DRN-5178300

The complaint

Mr I is unhappy that AXA PPP Healthcare Limited declined a claim made under a group private health insurance policy ('the policy').

What happened

AXA declined to cover three medical procedures to treat varicose veins on both legs. It concluded that the consultant Mr I wanted to undertake the procedures wasn't on its 'fee approved' or 'fee limited' lists. Further, the medical facility where the procedures were due to be carried out wasn't listed on its Directory of Hospitals.

Unhappy, Mr I complained to AXA and after it maintained its decision to not provide cover, he brought his complaint to the Financial Ombudsman Service.

Our investigator looked into what happened and didn't uphold Mr I's complaint. Mr I raised further points in reply. Those points didn't change our investigator's opinion so this complaint was passed to me to consider everything afresh.

I issued my provisional decision explaining why I was also intending not to uphold this complaint, taking into account further evidence Mr I provided after our investigator's view.

I said:

…….

AXA has a regulatory obligation to handle insurance claims promptly and fairly. And it mustn't unreasonably decline a claim.

The relevant terms of the policy

The terms of the policy (at section 3.6) say:

> If your treatment is covered, we will pay different amounts depending on what kind of arrangement we have with your specialist.
>
> - Fee approved specialist. Using a fee-approved specialist gives you maximum reassurance, as we pay all their fees…
> - Fee-limited specialist. You may need to pay some cost yourself.
> - Specialists we do not pay for. We do not pay any of their costs.

The policy terms go on to provide further details about the different types of specialists. And relevant to this complaint, under the heading "specialist we do not pay for" it says:

> We will not pay any of their costs, so you will need to pay all their costs yourself.
>
> There are some specialists that are not on either our 'fee-approved' or 'fee-limited' lists. This means that we will not pay any of their fees, or any fees for treatment

> under their direction. If you do not want to pay for treatment, call us before you start treatment. We will be happy to find a specialist whose fees we will cover.

The policy terms go on say (at section 3.8) under the heading "paying the places where you're treated":

> If your treatment is covered by your membership, we will pay your hospital fees in full. This is so long as a specialist is overseeing your treatment, and you use one of the following listed in our Directory of Hospitals…

Has AXA acted fairly and reasonably by not covering the claim?

I know Mr I will be very disappointed but for the reasons I'll go on to explain below, I don't intend to uphold his complaint.

It isn't disputed that the consultant and medical facility aren't covered under the terms of the policy. So, the costs associated with the three procedures aren't strictly covered.

As the third procedure recommended by the consultant can only be carried out at this medical facility, Mr I has said that he will pay for that procedure but has asked that AXA cover the costs of the medical facility and consultant up to the limit of the agreed fee structure it has in place with authorised consultants and medical facilities listed on its Directory of Hospitals.

I've carefully considered whether it would be fair and reasonable for AXA to step outside the terms of the policy on that basis, and in the particular circumstances of this case. And I'm not persuaded that it would be.

The policy terms reflect (at section 3.3) that AXA covers "treatment and surgery that is conventional treatment". It goes on to say:

> We define conventional treatment as treatment that is established as best medical practice and is practised widely in the UK. It must also be clinically appropriate in terms of necessity, type, frequency, extent, duration and the facility or location where the treatment is provided.
>
> In addition, to meet our definition it must be approved by NICE (The National Institute for Health and Care Excellence) as a treatment which may be used in routine practice. Otherwise, it must have high quality clinical trial evidence proving it is effective and safe for the treatment of your medical condition (full criteria available on request).

I intend to find that the third procedure Mr I would like covered doesn't amount to 'conventional treatment' because as at date of the final response (July 2023) I've not seen any evidence which persuades me that it was treatment that is widely practiced in the UK.

Mr I says its only undertaken at the one medical facility he would like AXA to cover outside of the policy terms.

Further, and in the alternative, the parties accept that the procedure isn't approved by NICE and although I've been referred to some medical studies, I'm not satisfied that there's high quality clinical trial evidence proving that this procedure is effective and safe. One of the studies Mr I has referred me to dated 2018 concludes that although this procedure has lots of advantages "including being…high efficacious", it has a "guarded safety profile". The five-year study from the medical facility undertaking the procedure (dated 2009) concluded that

the procedure was effective. However, this was based on 37 patients, and I'm satisfied AXA has fairly concluded doesn't demonstrate persuasive evidence of significant clinical outcomes on pain, quality of life and mobility.

Mr I also says that the consultant and medical facility are approved by other private medical insurers. That may be the case, however, I don't think that means that AXA reasonably ought to cover the claim (either in full or in part). Each insurer will have different approved consultant and medical facility lists.

