DRN-5036608

The complaint

Mr W is unhappy that Western Provident Association Limited ('WPA') declined to cover a claim made on a private medical insurance policy he benefited from ('the policy') and the way the claim was handled.

What happened

Mr W made a claim on the policy which was ultimately declined by WPA. It said that Mr W had symptoms before the policy started and as the policy was underwritten on a moratorium basis, the treatment wasn't covered.

Unhappy, Mr W complained to WPA and after it maintained its position, Mr W brought his complaint to the Financial Ombudsman Service.

Our investigator looked into what happened and upheld the complaint. He recommended WPA reimburse Mr W for treatment costs along with simple interest at a rate of 8% per year.

WPA disagreed and raised further points in reply. These didn't change our investigator's opinion, so this complaint has been passed to me to consider everything afresh 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.

WPA has an obligation to handle claims fairly and promptly. And it mustn't unreasonably decline a claim.

The relevant policy terms and conditions

Under the "what is not covered" covered section of the policy terms provided to us by WPA, it says (subject to the underwriting of your policy), a pre-existing condition isn't covered.

It goes on to explain that this is:

> Any condition, disease, illness or injury, whether symptomatic or not. This includes:
>
> - Anything for which you have received medication, advice or treatment; or
> - Where you have experienced symptoms, whether the condition has been diagnosed or not, before the start of your cover; or
> - Any symptoms or condition, whether diagnosed or not, which occurs in the first 14 days of cover, unless agreed and accepted by us in writing in advance.

Mr W's policy is underwritten on a moratorium basis. The policy terms explain:

> If you have moratorium underwriting you will not be eligible to claim for at least two years, for any condition(s) which you had during the five years before your policy

> starts or which occurred in the first 14 days after you joined us. We call these pre-existing medical conditions.
>
> If you do not have any symptoms, treatment, medication or advice for pre-existing conditions for two continuous years after the policy starts, benefit will then be available. We refer to this as the two year clear period.
>
> This means that you will not be able to claim for:
>
> Any conditions that existed during the five years before the date that you joined us, unless you have a two year clear period after your join date.

The policy schedule confirms the join / underwriting date for the purposes of the moratorium is a day in February 2023.

Has WPA fairly and reasonably declined the claim?

It isn't disputed that Mr W experienced back ache in the five years before the policy started and that he received medical treatment for this.

However, in the circumstances of this particular complaint, I don't think WPA has acted fairly by concluding that the treatment Mr W required within the two years of the policy start date (to also relieve lower back pain / aches) was for a pre-existing condition.

On the balance of probabilities, I'm satisfied that the cause of the back aches Mr W experienced before the policy was taken out had been resolved and was, more likely than not, caused by something else. So, although he'd had symptoms of back pain and was treated for this, based on the available medical evidence, I'm not persuaded that it has been fairly established that this was due to a condition, disease, illness or injury that he had before the policy started. I'll explain why.

- I don't think WPA has fairly and reasonably concluded that regardless of the cause, because Mr W had similar back symptoms in 2022 and later in 2023, the consultations, investigations and treatment Mr W wanted covered are related to a pre-existing condition under the policy.
- The medical evidence from Mr W's consultant orthopedic physician supports that in 2022, Mr W was experiencing lower back ache which would occur after standing or sitting for more than half an hour. An examination at the time revealed that his pelvic tilt and leg length discrepancy had recurred with associated lumber scoliosis and this was due to his sacra-iliac subluxation.
- The same medial evidence also supports that with soft tissue technique and manipulation his anatomical position was restored and his symptoms were released. In order to stablise the joint, an intra-articular injection was given and he was symptom free.
- Mr W says that he was able to go abroad to play a particular sport for many months without any issues with his back. It was only when he when he returned home, when playing that sport in the UK he was injured and felt pain in his back again. This was over a year after the back issues and treatment he had in 2022. I have no reason to doubt what he says about that. There's nothing in medical evidence I've seen which contradicts this and I find his submissions on this point to be plausible, consistent and persuasive.
- The medical evidence from Mr W's consultant orthopedic physician in November

2023 supports that he had symptoms on the left side of his lumbar spine at the level of L3/4 which occur when sitting or standing for five minutes.

