An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0379
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Claim handling delays or issues
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

This complaint arises out of a health insurance policy held by the Complainants. The policy was incepted with the Provider through the Second Named Complainant's employer on **1 January 2017.**

The Complainants' Case

The First Complainant states that "*In May 2019* [she] *started to experience chronic back pain which was very debilitating"*. The First Complainant attended her GP and Physiotherapy for pain management; however, "*the physio had to stop in August as the pain was acute*". The First Complainant says that "*All of this only gave very limited pain relief, and absolutely no amelioration of the underlying condition*".

The Complainants set out that an MRI was carried out and the First Complainant was diagnosed with a bulging disc and referred for treatment with [her consultant]. The First Complainant states in her correspondence to this Office that:

> *"I attended on September on 26th. He recommended PRP (Platelet Rich Plasma) treatment. This entailed a course of three treatments every four to six weeks apart."*

The First Complainant submits that at this time, she was in "*a lot of pain, was not mobile in any real way and had not been sleeping due to the constant pain".*

The Complainants state that the above-mentioned treatment was deemed urgent and it was administered immediately. They say that this was the only treatment that was effective at delivering relief to her pain symptoms:

> *'[The First Complainant's Consultant] brought me in for PRP the next day due to the urgency. When I left the hospital that day the pain was considerable but had ameliorated and it was the first time I could walk someway straight in months. This was the only treatment that gave any relief and I stopped taking the anti-inflammatories."*

The Complainants set out that Part Two of the Three Part PRP treatment plan was scheduled for **25th October 2019**. However, the Complainants submit that on the **23rd October 2019** (two days before the scheduled treatment), they were notified by the First Complainant's consultant that the Provider would not provide cover for the procedure. The Complainants submit that on **23rd October 2019**, they received confirmation of insurance cover for Procedure 5612 by email:

> "*On the 23rd October, [First Complainant's Consultant] contacted us to say that [the Provider] were not happy to cover the treatment on the 25th. I checked on line and received the attached email which said that we were covered."*

The Complainants submit that they contacted the Provider by telephone. The Provider notified them that they were only eligible for cover in respect of one such procedure (Procedure 5612) every six months, meaning that only the first of the three prescribed injections would be covered:

> "*We then rang [the Provider] and after some initial confusion they said that cover was for one procedure every six months. We argued that the medically advised treatment was for three injections four to six weeks apart. In other words, [the Provider] were saying that they would only cover one third of the medically advised treatment".*

The Complainants submit that they were unable to locate any reference to a requirement for a six-month interval between repeated treatments with Procedure 5612, other than in the Provider's Final Response Letter dated **29 January 2020**.

The Complainants also state that the Provider had recently changed the type of cover offered and that if their claim had been submitted earlier in time, their claim would have been successful:

> "*We are not sure when* [the Provider] *changed their approach but it seems that if we went for the treatment earlier in the year we would have been fully covered."*

The Complainants refer to the e-mail received from the Provider on **23rd October 2019** confirming that they would receive cover for Procedure 5612:

/Cont'd…

> "*There is no mention of payment conditions, any special notices or clinical indicators. Additionally, it clearly refers to three admissions."*
>
> *"Also the email dated 23rd October confirming that we were covered underlines how unclear or hidden* [the Provider's] *approach is".*

The Complainants also refer to the Final Response Letter issued by the Provider **on 29 January 2020:**

> "*Indeed, the 'Final Response' letter is confusing. Firstly, the fourth bullet point under the procedure Code paragraph states that 'Treatment is provided as part of a comprehensive pain management programme'. This is exactly the point we were making, the comprehensive pain treatment was three injections four weeks apart. This is irreconcilable with the 6th bullet point, 'six months have elapsed'."*

The Complainants describe the final paragraph of the Provider's Final Response Letter as "*very confusing*":

> "*It states that the claim is "*not eligible for benefit"*, but also states that we are "*not liable for the costs associated with this claim*"."*

The Complainants say that the Provider has wrongfully declined their claim. At the time of making their complaint, the Complainants specified what they were seeking from the Provider in resolution of their complaint as follows:

> "*We require* [the Provider] *to pay for the treatment on 25th October 2019, and to give the go-ahead for the third treatment."*

<u>The Provider's Case</u>

The Provider says that its records indicate that the Complainants have held the same health insurance policy with the Provider since its inception via the Second Complainant's employer on **1 January 2017**.

