DRN-5392814

The complaint

Mrs S is unhappy that Vitality Health Limited (Vitality) partly settled her claim under her private medical insurance policy.

Mrs S is being represented by her husband, Mr S, on this complaint. For ease, I've referred to both Mrs S and Mr S in this decision.

What happened

Mrs S has a private medical insurance policy which started in 2018 and has been renewed annually. The policy underwriter is Vitality.

In January 2024, Mrs S had a fall and unfortunately fractured her pelvis. She received treatment in a hospital and had daily physiotherapy. Due to accessibility restrictions in her home, when Mrs S was discharged in February 2024, she went into a care home for three weeks and had further physiotherapy from a different provider. Mr S says Vitality didn't provide a physiotherapist so the family located one who could assist while Mrs S was in the care home.

Mr S made a complaint to Vitality. It said the treatment wasn't authorised by it and the physiotherapist and the clinic Mrs S used were not registered on the policy. Vitality also said rehabilitation cover wasn't available on the policy for Mrs S.

Unhappy, Mr S brought the complaint to this service. Our investigator partly upheld the complaint. She didn't think the claim was unfairly declined. And regarding the invoice for £18.40 for the ward prescribed medication and dressing, she didn't think it was fair for Mrs S to now obtain the refund from the provider. So, she recommended for Vitality to reimburse Mrs S and add 8% simple interest and pay £50 compensation for the inconvenience caused to her.

Mr S disagreed and asked for the complaint to be referred to an ombudsman. So, it was passed to me.

I issued a provisional decision on 6 March 2025 to both parties. I said the following:

I've considered all the available evidence and arguments to decide what's fair and reasonable in the circumstances of this complaint.

Industry rules set out by the regulator (the Financial Conduct Authority) say that insurers must handle claims promptly and fairly and shouldn't unreasonably reject a claim. I've taken these rules into account when considering Mrs S's complaint.

The key issue I need to determine is whether I think Vitality acted fairly in declining to pay for Mrs S's physiotherapy sessions.

Vitality's reasons for declining the claim are as follows:

• *Mrs S's physiotherapy sessions were for rehabilitation and cover for this is only available in*

the case of patients suffering from a stroke or brain injury.

• Mr S didn't obtain authorisation for the physiotherapy and the physiotherapist wasn't covered under the policy.

• The physiotherapy cover on Mrs S's policy is on an out-patient basis. And out-patient is defined as: 'A patient who attends a hospital, consulting room or out-patient clinic and is not admitted as a day-patient or an in-patient.' On this basis, there is no cover for physiotherapy for Mrs S as she didn't attend any of these as an out-patient, but they took place in a care home.

• Whilst Mrs S did obtain physiotherapy and Vitality were advised that it was deemed medically necessary, the treatment was completed daily in the care home (and as if she was an in-patient) to restore mobility and function following a hospital stay rather than being used to treat an acute illness, injury or disease. So, there's no cover on the policy for this.

I've considered the terms and conditions of Mrs S's policy and the reasons provided by Vitality for declining the claim. I'll address each point above in turn and in conjunction with the terms and conditions of the policy.

• Mrs S's physiotherapy sessions were for rehabilitation and cover for this is only available in the case of patients suffering from a stroke or brain injury.

> *The rehabilitation benefit is described in the policy on page 21 as:*
>
> *'Rehabilitation*
>
> *This benefit provides you with up to 21 days of in-patient or day-patient rehabilitation treatment following a stroke or serious brain injury. The treatment must:*
>
> *o immediately follow a period of inpatient treatment*
>
> *o start no more than two months after the initial diagnosis or date of injury*
>
> *o be undertaken in a rehabilitation unit at a recognised rehabilitation facility'*

Rehabilitation in the policy is defined as:

> *'Medical services aimed at restoring a person's function and independence following in-patient treatment of a disease, illness or injury.'*

Mrs S's consultant informed Vitality that she required rehabilitation on 9 February 2024. And according to the policy, rehabilitation is only available for in-patients or day-patients following a stroke or serious brain injury. I understand that Mrs S required her function and independence to be restored while in the care home (as an in-patient treatment) following an injury. But this benefit is only available for a patient who's suffered a stroke or brain injury. I don't think therefore the claim is covered under this section of the policy.

