital benefit is not provided for patients requiring investigation only such as radiology, pathology or MRI scans unless they also require the intensity of service that would justify an in-patient admission (e.g. patients who require intravenous treatment, intensive monitoring of vital signs or other active management that could only be provided in an acute hospital setting)"*.

The Provider states in its submissions that *"as there was no intensity of service provided to this Complainant to justify the inpatient admission"*, the MRI which was part of this inpatient admission, was rejected, as the whole claim was deemed not medically necessary. The Provider states that as the MRI could have been performed on an outpatient basis, it states that if the Complainant has a receipt for the MRI, she can claim back for this cost towards her everyday medical expense benefit. The Provider states that the Complainant's policy provides a refund for radiological technical fees up to €500 per year, subject to a €150 excess.

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In response to the Complainant's claim that *"there were clinical indications"* for her admission and the admission was the *"opinion of the rather experienced emergency room consultant"*, the Provider states that the service agreement it has with the private hospital in question provides that:

> *"**Medically Necessary**" means a decision by a Consultant that a Member's treatment, test, stay in hospital, drug or procedure is necessary to treat the diagnosed medical problem for which the Member has health insurance cover with [the Provider] provided always that [the Provider] shall have the right to dispute the fact that treatment was Medically Necessary and in such instances it shall notify the [Hospital] in writing of its intention to seek a second opinion confirming the treatment was in fact Medically Necessary"*.

The Provider further states that the General Rules for Payment in the Schedule of Benefits for Professional Fees for Consultants state:

> *"Medically necessary treatment is that which, in the opinion of [the Provider's] Medical Advisors, is for the diagnosis or treatment of illness or injury of a person which would be accepted generally by the medical profession in Ireland as appropriate and necessary having regard for good standards of medical practice and the nature and cost of any other recognised forms of treatment. The treatment should:*
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> *a) Be consistent with the symptoms or diagnosis and treatment of the injury or illness;*
> *b) Be necessary for such a diagnosis or treatment;*
> *c) Be furnished at the most appropriate level which can be safely and effectively provided to the patient and only provided for an appropriate duration of time;*
> *d) Not be furnished primarily for the comfort or convenience of the patient, the doctor or other provider;*
> *e) Not be to avoid out-patient costs or to facilitate an investigation that would otherwise incur costs for the patient.*

The Provider states that having reviewed the medical notes received with this claim, in conjunction with the Service Agreement and the General Rules for payment of professional fees, the Complainant's medical notes do not support the Consultant's assessment that this admission was medically necessary.

The Provider outlines the patient's history as follows:

> *"…the Complainant presented to the Emergency Department at the [Hospital] at approximately 15.00 on Thursday 15 March 2018 with symptoms of moderate back pain and urinary incontinence.*
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> *An MRI of the lumbar spine was ordered at 15.10 to exclude the possibility of cauda equine. This MRI was scheduled for 15.50. As this did not show significant neural decompression an acute cause was eliminated.*

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Nonetheless, the Complainant was admitted overnight and had a consultation with [a doctor] at 09.15 the following morning, 16 March 2018, and was discharged thereafter on oral analgesia as per the notes signed by [the doctor]. [The Provider] believes if this consultation had taken place on the night of 15 March 2018, no admission would have taken place.

Furthermore, no further clinical interventions; other than the MRI and routine pathology were carried out during the course of the overnight admission and no medical necessity could be established to warrant an acute inpatient admission.

It was considered that the Complainant could have been discharged home after the MRI for an outpatient follow-up."

The Provider states that the claim was reviewed by its utilisation review team who considered that it did not meet the criteria for inpatient admission as the treatment could have been safely carried out as an out-patient once the acute cause had been ruled out. The Provider also re-emphasises that the claim was then reviewed externally by an Orthopaedic Surgeon.

The Provider maintains that the admission was not medically justified and therefore the claim was correctly rejected.

The Provider states that the Complainant contacted the Provider at 15.34 on **15 March 2018** to check her cover for the hospital in question. The Provider states that its representative advised the Complainant that *"once it's medically necessary to admit you, you'll be covered with a €200 shortfall and €150 excess"*.

