DRN-4873828

The complaint

Ms O complains about the way AWP P&C S.A. has handled a number of claims she made on a personal private medical insurance policy.

All references to AWP include the actions of the agents and administrators authorised to act on its behalf.

What happened

The background to this complaint is well-known to both parties. So I've simply set out a summary of what I consider to be the main events.

In August 2017, Ms O took out a personal private medical insurance policy. At the policy renewal in August 2021, AWP became the underwriter of the policy. The contract was underwritten on moratorium terms, which meant that AWP wouldn't cover any medical conditions Ms O had had in the five years before the policy began.

Ms O made a number of claims on the policy, some of which have been paid by AWP. However, she's unhappy because AWP has turned down a number of claims she's made. I've listed these below, along with the reasons why AWP concluded the claims weren't covered:

- Continued treatment from a doctor I'll refer to as Dr N. AWP concluded that Ms O's symptoms existed before the policy began. It also considered that her symptoms were likely to be chronic – which was specifically excluded by the policy terms;

- Treatment from a specialist I'll call Mr S. Again, AWP concluded that Ms O's symptoms existed before the policy started and that they were likely to be chronic;

- Physiotherapy treatment Ms O underwent between 2019 and 2021. AWP says Ms O didn't submit the claim for payment until September 2022. The policy says that invoices must be submitted within six months of treatment. And in this case, Ms O had benefited from a renewal discount in 2022 based on her claims history, prior to submitting the invoices. So AWP concluded its position had been prejudiced by Ms O's actions;

- A mammogram Ms O underwent in June 2022, with a specialist I'll call Dr F. AWP considered that the screening had taken place for monitoring purposes and therefore wasn't covered by the policy terms;

- Treatment Ms O says she underwent for high cholesterol with a specialist I'll call Dr K. AWP concluded that evidence showed Ms O had been given weight loss advice. As the policy specifically excludes treatment for weight loss, AWP said the claim wasn't covered. AWP also said it wouldn't have authorised private treatment of high cholesterol;

- An MRI and consultations Ms O had with a doctor I'll call Dr N in June 2022. AWP

said there had been no referral to Dr N by a GP; that the MRI had been carried out for monitoring purposes, rather than for treatment of an acute condition; and it felt Ms O's symptoms may have existed before the policy started.

Ms O asked us to look into her complaint.

Our investigator didn't think AWP had treated Ms O unfairly. He considered the medical evidence showed that Ms O had consulted Dr N and Mr S with respiratory symptoms, which appeared to have been ongoing for some time. He noted Ms O had had investigations into her symptoms but no diagnosis had been made. So he didn't think it had been unfair for AWP to conclude that Ms O's respiratory symptoms were chronic and therefore excluded by the policy terms.

The investigator explained that the policy terms required invoices to be presented to AWP within six months, but in this case, Ms O had sent it physiotherapy invoices significantly later. He concluded AWP had been prejudiced by the late submission of the invoices. That's because Ms O had benefitted from a discounted policy renewal based on her claims history shortly before she sent the invoices in.

The investigator didn't think the available evidence indicated that Ms O had suffered an acute breast condition in June 2022, which had required her to undergo a mammogram. Neither did he think the mammogram had been pre-authorised, nor any GP referral made. So he felt it had been fair for AWP to turn down the claim.

Turning to Ms O's claim for high cholesterol, as Ms O's treatment didn't appear to be directly related to treatment of high cholesterol, the investigator felt AWP wouldn't have agreed to authorise the claim. And in terms of the MRI claim, the investigator felt the medical evidence indicated that Ms O had been referred for monitoring, rather than for the diagnosis of an acute condition.

In the round, the investigator thought AWP had acted fairly and reasonably and in line with the policy terms.

Ms O disagreed and I've summarised her response:

- She hadn't thought all referrals had to go back to a GP, given she'd been given onward referrals by specialists. She considered it was highly inefficient to require a policyholder to go back to the GP each time they needed a new referral;

- The investigator had failed to take into account medical evidence from Mr S which showed her cough hadn't been long-standing;

- The consultation with Dr K had not been for weight-loss treatment, it had been for the treatment of high cholesterol. She provided a letter from Dr K which stated that the appointment had been for high cholesterol – and there was no way she could have known before the appointment that the treatment would be weight management;

- The investigator had disregarded clarification letters from Ms O's treating doctors. She had provided evidence that the MRI had not been a review appointment but rather to check new symptoms;

- Ms O asked for a full review of her medical records to allow a full assessment of her medical history.

The complaint's been passed to me to decide.

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.

