DRN-5848719

The complaint

Mr S has complained that Cigna Europe Insurance Company SA has declined to fully cover a claim under his private medical insurance policy.

What happened

Mr S injured his knee and submitted a claim for treatment in November 2024. Cigna paid the claim for physiotherapy but declined part of the claim relating to shockwave treatment, due to it being a non-conventional treatment.

Our investigator thought that Cigna had acted fairly and reasonably, in line with the policy terms and conditions. Mr S disagrees and so the complaint has been passed to me for a 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.

I've carefully considered the obligations placed on Cigna by the Financial Conduct Authority (FCA). Its 'Insurance: Conduct of Business Sourcebook' (ICOBS) includes the requirement for Cigna to handle claims promptly and fairly, and to not unreasonably decline a claim.

Cigna's position is that Mr S didn't seek advance authorisation for the shockwave treatment. as required under the policy terms and that, had he done so, it would have declined cover.

Mr S bought the policy on 1 November 2024. On 26 November 2024 he submitted a claim for reimbursement for one session of physiotherapy that he'd received on 13 November 2024, costing 120euros. So, the claim, as set up by Mr S at this point, was for physiotherapy only.

As he was making a claim so soon after the policy had begun, Cigna required more information before it could confirm coverage. It therefore asked for a detailed medical report that included information about when the symptoms started, the diagnosis if he had one, date he first consulted a doctor, medical history relating to the same symptoms and a treatment plan.

Mr S said he would get this information but also said that he didn't think he'd need to do that for physiotherapy. Therefore, Mr S is clear at this point that his claim is just for physiotherapy and that the extra enquiries that Cigna is making is just to confirm coverage for the physiotherapy.

Mr S responded that his next appointment with the doctor was on 10 December 2024 and he would provide the information then. The treating doctor then provided a report and this did mention that the treatment plan was for shockwave treatment and physiotherapy. However, the report did not provide all the information requested, such as the history of the onset of the condition.

When Cigna then contacted Mr S on 11 December 2024 to ask for that information again, it stated: 'With regard to a claim that you submitted on 26/11/2024....'

On 13 December 2024 Cigna made direct contact with the physiotherapist. It didn't receive a response and so wrote to Mr S on 23 December 2024 in relation to the invoice for 120euros and saying: '*we require the medical report regarding that invoice and full clinical picture...*'

As Mr S simply referred Cigna back to the report dated 10 December 2024, it then made direct contact with the treating doctor on 27 December 2024. It received a response back on 7 January 2025 that did finally answer the medical history questions.

However, Cigna required clarification as to why Mr S had received treatment on 13 November 2024, prior to receiving a diagnosis. So, it directly contacted the physiotherapist again on 18 January 2025 and 29 January 2025.

The response from the physiotherapist was received on 10 February 2025 and the claim was processed from 14 February 2025.

Looking at the above correspondence, I consider that Mr S should have understood that Cigna's contact and information requests were solely in relation to the original claim for physiotherapy that he had made on 26 November 2024.

Mr S's argument is that, because the doctor's report of 10 December 2024 mentions shockwave treatment, Cigna should have known that that treatment would eventually form part of the claim.

I've thought very carefully about this point but, overall, I'm not persuaded that Cigna has done anything significantly wrong. It was reviewing the documentation in relation to a claim for physiotherapy. Mr S had not contacted Cigna to request pre-authorisation for shockwave therapy. It wasn't until he made an online claim for the treatment, attaching invoices, that Cigna was in a position to decline cover. Whilst it would have seen the report dated 10 December 2024, it wouldn't be fair to conclude that Cigna should have assumed he'd definitely go on to have shockwave therapy and therefore should have contacted him in advance of an anticipated claim or request for pre-authorisation.

Contrary to what Mr S has said, the shockwave treatment was not part of the three-month physiotherapy plan that he had originally claimed for. Shockwave therapy is a separate and distinct treatment to physiotherapy, and the onus was on Mr S to seek authorisation before undergoing any type of treatment. So, I don't agree that Cigna had given him a 'general green light' or led him to believe that the whole proposed treatment plan would be covered.

As he hadn't sought pre-authorisation, Cigna then carried out a review of the treatment. It concluded that shockwave therapy was not covered as it is a treatment which is experimental or not proven to be effective for Mr S's diagnosis.

Mr S has said that the policy wording excludes experimental treatments but doesn't specifically list shockwave therapy, which is widely used in clinical practice. He thinks that applying such a broad interpretation only at the claims stage leaves customers exposed to unexpected costs. However, had Mr S sought pre-authorisation, it would have been declined at that point, without him having incurred any costs.

He has provided information from another doctor that they routinely treat Cigna policyholders with shockwave therapy, whose claims are then paid. However, it's unclear whether those patients had exactly the same diagnosis as Mr S and therefore, overall, I'm not persuaded

by this anecdotal evidence. I can only look at the circumstances of this complaint to decide what is fair and reasonable.

Mr S has now seen Cigna's Coverage Policy document. He says that if he had been provided with this back in December 2024, he would not have proceeded with the shockwave therapy. I take that to mean that he now accepts that such treatment is excluded from cover. He says that the failure to disclose such critical information until after he'd had the treatment wasn't fair. But again, had Mr S contacted Cigna about the shockwave therapy, and to seek pre-authorisation, it would have been explained at that time that the treatment was excluded.

I'm sympathetic to Mr S's situation. He undertook the treatment plan as advised by his doctor, for the benefit of his health, with an expectation of full cover. However, my role is to look at the circumstances of this complaint to decide whether a business has done anything significantly wrong. Overall, I'm satisfied that Cigna acted reasonably in declining the claim, in line with the policy terms and conditions. Therefore, whilst I know it will be disappointing to Mr S, it follows that I do not uphold the complaint.

My final decision

For the reasons set out above, I do not uphold the complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr S to accept or reject my decision before 14 January 2026.

Carole Clark
Ombudsman