> *• Mr S didn't obtain authorisation for the physiotherapy and that the physiotherapist wasn't covered under the policy.*

I note Vitality's argument for declining the claim has also been that Mr S didn't obtain authorisation for the physiotherapy sessions at the care home. It said a referral hadn't been received from the consultant and so it couldn't authorise the treatment. However, I note that Mrs S's consultant did send an email to Vitality, on 13 February 2024, to confirm it was

medically necessary for her to have the physiotherapy following her discharge from hospital. The referral was received, and I don't think Vitality acted on this to inform Mr S whether there was cover for the physiotherapy sessions. Mrs S's family therefore went ahead and arranged the sessions as it hadn't heard from Vitality. Vitality did inform them more than once that there was no cover for the therapist as he wasn't included on the approved list. Vitality also offered a name of another provider who was listed but the family had already gone ahead with their arrangements. When the email from the consultant was received by Vitality, it didn't take any further action to inform Mr S of whether cover was now available. I'm therefore not persuaded that this is a reason to decline the claim. And bearing in mind that other more relevant sections of the policy apply in this case, I don't think this reason is sufficiently valid.

- *The physiotherapy cover on Mrs S's policy is on an out-patient basis. And out-patient is defined as: 'A patient who attends a hospital, consulting room or out-patient clinic and is not admitted as a day-patient or an in-patient.' On this basis, there is no cover for physiotherapy for Mrs S as she didn't attend any of these as an out-patient, but they took place in a care home.*

I've considered the terms of the policy. Mrs S has 'Out-patient Cover' under her policy. In the membership certificate, the physiotherapy aspect of this benefit is described as 'Full cover for in-network physiotherapy. Out-of network physiotherapy is covered up to £35 per session.'

Out-patient is defined in the policy as:

> *'A patient who attends a hospital, consulting room or out-patient clinic and is not admitted as a day-patient or an in-patient.'*

Out-patient Cover on page 17 of the policy document sets out the cover for physiotherapy:

'Your out-patient cover also includes physiotherapy. We have agreed tariffs in place with a select panel of physiotherapists across the country. Providing you contact us so we can arrange for you to see a physiotherapist on our panel, we'll cover each physiotherapist session in full… It is not necessary to obtain a referral from a GP if you follow this process.

Physiotherapy arranged by your consultant following surgery will also be covered in full and will not be subject to any limits on your Out-patient Cover.

If you arrange your own physiotherapy then we'll only pay a set amount per session, it will be subject to any limits on your Out-patient Cover and you'll have to pay the provider direct yourself…'

The issue here is that Mrs S had the physiotherapy in the care home – the sessions wouldn't be considered as being under the out-patient cover. I appreciate and understand the reasons to situate Mrs S in a care home given there were accessibility concerns in her home. However, whether Mrs S had the sessions in the care home or her own home, either way, they would still have been in one of those locations. The sessions weren't conducted in a hospital, consulting room or out-patient clinic (on an out-patient basis). Whilst the policy provides cover for physiotherapy, this is only on an out-patient basis. I don't think there is cover for these sessions as Mrs S's policy has cover for physiotherapy as an out-patient. And whilst Mrs S had physiotherapy while she stayed in hospital, that was because she was an in-patient, and they were arranged by her consultant and for which she had cover.

> *• Whilst Mrs S did obtain physiotherapy and Vitality were advised that it was deemed medically necessary, the treatment was completed daily on an in-patient basis to*

restore mobility and function following a hospital stay rather than being used to treat an acute illness, injury or disease.

Without wanting to repeat too much of what I've said above, the issue is that Mrs S had physiotherapy as an 'in-patient' in the care home rather than as an 'out-patient'. And for the purposes of the policy, there is no cover for this.