The Provider states that the total cost of the claim is €1,291.40 comprising:

- Overnight admission: €898
- Routine pathology: €59.40
- Radiology professional fees for an MRI of the lumbar spine: €170
- An invoice for inpatient attendance with the Consultant: €164

The Provider also submits that Clause 3.14 of the Provider's Service Agreement with the hospital in question is relevant. It states that, pursuant to this clause, the hospital:

"waives its right to Balance Bill any Member for Services provided, save where the Member does not hold full…cover for the bed occupied or treatment or procedure carried out in the hospital. In such circumstances the Member will be liable for the shortfall or excess effective on the admittance date between the…cover held by the Member and the specified Hospital Charges for the Member only."

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The Provider states that due to this Service Agreement, the explanation of benefits sent to the Complainant on **10 April 2019** advised that she did not owe anything. Following this rejection, the Provider states that it wrote to the hospital and consultant in question on **26 March 2019**, to advise that the claim had been declined for benefit as no medical necessity could be established. On **21 May 2019**, the Provider again wrote to the consultant following his appeal of this rejection, stating that as the MRI ruled out an acute cause, the Complainant could have been discharged home on the **15 March 2018**.

The Provider states that as the medical necessity for this admission could not be established, the Complainant should not have received a bill for this admission from the hospital. The Provider states that it has informed the private hospital that by billing the Complainant the hospital is in breach of clause 3.14 of the Service Agreement.

The Complaint for Adjudication

The complaint is that the Provider has wrongfully declined the Complainant's claim for an MRI and overnight stay in a hospital.

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 5 November 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.

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Following the issue of my Preliminary Decision, the Provider made a submission to this Office under cover of its e-mail, together with attachment to this Office dated 20 November 2020, a copy of which was transmitted to the Complainant for her consideration.

The Complainant has not made any further submission.

Having considered the Provider's additional submission and all submissions and evidence submitted by both parties to this Office, I set out below my final determination.

I note that the parties to this dispute are in agreement as to the fundamental timeline/facts of the dispute. It is accepted that the Complainant contacted the Provider on **15 March 2018** to check her cover for the hospital in question and that the Provider's representative advised the Complainant that *"once it's medically necessary to admit you, you'll be covered with a €200 shortfall and €150 excess per claim"*. It is also accepted that later that evening, the Complainant attended the hospital complaining of acute back pain and episodes of urinary incontinence. I note that the Complainant then underwent an MRI scan which, according to the letter dated **5 May 2019** from the consultant spine surgeon from the hospital in question, *"did not show significant neural compression"*. However, the consultant spine surgeon stated that *"the emergency consultant felt that she needed admission for observation overnight"* because of *"significant back pain and tingling in her legs and feet"*. I note that the consultant spine surgeon is very clear that *"there were clinical indication for admission"* in both his opinion and the opinion of the emergency room consultant.

I note that Regulation 6(1) of the Health Insurance Act, 1994 (Minimum Benefit) Regulations, 1996 states that *"A registered undertaking shall not be required to make the prescribed minimum payments…in respect of in-patient services if, on receipt of appropriate medical advice, the undertaking determines that the health services provided to the insured person could have been provided as day-patient services or out-patient services rather than in-patient services…"* and Clause 8(j) of the Scheme Rules states: *"We do not have to pay benefits for in-patient treatment provided by a hospital if we are of the reasonable opinion, based on appropriate medical advice, that the treatment could have been received as day-case treatment or out-patient treatment.*

I note that the Provider has relied on an internal review as well as an external review before coming to its decision to reject this claim. The external review report dated **13 March 2019** has been provided to this Office and I accept the submission of the Provider that it states that it was not necessary for the Complainant to be kept in the hospital overnight. I note that the external review acknowledges that the Complainant was suffering for 3 weeks from moderate back pain with pins and needles in her right foot and bilateral thigh stabbing pain, however, it then narrowly focuses on the fact that the MRI ruled out the risk of the Complainant suffering from cauda equina syndrome and therefore, according to the external expert, there was no necessity to admit the Complainant overnight. This external report fails to acknowledge that two medical consultants, who had the opportunity to review the Complainant first-hand, made the decision to admit her overnight based on the significant back pain and pins and needles she was suffering in her legs and feet.