On **27 September 2019**, the First Complainant, the wife of the Second Complainant who is a insured person on the policy, underwent Procedure 5612 which is classified in the policy under '*Pain Management-Orthopaedic Procedures*'. The First Complainant's Consultant had prescribed a second and third such procedure as part of a course of three such treatments. The Provider is satisfied that it correctly declined the resultant claim in respect of the second procedure undergone by the First Complainant on **25th October 2019**, because the Complainants' policy provides no cover in respect of additional courses of Procedure 5612 within the same six-month period.

In this regard, the Provider's Schedule of Benefits pertaining to Procedure Code 5612 states:

/Cont'd…

> "*[The Provider] will provide benefit for procedure code 5612 if the following criteria are met:*
> *"..at least six months have elapsed since prior treatment for patients undergoing a repeat procedure at the same site (if previously administered, please indicate date of previous procedure)"*

The Provider notes that the Complainants did not contact it immediately before undergoing the first procedure on **27 September 2019** to query cover. The Provider states that it was unaware when assessing the claim in respect of the procedure undergone on 27 September 2019, that future treatments were intended:

> "*On 14 October 2019,* [the Provider] *received a claim form from* [the clinic at which the First Complainant attended for treatment] *for the Complainant's admission on the 27 September 2019; no mention is made on this claim form that future admissions would be required. This was paid directly to the hospital in November 2019 as per scheme rules and table of benefits"*

On **23 October 2019**, the Second Complainant telephoned the Provider, because the clinic at which the First Complainant was scheduled to attend for her second Procedure 5612, had advised the Complainants that this procedure code was only covered once every six months. The Provider submits that its agent confirmed to the Second Complainant that for cover to be applicable, six months must have elapsed since Procedure Code 5612 was carried out previously. On that date and during a subsequent telephone conversation, the Provider's agent advised the Second Complainant that pre-authorisation for cover in respect of the additional procedure could be requested by the First Complainant's consultant on her behalf.

The Provider elaborates on the meaning of 'pre-authorisation':

> "*Pre-authorisation is where the consultant requesting the treatment would provide medical information to the Medical Practice team, in advance of any treatment taking place, the Medical Practice team in turn would review the medical necessity of the treatment and would decide whether the treatment is eligible for benefit".*

The Provider submits that such pre-authorisation was not sought, and the First Complainant attended the procedure as scheduled on **25 October 2019** in the knowledge that the Provider only covered such procedures once, every six months.

On **11 November 2019**, the Provider received a claim for Procedure 5612 from the clinic where the First Complainant was admitted on 25 October 2019. The Provider submits that this claim was assessed by the Provider's claims department and declined on the basis that this was the second Procedure 5612 undergone by the First Complainant within a six-month period.

The Provider sets out that an appeal was opened on **13 January 2020** in respect of this claim. On **29 January 2020**, following an appeal, the claim was again declined for benefit on the basis of the criteria for Procedure 5612, in line with the Provider's Schedule of Benefits for

/Cont'd…

Professional Fees and the Provider's agreements with the clinic at which the First Complainant attended.

The Provider submits that its policy for Procedure 5612 did not change during 2019, as is suggested by the Complainants:

> "*… in fact, this criteria has been the same since the Complainant joined* [the Provider] *on the 1 January 2017. All consultants and hospitals are aware of the criteria associated with certain procedure codes and both have access to the Schedule of Benefits where these criteria are outlined.*

In response to the Complainants' statements that the recommended treatment was "*three treatments every four to six weeks apart*" and that the Provider "*would only cover one third of the medically advised treatment*", the Provider submits that it cannot comment on the advice of the First Complainant's medical practitioner:

> "[The Provider] *advise members on what is available under their chosen level of cover as set out in their table of benefits and in their rules booklet."*

The Provider states that its Medical Board advises that for Procedure Code 5612:

> "*It is not recommended within pain management guidelines to repeat Pulsed Radio Frequency (PRF) the duration between the injection should be at least 6 months*".