Overall, whilst I do understand there has been confusion in Vitality's communication about why it's declining the claim, having considered this carefully, I don't think the claim for the physiotherapy sessions are covered under the policy. Even though the consultant provided the letter to confirm the sessions were medically necessary, Mrs S still wouldn't have been covered. I understand the strength of feeling on this matter but having reviewed everything, there is no cover for the claim.

I've considered Vitality's handling of this claim. I do think Vitality could have been a lot clearer in its communication and providing the reasons for the decline. The lack of clarity has caused a great deal of confusion and I think it's fair to say this has been a frustrating time for Mrs S. Mr S has sought a clearer explanation about why the claim was being declined and at first Vitality said it was because rehabilitation wasn't covered. Then Vitality said the sessions weren't authorised and the provider wasn't on its panel of approved providers. It asked for a referral letter from the consultant which was then provided but not further actioned. In its submissions to us, Vitality's said that there is no cover for physiotherapy under the out-patient section of the policy as Mrs S had these in the care home. And in regard to the invoice for £18.40, Vitality asked Mrs S to request the amount from the hospital as it had been paid directly to it, but she wasn't aware. This has caused Mrs S some distress and inconvenience. The situation has been difficult for her, and I can see she has struggled to understand the communication from Vitality as it wasn't clear. I am minded therefore to award a total compensation amount of £250 in recognition of Vitality's lack of clarification and confusing communication. This would include the £50 already recommended by the investigator.

Putting things right:

My intention is to ask Vitality to put things right by:

• Reimburse Mrs S £18.40 for the medication and dressing and add 8% simple interest per annum from the date Mrs S paid the invoice to the hospital to the date of settlement.

• Pay £250 total compensation for the distress and inconvenience caused.

Both parties responded to my provisional decision.

Mr S responded and said they have no knowledge of Vitality informing them of a physiotherapy provider from their panel. Vitality hadn't either before or after they instructed their own physiotherapist did Vitality provide a name of someone from its approved list. Mr S has asked for proof of an email or letter which confirms this.

Vitality responded and said it would make payment of the compensation.

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, as I've been provided with no new comments or arguments, I see no

reason to depart from the outcome reached in my provisional decision. I'll explain why.

I've reviewed Mr S's comments. Whilst I think he hasn't raised anything new and which I haven't already considered, for completeness, I will provide a response.

I appreciate that Mr S says they have no knowledge of Vitality informing them of a physiotherapist they could use from its approved panel. I can see Mrs S's daughter had a conversation with Vitality on 12 February 2024 where she was informed a physiotherapist from its panel could be used. I understand that they might not recall the conversation as I can see the family was busy with making arrangements for Mrs S's care. However, I can only go by the evidence that's been provided and this confirms there was a conversation about using Vitality's approved list of physiotherapists.

Ultimately, as I said in my provisional decision, the crux of the issue here is that Mrs S had physiotherapy as an 'in-patient' in the care home rather than as an 'out-patient'. And for the purposes of the policy, there is no cover for this. I'm sorry to disappoint Mrs S but I don't think Vitality declined the claim unfairly or outside the terms and conditions of her policy.

And in terms of the compensation award of £250 in recognition of the distress and inconvenience caused to Mrs S, I think this is fair and reasonable. Vitality has confirmed its acceptance of my provisional decision and has said the reimbursement of the medication invoice has been made. If it hasn't already been made, then Vitality should now do so.

Putting things right

I require Vitality to put things right in the following way:

- Reimburse Mrs S £18.40 for the medication and dressing and add 8% simple interest per annum from the date Mrs S paid the invoice to the hospital to the date of settlement.

- Pay £250 total compensation for the distress and inconvenience caused.

My final decision

For the reasons explained above, I partly uphold Mrs S's complaint about Vitality Health Limited. I require it to do as I've set out in the 'putting things right' section above.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs S to accept or reject my decision before 10 April 2025.

Nimisha Radia
Ombudsman