DRN-5311408

The complaint

Mr L complains about BUPA Insurance Limited's decision on a claim under his private health insurance policy.

What happened

Mr L holds a private health insurance policy through his employer, provided by Bupa.

Mr L had surgery in April 2023, and physiotherapy following this since May 2023. His physiotherapist requested ten further sessions on 10 January 2024, but Bupa said it would only pay for five of the recommended sessions. It said the policy provided cover for any eligible treatment for an acute condition, but not for treatment that is only temporarily relieving symptoms or managing a condition.

Bupa said that it had been nine months since Mr L's surgery, he was walking normally, had full range of motion, and only had 10% difference in strength to the other leg. So, Bupa said further improvement would come with time, self-management and exercises prescribed by Mr L's physiotherapist. It considered this could be delivered in three sessions over a six-to-nine-week period (Bupa had already allowed Mr L to have two interim sessions).

Mr L didn't think Bupa had treated him fairly. He said his physiotherapist was better placed and qualified to assess his physiotherapy needs. So, he brought a complaint to our service. In short, Mr L said Bupa should cover his physiotherapy treatment without limit, as recommended by his physiotherapist.

One of our investigators looked into what had happened. Having done so, she didn't think Bupa had acted fairly or reasonably when it declined to pay for all the ten recommended sessions. This was because the physiotherapist's report noted that Mr L had had a setback in his recovery, and so the treatment appeared to be for an acute condition as per the policy terms.

Mr L didn't think this went far enough. He wants Bupa to cover any remaining sessions without limit and pay him compensation due to a setback in his recovery. Bupa, on the other hand, said that Mr L had already had treatment for nine months, and the remaining treatment would be progressive strengthening programme. So, it maintained that the recommended treatment wasn't eligible treatment as per the policy terms.

As no agreement was reached, the complaint has 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.

Firstly, my remit is to consider the issues Bupa has already had the chance to consider and respond to. It's not within my remit to direct Bupa on any future claim decisions. If Mr L is not happy with how Bupa handles any future claims, he can raise a new complaint with Bupa in the first instance.

Industry rules set out by the regulator (the Financial Conduct Authority) say insurers must handle claims fairly and shouldn't unreasonably reject a claim. I've taken these rules, and other industry guidance, into account when deciding what I think is fair and reasonable in the circumstances of Mr L's complaint.

Mr L's policy covers eligible treatment, which is defined as:

> *"Treatment of an acute condition or a mental health condition, together with the products and equipment used as part of the treatment that are:*
> - *consistent with generally accepted standards of medical practice and representative of the best practices in the medical profession in the UK, and*
> - *clinically appropriate in terms of the type, frequency, extent, duration and the facility or location where the services are provided for example as specified by NICE (National Institute for Health and Care Excellence), or equivalent bodies in Scotland, in guidance on specific condition or treatment where available, and*
> - *demonstrated through scientific evidence to be effective in improving health outcomes and the treatment, services or charges are not listed in the 'What isn't covered' section in this guide, and*
> - *not provided or used primarily for the expediency of you or your consultant or other healthcare professional*
>
> *and the treatment, services or charges are not excluded under your benefits."*

An acute condition is defined in the policy 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."*

Bupa assessed Mr L's physiotherapist's report and said he was walking normally, had full range of motion, and only had 10% difference in strength to the other leg. Bupa also noted it had been nine months since Mr L's surgery, and it said that it normally took five to nine months for patients to return to sport following this type of surgery. Bupa has referred to a rehabilitation protocol, and other guidance, which it says supports its decision on Mr L's claim.

Having considered all of these, I don't think Bupa assessed all the information on the physiotherapist's report fairly. Bupa said Mr L was walking normally, but the physiotherapist scored Mr L's walking as 7/10 and noted that he had difficulty walking down steep stairs or hills, and he was unable to step down, lunge, run or jump. The rehabilitation protocol Bupa has referred to refers to jumping, and full range functional activities, being part of the programme during the rehabilitation period. Return to running and jumping were part of the plan that the physiotherapist recommended the ten sessions for.

Mr L's physiotherapist also noted a setback during the rehabilitation which caused a significant loss of function and increase in pain, which had lengthened rehabilitation timeframes. The physiotherapist said Mr L was having daily functional issues at the time.

Based on what I've seen, I think Mr L's physiotherapist's recommendation was in line with the rehabilitation protocol Bupa has referred to, and his recovery was progressing. I appreciate Mr L's rehabilitation was taking longer than usual. But I'm not persuaded that Bupa has shown the recommended treatment wasn't eligible as per the policy terms. So, I don't think Bupa acted fairly or reasonably when it declined to authorise the recommended ten physiotherapy sessions, and instead only authorised five.

Mr L had the five sessions that Bupa authorised, and then paid for two further sessions, until there was a change in circumstances which led to Bupa authorising further physiotherapy sessions anyway. Though as a self-paying patient he had to pay more for those two sessions than Bupa would have done. This has resulted in him using more of his benefit limit than would have been the case if Bupa had covered the sessions. Bupa should treat this claim as if it had authorised the ten sessions at the time. So, Bupa should only apply the amounts it would have paid against the benefit limit, rather than what Mr L paid. It should also treat any unused pre-authorised treatment as it would when there is a change in circumstances and further sessions are approved. This is to put Mr L back into the position he would have been in, had Bupa authorised the ten sessions at the time.

Mr L says Bupa's actions led to a setback in his recovery, as he spaced out and skipped some sessions. He says he pushed a bit too hard on one occasion which caused a slight reinjury. However, I don't think this is something I can fairly hold Bupa responsible for. It was ultimately Mr L's decision how to continue with the treatment recommended by his physiotherapist, whether this was paid for by Bupa or not. So, I don't think it would be fair or reasonable for me to tell Bupa to pay Mr L compensation for this. I also don't think Bupa should pay for any sessions Mr L didn't attend, as he hasn't suffered a financial loss.

Mr L questioned if Bupa's physiotherapists who assessed the claim were qualified to do so. But ultimately, Bupa wasn't assessing whether Mr L's treatment was appropriate or necessary – it was assessing if the treatment was covered under the policy terms. It's common practice for an insurer to assess claims based on the reports provided by treating professionals, as well as any relevant guidelines, to see if the recommended treatment is covered under the terms and conditions of the policy.

My final decision

My final decision is that I uphold Mr L's complaint and direct BUPA Insurance Limited to take the following action:

- accept Mr L's claim for the ten physiotherapy sessions requested in January 2024,
- pay for any invoices Mr L paid towards these sessions in line with the remaining terms and conditions of the policy (but only apply the amount Bupa would have paid for these sessions against the benefit limit), and
- pay 8% per year simple interest on these amounts from the date Mr L paid the invoice until date of settlement*.

*If Bupa considers that it's required by HM Revenue & Customers to take off income tax from the interest, it should tell Mr L how much it's taken off. It should also give Mr L a certificate showing this if he asks for one, so he can reclaim the tax from HM Revenue & Customers if appropriate.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr L to accept or reject my decision before 23 April 2025.

Renja Anderson
Ombudsman