An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0141
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Complaint handling (Consumer Protection Code)
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The complaint relates to a partially declined claim made by the Complainant under his health insurance policy with the Provider.

The Complainant's Case

The Complainant submitted a claim on his policy, having taken ill on **22 September 2019** while abroad.

The Complainant explained that when he took ill on **22 September 2019,** he first attended a *"medical clinic"* and was seen there for approximately 75 minutes during which time some tests took place. Subsequently, he was transferred by ambulance to a hospital some 30km away, and he remained at the hospital for 7 days. The Complainant says the cost of the treatment in the clinic amounted to €850 which he paid at the time with a credit card, but the Provider refunded €170 only to him, according to the pro-rata refund allowed on the Health Insurance Plan as an outpatient.

The Complainant first submitted a claim in respect of the €850 worth of bills from the medical clinic by way of email on **16 October 2019**. At this time, he stated that the cost of the treatment he received in the Hospital had been fully covered from **22 September 2019** to date of discharge on **29 September 2019** but that he was told to contact the Provider, concerning the separate bill in respect of treatment at the medical clinic.

The Complainant was informed by the Provider's customer service department to submit proof that his claim in respect of the clinic bills, related to in-patient treatment and he did this on **22 November 2019.**

Soon afterwards, the Complainant was further informed by way of emails dated **26 November 2019** and **28 November 2019** that his claim for the medical clinic bills, had been partially declined and on each occasion he challenged this declinature. On **28 November 2019**, the Complainant indicated that he wished to avail of the Provider's complaints procedure as he disagreed with the Provider's assessment of his treatment in the clinic as having been on an *"outpatient"* basis.

The Complainant made further submissions to this Office by way of email dated **10 August 2020**. In these submissions, the Complainant stated that the amount he paid by credit card to the medical clinic was €850.19 but he acknowledged that the amount on the receipt from the medical clinic was €800; he suggested that this may have been due to currency fluctuation. The Complainant confirmed that he received €147.50 from the Provider as benefit payment. The Complainant reiterates his contention in these submissions that all of his treatment should be considered inpatient treatment. He states that from the *"moment of admission to the medical centre there was no break in my treatment until I was discharged from hospital 7 days later"*.

The Complainant contends that the medical clinic claim *"should have been handled as an inpatient not as an outpatient"* and that he was an inpatient from when he entered the clinic on **22 September 2019**, until his discharge from the hospital on **29 September 2019**.

The Complainant states that he *"is out of pocket of €680"* and states that *"all treatment should be assessed as inpatient treatment. I was never released after I entered the medical centres care. There was no break in treatment"*.

The Complainant wants the Provider to assess his full health insurance claim as an *"inpatient"* and to refund the balance of the costs he paid to the medical clinic, which he states is €680.

The Provider's Case

The Provider says that it initially partially declined the medical clinic bills in or around **22 November 2019** and communicated this to the Complainant through its customer service department. At the request of the Complainant, the Provider reviewed this decision on **25 November 2019** and concluded that because the Complainant *"was treated in a clinic before being transferred to a hospital for admission…all these tests are outpatient so claim has been processed correctly."*. The Provider communicated this to the Complainant by way of email dated **26 November 2019**.

By way of email dated **28 November 2019**, the Provider informed the Complainant that as per the membership handbook, the definition of an outpatient is *"A patient who receives a procedure, treatment or medical service without being an in-patient or day case"* and that as the Complainant's tests were carried out while he was an outpatient at the clinic, his claim has been processed in line with the outpatient policy cover.

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The Provider, in its Final Response Letter dated **4 December 2019**, states that the Complainant had been initially treated in a *"doctors surgery and not a hospital"* and that the Complainant's treatment is *"considered outpatient, as you remained in the clinic for approximately 4 hours before you were transferred to the hospital via ambulance"*. The Provider references the policy membership handbook at page 30, section 11:

> *"outpatient – a patient who receives a procedure, treatment or medical service without being in-patient or day case.*
> *inpatient – a patient who is admitted to a medical facility and who occupies a bed overnight or for longer for medically necessary reasons"*

The Provider also references page 17, section 2.5 of the policy membership handbook:

> *"Where you have not been admitted for treatment as an inpatient, some of the costs incurred may be claimed under your outpatient benefits. Please refer to the outpatient section of your table of cover to see what benefits you may claim for and whether these are subject to an excess"*.

The Provider's Final Response Letter states that the invoices regarding pathology and radiology had been assessed and paid correctly pursuant to the Complainant's claim. The Provider stated that the invoice regarding prescription costs was declined correctly as *"this benefit is not covered on your policy"*. The Provider also stated that the consultant fees were declined correctly *"as there is an outpatient benefit subject to €200 on your policy which you have not reached"*. The Provider stated that it had paid the maximum of the pathology and radiology test costs pursuant to the policy (50%).

