DRN-5151456

The complaint

Mrs N is unhappy with the service she received from AXA PPP Healthcare Limited ('AXA'). She has complained about delays and errors in authorising treatment, incorrectly declining a claim and the general handling of her claim.

What happened

Mrs N has a private medical insurance policy, underwritten by AXA. Mrs N called AXA to make a claim. It authorised treatment with a consultant.

Mrs N complained and AXA sent various final response letters, paying a total of £350 compensation to recognise the impact on Mrs N.

Unhappy, Mrs N referred her complaint to the Financial Ombudsman Service.

Our investigator looked into the complaint and didn't think AXA had done enough to resolve the complaint. She recommended an additional £100 compensation for the stress ad inconvenience caused to Mrs N at a time when she was unwell – she said this warranted more compensation.

Both parties disagreed (although Mrs N had initially accepted). Mrs N didn't think the award was enough and AXA didn't think an additional £100 was appropriate. It felt its award was fair and reasonable, in line with our compensation guidelines.

And so the case has been passed to me for a final 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.

Having done so, I agree that AXA should pay Mrs N an additional £100 for the impact of the poor service on Mrs N whilst she was unwell. I'll explain why.

- The background to this matter is well known to both parties. I have considered all the information provided by both sides in detail. Whilst I won't comment on all the submissions made, I have thought about everything very carefully. In my decision, I will summarise and focus on what I consider to be key to my conclusions.

- The relevant rules and industry guidelines say an insurer should handle claims promptly and fairly and shouldn't unreasonably reject a claim.

- AXA issued a number of final response letters, and it offered a total of £350 compensation. It accepts its service fell below a reasonable standard when it initially failed to source the correct consultant and also when it didn't call back when promised. Additionally, it accepted that it should have passed Mrs N's medical records to the surgical team to review before making a decision on the claim.

- Our investigator recommended AXA pay an additional £100 compensation as she didn't think £350 took Mrs N's circumstances into account fully.

- Mrs N has provided evidence of treatment she had, treatment she tried to get and costs she paid as well as information relating to her employment and dismissal. I am sorry to hear of Mrs N's difficult circumstances and her ill health. When considering the complaint against AXA, I have to separate the actions of third parties and matters outside of AXA's control from those within AXA's control. I will consider what AXA did, what AXA should have done and the impact of any action or inaction on Mrs N. Mrs N has said that had she been seen on 4 April 2024, she wouldn't have suffered or paid what she did out of her own pocket. So I think it will be helpful to set out a timeline of key actions.

Timeline

31January 2024 – Mrs N contacted AXA as she had been taken to A&E by ambulance and said she wasn't treated properly by the NHS so she wanted to seek private treatment. AXA advised Mrs N it needed her to ask her GP to complete a medical information form (MIF).

12 February 2024 – Mrs N was admitted into hospital in Jamaica.

24 February 2024 – Mrs N called AXA and said she was still suffering with symptoms. AXA asked Mrs N to send it a GP referral and the MIF. Mrs N said she had to go to Jamaica to be hydrated.

27 February 2024 – AXA received the MIF.

28 February 2024 – AXA called Mrs N and confirmed it had received the MIF but it didn't mention her trip to A&E. So it asked for the A&E discharge summary for it to be assessed.

29 February 2024 – AXA emailed Mrs N and having reviewed the MIF and A&E summary, it said it needed further information. Mrs N provided this information.

2 March 2024 – Mrs N called for an update and AXA said it should be in touch within 3 working days.

4 March 2024 – AXA emailed Mrs N and confirmed the documents had been sent to the specialist claims team for review – and it asked Mrs N to allow up to 5 working days.

AXA sent further emails on 5 and 6 March 2024 asking for further information.

6 March 2024 – Mrs N called and emailed AXA – she said she didn't understand what AXA wanted. She said she was very ill and needed to speak to someone. AXA called Mrs N and confirmed it would approve an initial consultation with a neurogastroenterologist.

7 March 2024 – Mrs N said she was self-paying for a medical admission and wanted to readmit herself using the cover she had with AXA. AXA asked for her discharge summary.