Having done so, whilst I'm sorry to disappoint Ms O, I don't think AWP has treated her unfairly and I'll explain why.

First, I'd like to reassure Ms O that while I've summarised the background to her complaint and her detailed submissions to us, I've carefully considered all she's said and sent. In this decision though, I haven't commented on each point she's raised and nor do our rules require me to. Instead, I've focused on what I think are the key issues.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. I've taken those rules into account, along with regulatory principles, the contract terms and other relevant considerations, to decide whether I think AWP has treated Ms O fairly.

As this complaint spans a number of claims, I'll deal with each in turn. However, I've first considered the policy terms and conditions, as these form the basis of the contract between Ms O and AWP. I've set out below what I think are the key terms which apply to the circumstances of Ms O's claim.

The relevant policy terms

The policy says that private medical insurance is designed to provide cover for short-term, elective specialist treatment a policyholder needs because they're suffering from an acute condition. An acute condition is defined as:

'A disease, illness or injury that is likely to respond quickly to treatment which aims to return you to the state of health you were in immediately before suffering the disease, illness or injury, or which leads to your full recovery.'

Treatment is defined as:

'Treatment relates to surgical and medical (non-surgical) procedures that are carried out by, or under the care of, a specialist in order to:

- *diagnose acute symptoms to see what is causing them;*
- *to cure an acute condition to stop it coming back; or*
- *to bring symptoms of an acute condition under control and to minimise their effect when a full cure is not possible.'*

The policy says that AWP will pay for:

- *'a consultation with a specialist to discuss your symptoms after you have been referred to that specialist by your GP;*
- *diagnostic tests required by the specialist to investigate the cause of your symptoms, diagnose the underlying acute condition causing your symptoms, and to develop the correct treatment plan;*
- *the treatment plan put in place by the specialist to treat your acute condition;*
- *hospital, surgeon and anaesthetist fees if you need surgery to treat an acute condition; and*
- *a follow up consultation with the specialist to confirm the treatment was successful.'*

The contract terms also set out a list of things AWP has specifically excluded from cover. Again, I've set out below the exclusions I believe to be relevant:

- *'Chronic conditions;*
- *We do not pay for any treatment if you have not been referred by your GP or if your GP indicates that a referral for treatment is not necessary;*
- *precautionary or voluntary health checks, health screenings, fitness testing or genetic testing where you do not have any symptoms of an acute condition but undergo a series of tests to find out if you have an acute condition or are at risk of having an acute condition in the future;*
- *Weight loss treatment.'*

A chronic condition is defined as:

'A disease, illness or injury that has one or more of the following characteristics:

- *it needs ongoing or long-term monitoring through consultations, examinations,*
- *check-ups and/or tests;*
- *it needs ongoing or long term control or relief of symptoms;*
- *it requires your rehabilitation or for you to be specially trained to cope with it;*
- *it continues infinitely;*
- *it has no known cure; or*
- *it comes back or is likely to come back.'*

In addition, the policy also sets out relevant claims conditions. I've listed below those I think apply in this case:

'We prefer to settle invoices directly with the provider, but if you do pay any invoices yourself, you must send them to us within six months along with a written request for reimbursement.

If you do not send your claim within six months, we will not reimburse you.'

And importantly, the policy says:

'Pre-authorisation of a claim

All claims must be pre-authorised before you start treatment so we can confirm your claim will be covered. If you incur additional costs because a claim was not pre-authorised, we will not pay those additional costs.'

In my view, the policy is worded in a clear, fair and not misleading way, which sets out the relevant cover and exclusions. I've next gone on to consider whether I think AWP handled Ms O's claims fairly.

Claims for treatment from Dr N and Mr S

AWP agreed for an initial consultation with Dr N, diagnostic tests and a follow-up test. It considered Dr N's report dated March 2022 when deciding whether or not to cover further treatment.

Dr N referred to Ms O's 'present complaints' as including 'persistent cough' and 'breathlessness'. They stated that Ms O 'had always had some breathing difficulties'. And that while Ms O was between 24 and 25 years of age, she'd had *'multiple unexplained*

symptoms, headache, cough, breathing difficulty and chest pain.'

The report also stated that Ms O had been *'seen by many specialists, nobody was able to identify the cause.'* And it said that in July 2021, Ms O had developed a persistent cough.

