DRN-4447465

The complaint

Mrs C is unhappy with the way Vitality Health Limited handled a claim made under her private medical insurance policy.

What happened

The details of this complaint are well known to both parties, so I won't repeat them here again. Instead, I'll focus on giving my reasons for my decision.

What I've decided – and why

I've considered all the available evidence and arguments to decide what's fair and reasonable in the circumstances of this complaint.

The relevant rules and industry guidelines say that Vitality has an obligation to handle insurance claims promptly and fairly. And it mustn't unreasonably reject a claim.

I don't think Vitality has acted fairly and reasonably by not agreeing to cover the cost of Mrs C's ultrasound scan which took place in October 2022 ('the ultrasound') in the specific and individual circumstances of this case.

Under the exclusions section of the terms and condition of the policy, it says Vitality will not pay for the following treatments:

> Diagnostic tests that have been arranged by anyone other than your consultant, except minor diagnostic tests ordered by a Vitality GP or a private GP in our network I'm satisfied an ultrasound is a diagnostic test as defined by the policy.

The request for the ultrasound was from Mrs C's own GP because Mrs C had been having pelvic pain, abdominal bloating and loose stools. Recent blood tests also revealed raised CA125-42 levels.

So, under the terms and conditions of the policy, the ultrasound scan isn't covered as it hadn't been arranged by one of the listed medical professionals.

However, I don't think it's reasonable for Vitality to rely on this exclusion in the circumstances of this case.

Mrs C called Vitality to authorise the ultrasound. After providing Vitality's representative with some details about why she'd been advised to have an ultrasound (including that this had been requested by her GP), the representative said: "I'll try and get this authorised now for you…won't be long". Mrs C then explains which hospital she was planning to go to for the ultrasound and the representative replies: "that's one of ours… that's fine."

The representative then asks Mrs C to send the GP referral letter (which she is yet to collect) to Vitality. She agrees to do this and asks for her authorisation number. The representative then proceeds to read out a number and asks Mrs C to include that number on the email

when she sends on the GP referral letter.

The representative then says he'll keep an eye out for the referral letter and would call Mrs C the next day.

Mrs C did send the GP referral to Vitality the next day. And I've seen evidence that Vitality's representative tried to call Mrs C three times that day (either side of the time she sent the GP referral to Vitality) but without success. Vitality's call notes reflect that the calls went through to voicemail but there's nothing to reflect that a message was left for Mrs C to contact Vitality or that this was followed up by email – even though the representative checked Mrs C's email address towards the end of the call.

Vitality says that the number Mrs C was provided with during the call was a claims number, not an authorisation number. However, I'm satisfied that Mrs C wouldn't have reasonably known that. The number was provided immediately after she asked for the authorisation number.

So, I think it was reasonable for her to believe that the ultrasound had been authorised during the call. And although she was asked to send in the GP referral letter, having listened to the call, I'm satisfied that she wasn't told that the ultrasound was still subject to approval or unlikely to be covered as the referral had been made directly by her GP.

In the circumstances, and relying on what was said during the call, I can understand why Mrs C proceeded to book and go ahead with the ultrasound based on the information given by Vitality's representative and believing it had been authorised. I think that was a reasonable belief for her to have.

The ultrasound went ahead around a week after the call and I'm satisfied Mrs C didn't receive anything substantive back from Vitality before the ultrasound took place to say, for example, that it wasn't covered because the request had come directly from her GP.

Mrs C was only told that Vitality wouldn't cover the ultrasound several days after it had taken place.

Vitality has said that it's for Mrs C to familiarise herself with the terms and conditions of the policy. But in the circumstances of this case, she had phoned Vitality to authorise the ultrasound going ahead. The representative was made aware that the referral had been made by her GP. And instead of telling Mrs C that it was unlikely the ultrasound would be covered or that the request would need to be considered further, the representative provided Mrs C with a number immediately after she asked for her authorisation number.

I'm satisfied that it would've been upsetting and confusing for Mrs C to find out after the ultrasound had taken place that Vitality was not covering the cost. Particularly after being provided with, what she reasonably believed, was an authorisation number. She then had the continued distress of thinking that she would be responsible for the cost of the ultrasound.

Putting things right

Mrs C says she hasn't yet received an invoice for the ultrasound. So, she hasn't lost out financially. If she does receive an invoice for the ultrasound, she should promptly forward this to Vitality and I direct that it should make payment to the medical facility within 21 days of receipt of the invoice from Mrs C.

Vitality also needs to pay Mrs C £150 compensation for the distress and inconvenience it's

caused Mrs C.

My final decision

I uphold this complaint and direct Vitality Health Limited to put things right in the way I've outlined above.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs C to accept or reject my decision before 7 December 2023.

David Curtis-Johnson
Ombudsman