DRN-5272683

The complaint

Ms B complains that Western Provident Association Limited (WPA) has turned down a claim she made for nutrition treatment on a personal private medical insurance policy.

What happened

Ms B holds a personal private medical insurance policy. Unfortunately, in late 2023, Ms B was diagnosed with cancer.

WPA opened a claim for Ms B and covered the costs of her seeing a consultant. The consultant referred Ms B for integrative treatment at a clinic I'll call S under the care of Dr F. It seems Ms B was seeking treatment from a cancer nutritionist.

On 20 June 2024, Ms B got in touch with WPA online. She asked for authorisation for a consultation with Dr F at S on 3 July 2024. On 26 June 2024, WPA wrote to Ms B to confirm that her claim would be paid, subject to the policy terms and conditions. The letter also stated that Ms B should let it know about the details of any further proposed treatment as soon as possible. It seems that Ms B went on to enrol on a membership plan with S that day and incurred costs of around £780.

However, on 1 July 2024, WPA got back in touch with Ms B to let her know that it couldn't authorise the claim. That's because it said that S wasn't a registered provider with it and Dr F wasn't a recognised specialist. Therefore, it said the claim wouldn't be covered under the policy terms.

Ms B was very unhappy with WPA's decision and she complained.

WPA accepted it had made errors in its handling of Ms B's claim. It said it hadn't fully reviewed Ms B's clinic letter before authorising the consultation with Dr F. It maintained that Dr F wasn't one of the specialists the policy covered and S wasn't one of its recognised providers. WPA said it had been in touch with two other specialists at S who did meet its criteria to ask whether they'd like to register with it, so that they could potentially provide care. But the specialists hadn't responded.

To compensate Ms B for its error, WPA offered to cover the cost of her consultation with Dr F on 3 July 2024 (if Ms B provided it with an invoice). And it identified it hadn't always responded to her queries and concerns within its service standards. So WPA paid Ms B £300 compensation to reflect any stress and inconvenience this had caused her.

Remaining unhappy with WPA's position, Ms B asked us to look into her complaint.

Our investigator thought WPA had already made a fair offer to settle Ms B's complaint. He thought the policy terms made it clear that WPA covered specialists it recognised. In this case, while WPA didn't recognise Dr F or S, the investigator thought WPA had made attempts to contact other specialists working at S to see if they'd be interested in registering with it. And the investigator noted that there were other dieticians in Ms B's locality that were registered with WPA, so he thought Ms B could access the treatment she needed.

And the investigator thought the evidence showed that Ms B had asked for authorisation for a consultation with Dr F on 3 July 2024. But he didn't think the evidence Ms B had sent showed there'd been a consultation on 3 July 2024 or that WPA had authorised the costs of any treatment beyond that.

In the circumstances, the investigator considered WPA had already made Ms B a fair offer of compensation.

Ms B disagreed. She said the membership fees were the costs of the initial consultation, as someone couldn't have a consultation at S without signing up. She felt the referral letter clearly showed that treatment with S was a long-term commitment to treatment in place of other forms of treatment. She said she'd asked WPA for a nutritionist, not a one-off consultation. She didn't think the investigator had understood the situation.

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 very sorry to disappoint Ms B, I think WPA has already made a fair offer to settle this complaint and I'll explain why.

First, I was sorry to read about Ms B's diagnosis. I don't doubt what an upsetting and worrying time this has been for her. I've carefully considered all she's said and sent us. In this decision though, I haven't commented on each point that's been 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, amongst other relevant considerations, such as regulatory principles, the policy terms and the available evidence, to decide whether I think WPA has treated Ms B fairly.

I've first considered the policy terms and conditions, as these form the basis of the contract between Ms B and WPA. Ms B's claim was to obtain cancer specialist nutritionist treatment. The contract states that dietary services are covered when treatment is given '*by a dietician on the Register of Dieticians of the HCPC.'* The second page of the policy document sets out 'Very Important Information'. This says that when using the policy guide, there are a number of things to remember, including:

- *When we refer to Specialist or Therapist, we mean a Specialist or Therapist we recognise;*
- *When we refer to hospital we refer to a hospital on our list of recognised hospitals and in accordance with your chosen hospital option.'*

Page four of the policy booklet states that all claims must be pre-authorised. And page five goes on to say:

'*At each state you seek pre-authorisation we will check:*

- *That your Specialist or Therapist is recognised by us and on our list of recognised hospitals.'*

WPA defines a specialist as: *'A medical practitioner holding a licence to practise whose*

name appears on the current GMC Specialist Register and is certified as a specialist by the appropriate college or specialist body providing a regulatory function.'