The Provider maintains that the Complainant was notified of the fact that additional treatments of Procedure 5612 would not be covered within the same six-month period as the previous Procedure 5612:

> "*Prior to the Complainant's treatment on the 25 October 2019, both the* [clinic] *and* [the Provider] *advised the Complainants of the above criteria for procedure code 5612. "*

The Complaint for Adjudication

The complaint is that the Provider has wrongfully or unfairly, declined to pay the claim made by the Complainants on the policy, relating to a procedure that the First Complainant underwent on 25 October 2019.

The Complainants want the Provider to pay for the procedure carried out on **25 October 2019** and to provide cover for an additional treatment under the same procedure code.

Decision

/Cont'd…

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 **4 October 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. In the absence of additional submissions from the parties, within the period permitted, the final determination of this office is set out below.

Chronology of Events

- **27 September 2017:** The First Complainant undergoes a Platelet Rich Plasma (PRP) treatment, the first in a series of three such planned procedures prescribed by the Complainant's consultant. The Provider was not contacted by the Complainants in advance of this procedure.

- **14th October 2019:** The Provider receives a claim for the clinic in question, in respect of the First Complainant's admission of 27 September 2020. No reference is made to a requirement for future admissions.

- **23rd October 2019:**
    - The First Complainant's consultant contacts the Complainants advising them that the Provider is not going to cover the second PRP treatment, which is scheduled for 25th October 2019
    - The Complainants check the Provider's online portal and receive an email confirming that the First Complainant is covered for the procedure on 25th October 2019.

    - The Second Complainant telephones the Provider to check that cover is available for the procedure on 25th October 2019. The Provider's agent

/Cont'd…

informs the Second Complainant that cover is only available for Procedure 5612 where six months have elapsed before undergoing a repeat procedure.
    - The Provider's agent advises the Second Complainant that pre-authorisation can be sought to have additional cover granted. The Provider's agent advises that this can be done by the First Complainant's consultant submitting the medical reasons behind his/her recommendation for the repeat procedure to be carried out.

- **25 October 2019:** The First Complainant undergoes second PRP treatment (Procedure 5612).

- **11 November 2019:** The Provider receives claim from the clinic in question for an admission on 25 October 2019 for the First Complainant in respect of Procedure 5612. This claim is rejected on the basis that it was the second claim for the same procedure within a six-month period.

- **13 January 2020:** An appeal was opened with the Provider on behalf of the Complainants.

- **29 January 2020:** The Provider issued its Final Response Letter, declining benefit payment for the treatment undergone in October 2019, in accordance with the criteria attached to Procedure Code 5612 within the Provider's Schedule of Benefits for Professional Fees and its agreements with the clinic in question.

Evidence

(i) Documentary Evidence
It appears from the documentary evidence provided by both the Complainants and the Provider that the Complainants were notified of the fact that the Provider did not cover repeat treatments of Procedure 5612 within six months. It is also clear that the Complainants were notified of this fact in advance of the second PRP procedure, the subject of this complaint, which took place on **25th October 2019.**

The Complainants submit that "*On the 23rd October* [First Complainant's consultant] *contacted us to say that* [the Provider] *were not happy to cover the treatment on 25th".*

The Provider submits in a response to this Office that "*On 23 October 2019…the Customer Service Representative advised the* [Second Complainant] *that the clinic was correct and that as per the Schedule of Benefits, for cover to apply for procedure code 5612, at least 6 months must have elapsed since the same procedure code was carried out previously*".