It seems that Ms O saw Mr S in June 2022. AWP says that this referral wasn't pre-authorised. Again, I've looked closely at Mr S' letter of 8 June 2022 and set out what I think are the key points:

'Ms O mentioned background of symptoms, such as brain fog, lethargy and cough that she has had for many years. Interestingly, some of the symptoms began in her early twenties…

There was close temporal relationship with a (vaccine) in June 2021, as Ms O's symptoms became worse since then…

I note she has seen a number of colleagues in the last two years to understand the nature of her symptoms. I found lung function study from 2021 that showed normal spirometry , lung volumes and gas transfer. In 2021, she also had normal chest X-ray.'

Having considered the reports from both Dr N and Mr S, it does appear that Ms O had a history of chest problems, including a cough, which spanned years. The evidence also indicates that Ms O had been seen by other specialists, who had been unable to provide a diagnosis or cure. As such, I don't think it was unfair for AWP to conclude that Ms O's respiratory symptoms weren't of an acute condition. Instead, I think the medical evidence points towards Ms O having required ongoing monitoring and consultations, along with tests. And therefore, I don't think AWP acted unfairly when it concluded that the claim for continued treatment of respiratory conditions wasn't covered by the policy terms.

I appreciate Mr S provided a letter of clarification, dated October 2023, which stated that Ms O's cough was not long-standing and was a more recent problem which correlated with a vaccine. I've thought about this carefully. But the letter is dated around 15 months after the original appointment. And I don't think it explains why Mr S had previously referred to Ms O's symptoms of a history of cough and respiratory symptoms if these hadn't been discussed during the June 2022 appointment. I understand Ms O doesn't think Dr N's report represents her discussions with Dr N. But I don't think it was unreasonable for AWP to rely on the contemporaneous medical evidence to conclude that Ms O's respiratory symptoms were chronic and to decline the claim. I also don't find AWP acted unfairly by placing more weight on the medical evidence Mr S provided in their original clinic letter of June 2022 than the letter of clarification. I'd generally consider contemporaneous medical evidence to be more persuasive than evidence provided more than a year after the original appointment.

Overall, I think AWP was reasonably entitled to decline to provide ongoing cover for Ms O's respiratory symptoms.

Claims for physiotherapy treatment

In late September 2022, Ms O sent in copies of physiotherapy invoices dating back around four years, up until November 2021. Some of the invoices pre-dated AWP's time as policy underwriter. However, all of the invoices were clearly submitted more than six months after Ms O's physiotherapy treatment and therefore, were specifically excluded from cover under the policy.

AWP says that it won't always strictly apply this timeframe, which I consider to be fair and reasonable. But in this case, it says that only three weeks before Ms O sent in the invoices, she'd negotiated a renewal discount on her policy which took into account her claims history

and loss ratio. Therefore, it considered that Ms O had financially prejudiced its position. It also added that it didn't think it had been fair for Ms O to sit on the invoices for a period of years and it added that the claims hadn't been pre-authorised in any event. Taking all of those points into account, I don't find that AWP has acted unfairly or unreasonably here in the specific circumstances of this complaint. That's because I think AWP was reasonably entitled to conclude its position had been prejudiced by Ms O's late presentation of the invoices. And it's also because I haven't been given any persuasive explanation for the delay in sending the invoices either.

This means I'm not directing AWP to pay Ms O's physiotherapy claim.

June 2022 mammogram claim

In June 2021, Ms O saw Dr F for a mammogram, which AWP did authorise and pay for. Following that appointment, Dr F sent Ms O a letter which stated that there were no clinical concerns. But Dr F also said that Ms O should consider regular screening.

Ms O returned to Dr F for a further mammogram in June 2022. This doesn't appear to have been pre-authorised by AWP. Dr F's letter from the time says:

'I am writing to confirm our review. You have continued breast discomfort… On review there are no focal or clinically concerning areas in either breast. Bilateral mammograms today are satisfactory and unchanged from the previous imaging which is reassuring.

I have asked you to remain breast aware. Should you have any new changes I would like to see you again. You should enter the National Health Service breast screening program called. You can consider interval imaging between screening rounds.'

The letter stated that Ms O had a diagnosis of mastalgia.

AWP says that given there were no clinical concerns noted in 2021 or in 2022, it doesn't consider there was evidence that Ms O had an acute condition which would be covered by the policy. I don't think this was an unreasonable position for AWP to take. I'm mindful that it hadn't agreed to authorise the June 2022 test, in line with the policy terms. And the letter indicates that Ms O had ongoing breast discomfort, rather than a new clinically concerning symptom. In the circumstances, I don't think it was unfair for AWP to conclude that this mammogram was more likely to be a screening or monitoring appointment, rather than treatment of an acute condition.