- A subsequent CT scan which was reviewed by a spinal surgeon revealed that Mr W had facet joint degeneration L4/5 secondary to healed pars interarticularis fractures. The spinal surgeon's letter dated February 2024 reflects that Mr W previously had pelvic pain but "his symptoms have changed and he now has new hip and back pain rather than pelvic pain".
- A letter from the same consultant spinal surgeon addressed to "whom it may concern" dated March 2024 also reflects that Mr W: "previously had problems with his sacroiliac joint, and now he has a new issue in his spine with pars' injury which looks acute on his current imaging. I would appreciate your consideration that this is a new problem which he is suffering with rather than the old SIJ problem he previously consulted with".
- I've taken into account the opinion of WPA's chief medical officer ('CMO') that in their view, Mr W's previous symptoms in 2022 were due to the previous pars interarticularis fractures and facet joint degeneration. And that these underlying conditions, although not diagnosed then, were in existence prior to the policy starting in 2023. However, I've placed less weight on what the CMO says in the circumstances of this complaint. The CMO hasn't provided detailed reasons in support of this opinion. Nor am I satisfied that they've persuasively explained why their opinion, diagnosis and cause of the back pain / ache in 2023 differs from the opinion of the medical professionals directly involved in Mr W's care.
- As such, I've placed more weight on the medical professionals directly involved in Mr W's care, who diagnosed and treated the back pain / ache towards the end of 2023 / early 2024.
- I've also taken into account that Mr W experienced mechanical low back pain secondary to hype lordosis and leg length discrepancy in around 2019. However, I don't think the medical evidence supports that the condition which caused this is the same as the condition which caused the pain / ache in Mr W's back towards the end of 2023.

Claims handling and the impact of declining the claim unfairly

WPA accept that it unnecessarily delayed providing responses and that a call Mr W had with one of its representatives dated 1 December 2023 could've been handled better. I've also explained above why I'm satisfied that WPA declined Mr W's claim unfairly.

I don't think compnesation in the sum of £150 fairly and reasonably reflects the distress and inconvenience experienced by Mr W because of these errors.

Mr W had to provide further evidence in support of his claim from medical professionals involved in his care. I can appreciate that this would've been frustrating and upsetting at an already difficult time for him when he was vulnerable and in pain.

Looking at the timeline of events, I'm satisfied that Mr W's treatment wasn't significantly delayed because of the decision to decline the claim and he had the injection he required in March 2024. However, he had to self-fund consultations and medical treatment, and I accept that this would've caused him some worry around whether those costs would eventually be covered or not.

I'm satisfied that total compensation in the sum of £400 fairly reflects the distress and inconvenience he experienced.

Putting things right

Upon receipt of invoices reflecting that Mr W has paid for the costs claimed under the policy, and subject to the remaining terms of the policy (for example any policy excess), I direct WPA to cover the claim made under the policy relating to Mr W's back pain which started towards the end of 2023.

I also direct WPA to pay:

- simple interest of 8% per year from the date on which each payment was made by Mr W to the date of settlement*.
- £400 compensation for distress and inconvenience. It can deduct the amount of £150 it offered to pay Mr W in its final response dated June 2024 if that's already been paid.

*If WPA considers it's required by HM Revenue & Customs to take off income tax from any interest paid, it should tell Mr W how much it's taken off. It should also give him a certificate showing this if he asks for one. That way Mr W can reclaim the tax from HM Revenue & Customs, if appropriate.

My final decision

I uphold this complaint and direct Western Provident Association Limited to put things right as set out above.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr W to accept or reject my decision before 16 January 2025.

David Curtis-Johnson
Ombudsman