The Provider made submissions to this Office on **29 July 2020**. In these submissions, the Provider stated that the Complainant had advised over the phone on **16 October 2019** that the total bill he had paid to the medical clinic prior to being admitted to the hospital was €859 and when he submitted his receipts to the Provider by post on **6 November 2019**, that figure changed to €851.19. The Provider states that when it processed the Complainant's receipts, the actual figure paid to the medical clinic was €800, broken down into:

- Consultant fees: €315. Declined due to excess not being reached.
- Prescription costs: €190. Declined due to benefit not being covered.
- Pathology test costs: €95. 50% covered.
- Radiology test costs: €200. 50% covered.

On the basis of the foregoing, the Provider states that the total amount claimed was €800 and the total amount paid by the Provider to the Complainant was €147.50 (as opposed to €170 paid out of approximately €850 as suggested by the Complainant).

The Provider states that for the purposes of 'inpatient' overseas care, the benefit on the Complainant's plan allows him cover of up to €100,000 for 'hospital bill for inpatient treatment'. The Provider states that the full definition of what is covered under this benefit is contained in section ***'2.5 Overseas Benefits'*** of the membership handbook.

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Of note in this section, the Provider emphasises that to be covered, the Complainant must have received *"the emergency care in an internationally recognised hospital"*. The Provider, in these submissions, also reiterates the definitions of in-patient and out-patient treatment as explained in its Final Response Letter.

The Provider confirms that its overseas affiliate contacted the medical clinic and the medical clinic confirmed that it did not have any link to the hospital that the Complainant was admitted to, either administratively or in any other way. The Provider also states that while the medical clinic did have some in-patient facilities it did not have the necessary facilities to treat the Complainant and that is why he was transferred to hospital.

Essentially, the Provider's position is that the Complainant's initial treatment on **22 September 2019** at the medical clinic was correctly assessed and paid as *"outpatient"* care.

The Complaint for Adjudication

The complaint is that the Provider incorrectly assessed the Complainant's claim for the cost of treatment he received, as 'outpatient' treatment and on that basis, partially declined his claim.

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 **9 April 2021,** outlining the preliminary determination of this office in relation to the complaint. The parties were advised on that date, that certain limited submissions could then be made within a period 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.

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

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I note that the Complainant incepted a policy with the Provider in **February 2011** and he has renewed this policy every year since.

I note that the parties are in agreement as to the essential background facts leading to this complaint, namely that the Complainant attended a medical clinic abroad for treatment on **22 September 2019** where he was initially treated before he was transferred to a private hospital, due to the severity of his condition and a need to receive specialist, intensive care. The parties are in agreement that the Complainant then spent a period of 7 days in that hospital, before being discharged.

The crux of this matter is a dispute between the parties as to whether the treatment afforded to the Complainant at the medical clinic should be categorised as 'in-patient' or 'out-patient' treatment. In this regard, I note that both terms are defined in the membership handbook as follows:-

> *"outpatient – a patient who receives a procedure, treatment or medical service without being in-patient or day case.*
> *inpatient – a patient who is admitted to a medical facility and who occupies a bed overnight or for longer for medically necessary reasons"*

I also note page 17 of the policy membership handbook which details the procedure to apply to overseas benefits:

> *"Where you have not been admitted for treatment as an inpatient, some of the costs incurred may be claimed under your outpatient benefits. Please refer to the outpatient section of your table of cover to see what benefits you may claim for and whether these are subject to an excess"*.

Furthermore, I note that the table of cover effective on the Complainant's policy from **7 February 2019** submitted by the Provider shows that the Complainant was entitled to 50% of the cost of pathology tests and 50% of the cost of radiology tests as well as €60 per visit to a consultant (subject to a €200 excess). The table of cover stated that the Complainant was entitled to be covered for up to €100,000 inpatient treatment at a hospital. There is no reference to prescription costs being covered in the table of cover.

When assessing whether the decision by the Provider to categorise the Complainant's treatment at the medical centre as outpatient treatment was a reasonable one, I must take into account that the Complainant did not stay overnight in the medical clinic and that he was only treated there initially on a limited basis, before being transferred to a separate facility, namely an internationally recognised hospital where he stayed for 7 nights. Therefore, I accept that the treatment of the Complainant at the medical clinic, meets the definition of an 'outpatient' pursuant to the membership handbook, in that he underwent procedures (namely pathology and radiology tests) and medical treatment (from a consultant) without being an in-patient or a day case. I am satisfied that the treatment of the Complainant at the medical clinic did not meet the definition of an 'inpatient' pursuant to the membership handbook, as he was not admitted overnight to the medical clinic.

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I cannot therefore accept that the Complainant's treatment at the medical clinic was in-patient treatment and I do not therefore accept that the Provider incorrectly assessed his claim for payment of benefits.

As the evidence discloses no wrongdoing by the Provider, I am satisfied that it is not therefore appropriate to 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.

MARYROSE MCGOVERN
DEPUTY FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

10 May 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.