8 March 2024 – AXA booked an appointment for Mrs N with a gastroenterologist for 28 March 2024. Mrs N felt this was too late and asked how she was supposed to survive until then as she needed urgent treatment. AXA explained it didn't cover urgent care so it recommended that Mrs N go to A&E if she needed urgent treatment. It said it could look at alternative specialists at the Spire.

28 March 2024 – Mrs N called to say that the person they had booked her in with wasn't a neurogastroenterologist and she had waited three weeks for the wrong person. Mrs N complained.

1-3 April 2024 – Mrs N called to ask if she could have a consultation with a Dr M - AXA authorised an initial consultation and tests.

4 April 2024 – Mrs N sent a clinic letter to AXA and asked if it would authorise her claims. AXA said the claim was being reviewed. Mrs N said she had been waiting for a call and had been promised someone would contact her today. She said she felt misled. AXA apologised and said it would contact her as soon as possible.

5 April 2024 – AXA had reviewed the medical information and emailed Mrs N. It said the dates on the GP referral and the MIF were conflicting so it required further information. And it required consent to obtain medical records. Mrs N was unhappy as she felt she had not given conflicting information. She completed the consent form and this was sent to her GP.

Mrs N chased a number of times but AXA was still waiting to hear from her GP.

23 April 2024 – Mrs N told AXA the GP had emailed them but AXA said it hadn't received the emails. Mrs N asked to speak to a manager.

24 April 2024 – AXA spoke to the GP and learnt it had sent the information to an incorrect email address. The documents were then sent in the post.

26 April 2024 – AXA received the GP notes by recorded delivery.

29 April 2024 – AXA reviewed the medical notes and assessed the claim. It said symptoms relating to her heart were pre-existing. Mrs N replied to confirm that she didn't have heart issues in December and she'd had an unrelated issue.

8 and 22 May 2024 – AXA sent its final response letters regarding the incorrect specialist and failed call backs.

24 June 2024 – AXA confirmed it had reviewed the claim again as it had earlier said her claim was not eligible as she had experienced cardiac symptoms before the policy had started. AXA had passed Mrs N's medical records to the medical and surgical care team to review, who confirmed the reference to chest tightness would not necessarily relate to a cardiac issue. AXA agreed it would cover an initial consultation, tests and a follow up consultation. It had also arranged a cheque for £200 to be sent as it thought Mrs N's medical records should have been passed to the medical team before making a decision.

Following this, Mrs N found a cardiologist and AXA authorised further tests.

- AXA accepts it made a mistake when it booked a consultation for Mrs N with the wrong specialist which meant Mrs N waited 3 weeks only to find that the consultant wasn't the one she needed. I think this would have caused considerable distress especially since Mrs N was complaining about significant symptoms and AXA's mistake would have exacerbated and added to her worries.

- AXA also accepts that it failed to call Mrs N back when it said it would and that it had declined her claim without having had the medical records assessed by the medical and surgical team. The records were received by AXA on 29 April 2024 and the decision to accept the claim wasn't made until 24 June 2024. Although I don't necessarily agree that AXA should have requested medical records in January 2024,

I do think AXA delayed in authorising Mrs N's claim which would have caused her significant distress and worry. Had AXA referred Mrs N's medical records to the relevant team in April 2024, she wouldn't have had to wait until June 2024 to have her treatment authorised.

- Overall, I don't think £350 is enough to recognise the impact on Mrs N when her appointments had been delayed at least twice - firstly, when she wasn't booked in with the correct specialist and secondly, when her claim for cardiac issues was declined wrongly and therefore delayed. The compensation paid by AXA sits at the lower end of the compensation band published on our website so I think more is payable.

- An award of an additional £100 (a total of £450) is more appropriate. But I don't think anything more than that is payable. I say this because I think AXA was clear that Mrs N would need to attend A&E for emergency treatment and so she wouldn't be able to get urgent treatment through AXA. However, she could have had her consultations sooner had AXA not made mistakes and so I think the distress and inconvenience caused to Mrs N at a time she was unwell could have been avoided, to some degree. Mrs N was unhappy with the NHS and other issues but I can't hold AXA responsible for issues with third parties.

My final decision

For the reasons set out above, I uphold this complaint and direct AXA PPP Healthcare Limited to pay Mrs N an additional £100 compensation, in addition to the £350 it has already paid.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs N to accept or reject my decision before 28 January 2025.

Shamaila Hussain
Ombudsman