AXA has agreed to cover the cost of eligible treatment that takes place with a specialist and hospital recognised by it and has offered to help Mr I find an alternative specialist so that the first two procedures can be covered under the terms of the policy. I think that's fair and reasonable and in line with the terms of the policy.

I appreciate that does mean Mr I would need to have procedures undertaken at different medical facilities, if he did want to go ahead with the third procedure recommended by his consultant. However, unfortunately, as at the date of the final response letter, I'm satisfied that procedure isn't covered under the policy. I also note that the consultant's letter dated July 2023 (reflecting what was discussed with Mr I during clinic in June 2023) says that after the first two procedures, Mr I would be reviewed after four weeks and if needed, the third procedure would be scheduled. So, it doesn't seem that the three procedures would be carried out at the same time. And although I appreciate why Mr I would prefer all three procedures to be done by the same consultant at the same facility, there's no reason to think that Mr I couldn't proceed with self-funding the third procedure, even if the first two procedures are undertaken by a different consultant at a different medical facility.

……

I invited both parties to provide any further information in response to my provisional decision.

AXA didn't reply. Mr I replied, disagreeing with my provisional decision. In summary he said:

- I hadn't fully addressed several crucial aspects of his case.
- There was a disproportionate focus on the procedure that AXA says isn't conventional treatment and 87% of the proposed treatment consists of conventional, NICE-approved procedures that AXA accepts are valid treatments. He has offered to fund the remaining 13% of the total costs all three procedures and pay for the third procedure which AXA says isn't conventional.
- Another insurer (who'd previously provided cover before the policyholder switched cover to AXA) does recognise the medical facility and consultant he would like AXA to cover.
- Previous treatment (at a different facility and approved by AXA) had been unsuccessful, and he says treatment was inadequate. So, he sought greater specialism and expertise of the facility he'd like covered now.
- My decision doesn't adequately weigh the clinical benefits of receiving coordinated treatment at a single facility.
- My decision doesn't fully engage with the flexibility afforded by the policy regarding developing treatments. So, it would be fair for AXA to step outside the strict

interpretation of the terms of the policy in circumstances where he is offering to fund the part of the treatment plan which AXA doesn't consider to be conventional treatment.

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.

I thank Mr I for the detailed submissions he's provided in response to my provisional decision. I acknowledge that I've only summarised the points he's made – and in my own words. I'm also not going to respond to each point he's made. I hope Mr I understands that no discourtesy is intended by this.

Instead, I've focussed on what I think are the key issues here. The rules that govern the Financial Ombudsman Service allow me to do this as we are an informal dispute resolution service. If there's something I've not mentioned, it isn't because I've overlooked it. I haven't. I'm satisfied I don't need to comment on every point to be able to fulfil my statutory remit.

I know Mr I will be very disappointed, but the further points raised haven't changed my mind. To assure him, I had considered these points previously.

I know Mr I has offered to fund the (third) procedure which AXA has (I find, fairly) deemed not to be conventional treatment and not covered under the policy. But as I've explained in my provisional decision, the consultant that Mr I would like to undertake the first two procedures (as well as the third, non-conventional treatment) and the facility aren't covered under the terms of the policy. So, although the main bulk of costs may relate to conventional treatment, I'm not persuaded that it would be fair and reasonable for AXA to cover the facility and consultant's fees up to its usual rates it would generally pay.

I've also taken into account that the consultant and medical facility are approved by another insurer who had previously underwritten the private medical insurance Mr I had the benefit of though his employer. However, I don't think that means AXA reasonably ought to cover the claim (either in full or in part). I don't think it would be fair and reasonable for me to direct AXA to cover the medical facility and consultant outside of its terms because they would've been covered with the previous insurer. As I explained in my provisional decision, each insurer will have different approved consultant and medical facility lists.

Nor do I think it would be far and reasonable for AXA to cover the claim outside of the policy terms because of the treatment that Mr I says was unsuccessful previously at a facility and with a consultant that had been recognised by AXA and previously covered under the policy.

AXA has agreed to cover the cost of eligible treatment that takes place with a specialist and hospital recognised by it and has offered to help Mr I find an alternative specialist so that the first two procedures can be covered under the terms of the policy. I think that's fair and reasonable and in line with the terms of the policy.

So, for these reasons, and for reasons set out in my provisional decision (an extract of which is set out above and forms part of this final decision), I don't uphold his complaint.

My final decision

I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr I to accept or reject my decision before 2 January 2025.

David Curtis-Johnson
Ombudsman