(ii) Email of 23 October 2019 Confirming Cover

/Cont'd…

The Complainants then queried the cover using the Provider's online portal and subsequently received an email advising that the First Complainant was covered for *"Procedure 5612 – Radiofrequency treatment of the spine*". Under the heading '*Your Costs'* the email set out the following:

Admission costs:	An excess of €125.00 is payable by the member. The excess is not payable on the 1st and 2nd admission. It is payable from the 3rd admission.

(iii) Telephone Conversation

Despite receiving the above-mentioned email, the Second Complainant proceeded to telephone the Provider on 23rd October 2019 to ask whether the First Complainant was covered for the second PRP procedure. I have listened to a recording of the telephone call the Second Complainant made to the Provider on 23rd October 2019 and I note the following dialogue:

Second Complainant: *It's my wife,* [First Complainant], *she's here with me now…she was in* [clinic in question] *about a month ago getting injections, and she was due her second one this Friday, and I think the hospital were on now to say* [Provider] *won't pay…every six months or something. I checked online and she's covered, so there's obviously something gone askew, but I just need to figure it out before Friday.*

Agent: *The hospital advised this procedure wasn't covered?*

Second Complainant: *She had the first one four weeks ago, it's a three-injection process, one injection a month. They said* [the Provider] *got onto them and said about a six-month limit, but there's nothing about that in the policy. We're meant to go in at 7am Friday morning.*

[…]

Agent: *I'm going to look into this further. I can see that on the Schedule of Benefits, it does say that at least six months have lapsed since prior treatment for patients undergoing a repeat procedure. I'll enquire with the Medical Practice team if it was something that would be covered for consecutive months.*

The Provider's agent advised the Second Complainant that he would seek to clarify the matter and contact the Complainants again that day, with an update.

Below is an extract from a subsequent telephone conversation that took place between the Second Complainant and the Provider's agent on the same date:

/Cont'd…

Agent: I have had a response from the Medical Practice Team. They advised that, in general, that is the case for the 5612 procedure. It's only available once every six months. But, if the consultant is advising it, he could make a pre-authorisation request showing the medical reasons behind why he is recommending that to be carried out again…again, he'd be aware. That would go to our pre-authorisation team. The consultant will have all those details. He will have to provide medical reasons behind that for it to be eligible. The Medical Practice team will have to review it after receiving the information from him.

[…]

Second Complainant: I'll do that so, I'll pass that on, I'll pass that onto the consultant and leave him explain all that.

Agent: If you want it to be carried out again, the 5612, it's pre-authorisation from the consultant, if you want it before the six-month period.

Second Complainant: Okay, so we will get him onto that sharpish, or we'll get his secretary or whoever to try and get that sorted for us.

Agent: Exactly.

(iv) Final Response Letter

The Provider's Final Response Letter, which issued to the First Complainant on 29 January 2019 stated that:

> "*As a period of less than 6 months lapsed between your procedure on 25 October 2019 and your previous claim for Procedure Code 5612 on 27 September 2019 your claim is not eligible for benefit. This is in line with* [the Provider's] *Schedule of Benefits for Professional Fees and our agreements with* [the clinic]".

(v) General Rules Policy Booklet

As per the Provider's scheme rules, a copy of which the Complainants received upon their inception of their policy on 1 January 2017, 'Schedule of Benefits' is defined as follows:

> "*This is the Schedule which we publish from time to time for the purpose of our medical insurance schemes in Ireland. This Schedule lists various surgical and diagnostic procedures and medical illnesses. Certain procedure codes listed in the Schedules have Clinical Indications or conditions of payment indicators attached to them. It also explains the amount of the benefits we shall pay for treatment provided by a consultant and for surgical out-patient treatment provided by a general practitioner. Certain procedure codes listed in the Schedules have Clinical Indications*

/Cont'd…

or conditions of payment indicators attached to them therefore it is important that you contact us in advance of your procedure to check your cover.