I think the policy terms make it clear that, in common with most private medical insurers, WPA will only pay for treatment provided by specialists and clinics it recognises. So I don't generally think WPA is obliged to pay for care provided by a doctor it doesn't recognise or that takes place in a clinic it doesn't recognise.

In this case, there's no dispute that Ms B's consultant referred her to see Dr F at S. I've seen a copy of the authorisation request Ms B made to WPA on 20 June 2024. The online form stated:

'*Urgent request via the web – Pre-authorise upcoming Consultation/Tests/Treatment…*
Pre-authorise consultation
Treatment date: 03/07/2024
Hospital Name: S
Specialist name: Dr F' (My emphasis added).

Both parties agree that WPA sent Ms B an authorisation letter on 26 June 2024. The letter said:

'Based on the information supplied we are pleased to confirm that this claim will be covered, subject to the rules and benefits of your chosen policy…please contact us to let us know…details of any further proposed treatment as soon as possible. This will give us the information we need…and ensure that benefit is available for the treatment you will be having.'

I can entirely understand why based on the authorisation letter, Ms B would've understood that her consultation with Dr F at S would be covered and why she might have gone ahead and booked such a consultation with Dr F on 3 July 2024. After all, that's what she'd asked WPA to pay for.

On 1 July 2024, WPA noted its error and told Ms B that the consultation wouldn't be covered after all, given it didn't recognise either S or Dr F. Having checked WPA's online directory, I'm satisfied this was correct. And I can see too that there were specialist cancer dieticians WPA did cover in Ms B's local area. On a strict interpretation of the policy then, I think it was fair for WPA to conclude that the consultation Ms B had asked for wasn't covered.

It's unfortunate that WPA didn't identify that it didn't recognise Ms B's preferred clinic and treating specialist before it sent the pre-authorisation. This was a clear mistake on WPA's part. And I also think it led to Ms B making arrangements with S that she might not otherwise have done had she known the costs wouldn't be covered. I can see she paid around £780 in membership fees and for precision health and integrative medicine. So I've thought about whether it would be fair for me to direct WPA to reimburse Ms B for all of the costs she incurred.

On balance though, I don't think it would. As I've set out above, Ms B clearly asked WPA to pre-authorise the cost of a consultation with Dr F on 3 July 2024. But I can't see that Ms B booked a consultation with Dr F. The costs she incurred are membership fees and precision health and integrative medicine. WPA didn't agree to cover those costs and Ms B didn't seek pre-authorisation for them. While it might be the case that Ms B needed to sign up to S before she could book an appointment, I don't think membership costs were something WPA agreed to pay for. So it seems to me that its liability here for its error would be limited to the costs of the treatment it did wrongly pre-authorise – the cost of a consultation with Dr F on 3 July 2024. WPA has previously offered to cover that cost. It remains open to Ms B to send

WPA evidence of the costs of that consultation if she wishes to do so. But, in the circumstances, I won't be telling to WPA to cover any costs above that consultation or which Ms B incurred once she learned that it didn't recognise Dr F or S.

I'm also mindful that WPA did take steps to try and contact specialists at S who would meet its recognition criteria so that they could provide Ms B with treatment. I think this was a very reasonable action for WPA to take and it isn't responsible for any failure of those specialists to engage in such a process.

WPA also accepts that it made some errors in its handling of the claim. It says it didn't always respond to Ms B in line with its own service standards and it's paid her £300 compensation to reflect that. In my view, the handling of the claim wasn't significantly prolonged and I think WPA set out its ultimate position on the claim promptly. So I find the £300 it's already paid Ms B is fair, reasonable and proportionate to reflect the impact on her of any delays in the handling of her claim.

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 B to accept or reject my decision before 6 March 2025.

Lisa Barham
Ombudsman