DRN-4537205

The complaint

Ms S is unhappy with the way Vitality Health Limited handled a claim made on her private medical insurance policy.

What happened

Ms S wanted Vitality to cover a claim for mental health inpatient treatment. The claim was ultimately declined by Vitality as it concluded that the referral hadn't been made by a psychiatrist.

However, Vitality did accept in its final response letter dated May 2023 that there had been delays. It said it "recognised the importance of providing a clear and prompt response to members seeking support for sensitive issues, such as mental health concerns", apologised to Ms S and offered her £150 compensation.

Unhappy, Ms S complained to the Financial Ombudsman Service. Our investigator didn't think Vitality had to do anything more to put things right in this case. Ms S disagreed. Her complaint has now been passed to me to consider everything afresh 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.

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

I appreciate that Ms S has been through a very difficult time, and I have a lot of empathy for her situation. I know she'll be disappointed but for the reasons set out below, I don't think it would be fair and reasonable for Vitality to do anything more to put things right in this case.

The decision to not cover mental health inpatient treatment

The policy terms and conditions say at page 16:

> Mental health treatment
> …all treatment must be arranged by a psychiatric consultant, following a referral from your GP, except:
>
> Out-patient consultations with a clinical/counselling psychologist who you were referred to by your GP
>
> Treatment arranged by our mental health panel.

I've seen nothing which persuades me that Ms S was referred for inpatient treatment by a psychiatric consultant. The consultant psychiatrist's letter dated December 2022 does make

reference to Ms S's belief that intensive inpatient care is required. But the consultant psychiatrist doesn't specifically recommend it. A particular type of therapy is recommended.

So, I don't think Vitality has unfairly relied on the terms of the policy to decline cover for inpatient care.

Ms S says that this isn't a case of her making a self-referral for inpatient care. She says the psychiatrists didn't listen to her or evaluate her correctly. However, I don't think Vitality has acted unreasonably by relying on the medical opinion received.

The service received from Vitality

Vitality had requested Ms S' medical records from her GP before arranging for a psychiatric assessment. I'm satisfied that this was reasonable in principle and is not uncommon when the policy has been underwritten on a moratorium basis.

In this case, Vitality doesn't pay claims for the treatment of any medical condition or related condition, which in the five years before cover started, Ms S had received medical treatment for, had symptoms of, asked advice on, or was aware existed.

But subject to the remaining terms of the policy, the pre-existing medical condition can become eligible for cover provided Ms S hasn't consulted anyone for medical treatment or advice - or taken medication for that pre-existing medical condition or of any related condition for two continuous years after the cover start date.

So, I think it's reasonable for Vitality to want to ask for Ms S' medical notes to ensure the condition she wanted inpatient treatment for could be covered, subject to the remaining terms of the policy.

Vitality accepts that the time taken to obtain the medical records was "significant" and that it was "an unacceptable period to wait for mental health support". However, having considered Vitality's contact notes, I'm satisfied that the delays were mainly outside of Vitality's control and mainly due to the GP surgery. I'm satisfied Vitality was trying to proactively chase the GP surgery and it did update Ms S on occasion. Vitality seems to accept that there were times where it could've done more and that's why it's offered Ms S £150 compensation. That also includes occasions where Vitality accepts that Ms S had to call on multiple occasions to chase the outcome of her complaint.

So, although I think the delays were mainly outside of Vitality's control, I think £150 compensation fairly reflects the distress and inconvenience caused to Ms S as a result of what Vitality could've done better at a very difficult time for her.

Other service issues

Ms S is also unhappy with the service she received from Vitality in 2022. However, I don't have the power to consider those which were addressed in Vitality's final response letter 19 October 2022 – and which occurred up until that date.

That's because the rules which govern the Financial Ombudsman Service – the DISP rules - issued by the Financial Conduct Authority, set out at DISP 2.8.2 that the Financial Ombudsman can't consider a complaint if referred more than six months after the date on which the financial business (in this case Vitality) sent its final response. That's unless the Financial Ombudsman Service is of the view that the failure to comply with that time limit was as a result of exceptional circumstances.

Ms S brought her complaint to the Financial Ombudsman Service in July 2023 – two months after the date the final response letter dated May 2023 which addresses the complaint I've decided above. But that's over six months after the date of the final response letter dated October 2022.

I know Ms S was going through a difficult time, but I'm also satisfied from Vitality's contact notes that she was able to communicate with her GP surgery and Vitality within the six months period immediately after the date of the final response letter dated October 2022. So, I'm satisfied that there aren't any exceptional circumstances for Ms S not bringing any of the concerns addressed in that final response letter to the Financial Ombudsman Service within the stipulated timeframe.

Other issues

Ms S is unhappy that Vitality agreed to cover therapy which was recommended in the psychiatry assessment. She says that she'd previously been told by a psychiatrist that this that type of therapy would be dangerous for Ms S in her circumstances. I don't think Vitality has unfairly said it would be willing to cover the treatment recommended in the psychiatric report dated December 2022. I think it was entitled to rely on this. As Vitality says in its final response letter, it doesn't influence the course of treatment. It relies on the medical opinion when doing so. I don't think that's unreasonable.

Putting things right

I understand the offer of £150 compensation set out in the final response letter wasn't accepted so hasn't been paid. That being the case, I'm satisfied Vitality Health Limited should pay £150 compensation for distress and inconvenience it's already offered.

My final decision

My final decision is that Vitality Health Limited should pay £150 to Ms S if it hasn't already done so.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss S to accept or reject my decision before 31 January 2024.

David Curtis-Johnson
Ombudsman