(vi) Schedule of Benefits

I note that conditions (such as those referred to in the above definition) attach to Procedure Code 5612 per the Provider's Schedule of Benefits, which states as follows:

Proc Code - 5612	**Non-destructive pulse radiofrequency (PRF) lesioning of medial branch (facet) or dorsal root ganglion, one or more levels under image guidance including sensorimotor testing (see note below)**
	[The Provider] will provide benefit for procedure code 5612 if the following criteria are met: • Patients aged over 18 years • Documentation on claim form details failure of six months of conservative treatment, such as medication and physiotherapy • One anaesthetic diagnostic block of the medial branch of the dorsal rami innervating the target facet joint has been administered and a significant reduction in pain has been demonstrated • Treatment is provided as part of a comprehensive pain management programme • A maximum of four facet joint denervations are provided per treatment episode • **At least six months have elapsed since prior treatment for patients undergoing a repeat procedure at the same site** (if previously administered, please indicate date of previous procedure). [My emphasis added]

It is also stated within the documentary evidence that a copy of the Schedule of Benefits is issued to all participating consultants including the First Complainant's consultant.

Analysis

The complaint at hand is that the Provider wrongfully or unfairly declined the Complainants' health insurance claim in respect of the First Complainant's pain management procedure in October 2019, the second such procedure in a course of three prescribed by the First Complainant's medical practitioner.

Having considered the documentary evidence before me and having listened to the recording of the telephone calls relating to this matter, I am satisfied that the Complainant was notified in advance of undergoing the second Procedure 5612, that the Provider would not cover the associated cost.

/Cont'd…

Although the First Complainant's consultant may have prescribed three treatments of Procedure 5612 within a short period, it does not follow that the Provider was obliged to cover the cost of all three procedures.

The fact that the three procedures were scheduled to take place within one six-month period does not make it a single treatment comprising of a "*course of three".* Furthermore, it seems that the First Complainant's consultant was on notice of and ought to have been aware of these criteria attached to Procedure 5612.

I note that the Provider clearly advised the Second Complainant that the only way the Provider would be able to cover a second such procedure would be by obtaining a 'pre-authorisation'. This process, which would have involved the First Complainant's consultant submitting evidence to the Provider outlining the medical necessity for the procedure, within that period, was explained clearly to the Second Complainant. The Second Complainant communicated his unequivocal understanding of what was required, stating that "*we will get onto him sharpish"*. No such pre-authorisation was sought from the Provider however, on behalf of the First Complainant, but the treatment proceeded nonetheless.

In respect of the email received by the Complainants on 23rd October 2019, reference is made to three 'admissions' in the context of the excess payable by the Provider's members in the event of such treatment, it is acknowledged that the Complainants may have interpreted this reference to three potential admissions, as specifically referring to the three PRP treatments prescribed to the First Complainant by her consultant.

The Provider has explained that this reference to the cost of multiple admissions, is a breakdown of the general benefits available under the policy subscribed to by the Complainants. I am of the opinion that this was less than clear in the email correspondence received by the Complainants but it does not follow that on this basis, the complaint should be upheld, because despite receiving the said confirmation from the online inpatient 'checking cover' portal, I note that the Second Complainant telephoned the Provider to establish whether cover was in fact available for the second treatment, and the position was then made clear to him.

In respect of the statement that if the First Complainant had undergone treatment "earlier in the year we would have been fully covered", I am not satisfied that this has been established. No evidence substantiating this claim has been put forward by the Complainants. In its response to this Office, the Provider states that:

> "[The Provider's] *policy for procedure code 5612 did not change during 2019; in fact, this criteria has been the same since the Complainant joined* [the Provider] *on the 1 January 2017. All consultants and hospitals are aware of the criteria associated with certain procedure codes and both have access to the Schedule of Benefits where these criteria's are outlined*."

/Cont'd…

Having considered the matter, I am satisfied that the Provider's conduct in refusing to cover the claim was reasonable, based upon the evidence available, details of which are outlined above. I am satisfied that the Provider acted in accordance with the terms and conditions of the policy, its Schedule of Benefits for Professional Fees and its agreements with the clinic in question, in declining the claim for the First Complainant's treatment. Accordingly, I take the view that there is no reasonable basis upon which this complaint can be upheld.

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

27 October 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.