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Therefore, it is my view that the decision made by the Provider *"that the treatment could have been received as day-case treatment or out-patient treatment"* pursuant to Clause 8(j), was not a *"reasonable decision"*. Furthermore, the evidence submitted to this Office from the Complainant's treating consultant discloses that it was "medically necessary" to admit the Complainant to hospital overnight for *"observation"* and it is important to stress that this was a decision made solely by the emergency consultant and the spine surgeon consultant and not a decision made at the behest of the Complainant. She stated in a phone call to the Provider "*it wasn't me that decided to stay".*

Recordings of phone calls between the Complainant and the Provider have been provided in evidence. I have listened to these recordings. It is clear to me from the content of these calls that the communication surrounding this claim by the Provider fell short of what the Complainant was entitled to expect.

Finally, I note that when the Complainant contacted the Provider to establish if she was covered for the procedure/admission, she was informed "*once it's medically necessary to admit you, you'll be covered with a €200 shortfall and a €150 excess per claim*".

I believe it was perfectly reasonable for the Complainant to take the view, based on this information, that if her treating physician deemed the procedure/admission medically necessary that the procedure/admission would be covered under the policy. I can find no evidence that the Complainant was advised on these calls that it was in fact the Provider's medical experts who would decide whether the procedure/admission was medically necessary.

This was crucial information which should have been furnished to the Complainant on the telephone call where she enquired as to what was covered.

The Consumer Protection Code 2012 (CPC) requires that a regulated entity must ensure that in all its dealings with customers and within the context of its authorisation it:

> 2.1 acts honestly, fairly and professionally in the best interests of its customers and the integrity of the market;
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> 2.2 acts with due skill, care and diligence in the best interests of its customers;
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> …
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> 2.6 makes full disclosure of all relevant material information, including all charges, in a way that seeks to inform the customer;
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> …
>
> 2.8 corrects errors and handles complaints speedily, efficiently and fairly;

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> 4.1 A regulated entity must ensure that all information it provides to a consumer is clear, accurate, up to date, and written in plain English. Key information must be brought to the attention of the consumer. The method of presentation must not disguise, diminish or obscure important information.
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> 4.2 A regulated entity must supply information to a consumer on a timely basis. In doing so, the regulated entity must have regard to the following: a) the urgency of the situation; and b) the time necessary for the consumer to absorb and react to the information provided.

It is my view that the manner in which the Provider has dealt with the Complainant's claim falls short of what is required of it under the CPC.

Furthermore, I note that the Complainant only became aware that the claim had been rejected by the Provider when she started receiving invoices from the hospital. This is evident from the Complainant's phone call to the Provider when she telephoned the Provider to inform it that she had received correspondence from the hospital. When she asks why her claim was rejected, the Provider's agent informs her that it "*was not medically supported"* and "*not medically necessary*". The Complainant responds "*I didn't hardly decide to stay in hospital myself*". The Complainant also asks who decided that it was not medically necessary. Only then is she informed that it was the Provider's medical experts and not her treating physician.

I note the Provider's agent states "*you might be getting a letter or it might be sent by email*".

I find that far better communication was required from the Provider.

Therefore, based on the foregoing, I am satisfied that the Provider wrongfully declined the Complainant's claim and is under an obligation to indemnify the Complainant. For that reason, I uphold the complaint and direct that the Provider reimburse the Complainant for the full sum of her costs/expenses from the hospital minus any required excess. (I note the Complainant has already paid over €500 in this regard). In light of the inconvenience this incident has caused the Complainant, I also direct the payment of €500 to the Complainant by way of compensation.

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) (b) 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 reimburse the Complainant for the full sum of her costs/expenses from the hospital minus any required excess. (I note the Complainant has already paid over €500 in this regard).

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In light of the inconvenience this incident has caused the Complainant, I also direct the payment of €500 to the Complainant by way of compensation. These sums are to be paid into 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.

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

4 February 2021

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

(a) ensures that—

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

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

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