In October 2023, Dr F wrote a new letter which said that Ms O had visited her for a mammogram in June 2022 because she had new breast symptoms. It isn't clear that AWP has seen this letter but it says it would place more weight on medical evidence from the time of the claim. I note the original letter doesn't refer specifically to new symptoms Ms O was experiencing and nor does the October 2023 letter explain what these symptoms were. In the circumstances, I don't think AWP acted unfairly by relying on the medical evidence which was available to it when it assessed Ms O's claim and complaint. And the later letter of October 2023 doesn't change my decision on this point.

Therefore, I don't think AWP acted unreasonably when it turned down this claim.

Claim for consultation with Dr K

AWP turned down the claim because, based on the original medical information provided, Dr K largely provided Ms O with weight management advice, rather than specific treatment for high cholesterol. I don't think this was unreasonable in the context of Dr K's original

clinical report. I can see though from a further letter sent by Dr K that the purpose of the review was for high cholesterol. Ms O was referred to Dr K by another specialist for the treatment of high cholesterol. So I can understand why Ms O thinks that her claim for treatment with Dr K should be treated as an acute condition.

However, as I've set out above, the policy terms require both a referral from a GP and pre-authorisation by AWP. In this case, Ms O wasn't referred for management of high cholesterol by a GP and nor did she obtain pre-authorisation from AWP. AWP says it was prejudiced by Ms O's failure to contact it ahead of undergoing the appointment with Dr K. It says many of the tests which were arranged for Ms K weren't for the treatment of high cholesterol. And it also says that it wouldn't have authorised Ms K seeing a specialist privately for high cholesterol, as this could be managed effectively by a GP on the NHS. Like the investigator, I too have looked at information available on the NHS website and don't think AWP's conclusions here were unreasonable.

So on that basis, I don't think that AWP acted unfairly when it didn't agree to cover Ms O's claim for a consultation with Dr K.

June 2022 MRI scan

In February 2022, Ms O let AWP know that she'd been referred to Dr N in December 2021 and had had an MRI scan in December 2021 for headaches and visual disturbances. Despite the claim not having been pre-authorised, I understand AWP settled these costs.

Subsequently, in June 2023, Ms O sent AWP an invoice for an MRI scan she'd undergone with Dr N in June 2022. I've looked carefully at Dr N's letter dated 6 June 2022 to understand why a repeat scan had been arranged at this time. Dr N said:

'She is still having problems with headaches…I have also arranged a repeat MRI scan of her brain just to check there has been no further change since the last scan we did last year.'

Based on this letter, I don't think it was unreasonable for AWP to conclude that this MRI scan had been arranged as a compare, contrast and monitoring scan rather than because Ms O had been experiencing new symptoms of an acute condition. It's latterly raised the possibility that these symptoms may also have existed before the policy began, given the totality of the medical evidence does indicate that Ms O had likely suffered from headaches previously. In these circumstances, I don't find that it was unfair for AWP to conclude that Ms O's MRI scan wasn't arranged to diagnose an acute condition.

In September 2023, Dr N provided a further letter in support of Ms O's claim. This said:

'I confirm that the MRI she had in June 2022 was not a monitoring scan, it was a result of the patient experiencing new symptoms (facial numbness, eye floaters and worsening headaches) since the previous MRI in December 2021.'

Again, I've thought about this new evidence and in the circumstances, I'm satisfied that even if AWP hasn't seen it, for completeness, it's appropriate for me to consider it here. There is no reference in the June 2022 letter to Ms O having had facial numbness or eye floaters. And I can see that the original referral to Dr N in November 2021 stated that Ms O had headaches. This is also set out in the June 2022 letter, although Dr N doesn't indicate that Ms O's headaches had worsened. It seems then that these symptoms were already known and had been considered. As such, I still think it's fair for AWP to rely on the medical evidence from the time of the appointment.

Summary

I appreciate Ms O will be very disappointed by my final decision. I understand that she has significant bills to pay and I sympathise with her situation. But, in the round, I think AWP has treated her in a fair and reasonable way. It hasn't relied on a strict interpretation of its terms when considering some of these claims and it's taken into account relevant medical evidence. If Ms O feels AWP might reach a different decision if it considered her entire medical record, it's open to her to send this to AWP directly.

But, overall, I'm satisfied that AWP has considered Ms O's claims promptly, fairly and hasn't turned them down unreasonably. So I find that it was fair for AWP to turn down the claims I've set out above in all the circumstances.

My final decision

For the reasons I've given above, my final decision is that I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms O to accept or reject my decision before 10 September 2024.

Lisa Barham
Ombudsman