DRN-4497083

The complaint

Miss D complains that American International Group UK Limited (AIG) has turned down a claim she made on a private medical insurance policy.

What happened

The background to this complaint is well-known to both parties, so I've simply set out a summary of what I think are the key events.

Miss D is insured under a private medical insurance policy. The policy provides specified benefits for a defined list of procedure codes. In December 2022, she underwent surgery in hospital. She made a claim on the policy for benefit.

AIG looked into Miss D's claim, taking into account the procedure codes it was given by the treating hospital. It didn't think the procedure Miss D had undergone was covered by the policy. So it turned down her claim.

Miss D was unhappy with AIG's decision. She provided evidence from the treating hospital which suggested that Miss D's procedure code had actually been a different code, which AIG did cover.

AIG investigated further with the specific consultant who'd carried out Miss D's surgery and obtained confirmation of the actual surgery Miss D had undergone. It concluded that the procedure wasn't covered by the policy and so it maintained its decision to turn down Miss D's claim. However, it accepted there'd been issues with the way it had handled the claim and so it offered Miss D £75 compensation.

Remaining unhappy with AIG's position, Miss D asked us to look into her complaint.

Our investigator thought Miss D's complaint should be upheld. She felt the surgery Miss D had undergone was closely related to procedures which AIG did cover. And therefore she thought it would be fair and reasonable for AIG to accept and pay Miss D's claim.

I issued a provisional decision on 21 November 2023, which explained why I didn't think it had been unfair for AIG to turn down Miss D's claim. I said:

'The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. So I've considered, amongst other things, the terms of Miss D's policy and the available evidence, to decide whether I think AIG treated Miss D fairly.

The policy terms and conditions

I've first considered the policy terms and conditions, as these form the basis of the contract between Miss D and AIG. Both parties accept that the policy terms set out a list of the specific procedure codes AIG covers. Page four of the contract terms explains what the policy is designed to do and says:

'It will pay for most consultations, diagnostic tests and investigations and if required a surgical procedure. The codes for the surgical procedures covered are listed in Section K 'Table of surgery'. Please note that if a surgical procedure code is not listed in Section K and the code you have been given by your surgeon is not an updated code for a surgical procedure covered as described in Section K, we will not provide any benefit towards the surgery performed.'

Section K states:

'Please note that if a procedure code is not listed in the tables below and is not an updated procedure code for a surgical procedure covered as described in the tables below we will not provide any benefit towards the surgery performed unless the surgeon could not have predicted before the surgery commenced that the additional procedure would be necessary.'

I've also looked closely at the Insurance Product Information Document (IPID), which sets out an at-a-glance summary of cover. Page one of the IPID includes a section called 'Are there any restrictions on cover?' It lists the following restriction:

'Only surgery that is shown in the Table of Surgery is covered under the policy.'

In my view, the policy documentation makes it sufficiently clear that AIG will only pay claims for surgery if the procedure is one AIG has specifically chosen to cover. AIG doesn't consider that the surgery Miss D underwent was covered by the policy terms. So I've next considered whether I think that was a fair conclusion for AIG to draw.

Was Miss D's surgery covered by the policy terms and conditions?

When Miss D initially made the claim, AIG relied on the information given by the treating hospital about the procedure she'd undergone. The surgery was recorded as: 'Laparoscopic unilateral right salpingo-oophorectomy.' I understand this was the removal of Miss D's right fallopian tube and ovary. AIG was provided with a list specific procedure codes – and having checked the policy terms, I can see that these weren't codes which AIG covered. So I don't think it was unfair for AIG to initially turn down the claim.

Following AIG's initial rejection of Miss D's claim, the treating hospital stated that, in fact, Miss D's surgery was coded differently and provided a code which was covered by the policy terms. AIG noted that the doctor who'd provided this information hadn't been Miss D's treating surgeon and so it contacted the consultant who had carried out the operation. I don't think this was an unfair or inappropriate step for AIG to take. The treating consultant responded to clarify that Miss D's exact type of surgery was:

'Laparoscopic right salpingo-oophorectomy + omental biopsy + biopsy of other peritoneal cystic nodules in pelvis.'

I don't think it was unfair for AIG to place more weight on the evidence of the surgeon who'd carried out Miss D's surgery to determine exactly what procedure she'd undergone. And this surgery matched the original codes AIG had been given – which weren't covered by the policy terms. So I don't think it was unreasonable for AIG to conclude that the procedure simply wasn't covered under the terms of the contract.

Section K includes cover for treatment of endometriosis. The policy says: 'Keyhole surgery is used to treat endometriosis, a poorly-understood condition where tissue similar to that usually found inside the womb is found elsewhere in the body (usually in the pelvis). Endometriotic lesions can be destroyed using a special telescopic instrument called a laparoscope, eliminating the need for a large surgical scar.'

Our investigator thought Miss D's surgery was similar to procedure codes AIG did cover. And she referred to NHS information which indicated that endometriosis could present in the form of ovarian cysts. Therefore, she thought it would be fair and reasonable for AIG to accept and pay Miss D's claim. I've thought about this carefully.

The available medical evidence indicates that Miss D's surgery was intended to remove an adnexal mass, together with her right ovary and fallopian tube. I haven't seen any persuasive medical evidence which suggests that Miss D had been diagnosed with endometriosis or that her ovarian cyst was caused by endometriosis. Neither have I seen any medical evidence that indicates Miss D's surgery was intended to treat endometriosis. As such then, I don't think it was unfair for AIG to conclude that Miss D's treatment didn't fall within the scope of the procedures it covered. On that basis, while I sympathise with Miss D's position, I don't think it would be fair or reasonable for me to direct AIG to accept and pay Miss D's claim outside of the policy terms.

AIG accepts that it didn't handle Miss D's claim as well as it could have done. And so it's offered to pay her £75 compensation. In my view, this is a fair and reasonable award to recognise the likely impact I think AIG's service errors had on Miss D. And so I'm not planning to tell AIG to pay anything more.'

I asked both parties to send me any further evidence they wanted me to consider.

AIG didn't respond by the deadline I gave.

Miss D disagreed with my provisional findings and I've summarised her response. She maintained that the definition of the surgery she'd undergone was the removal of an ovary, which she felt fell within AIG's covered procedure codes. She felt that different titles were given to surgeries, but it was the definition of those procedures which was key, so a patient understands what treatment is to be carried out. She provided me with a copy of her medical consent form which listed the title of the surgery and the intended benefits of it – to remove an ovarian cyst and give a diagnosis. She stated that other specialists had agreed that her operation code was indeed one which AIG covered. She felt that neither I nor AIG were gynaecological experts and that AIG hadn't considered the definitions of procedures it did cover.

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 Miss D, I still don't think it was unfair for AIG to turn down her claim and I'll explain why.

In my provisional decision, I explained the reasons why I didn't think it had been unfair or reasonable for AIG turn down Miss D's claim. I've carefully considered her response to my provisional findings. But overall, my final decision is the same as my provisional decision and for the same reasons. However, I will address what I consider to be the key further points Miss D has made.

It's important I make it clear that as I'm not a medical expert, I must necessarily make a decision based on the available medical evidence. In this case, I have weighed-up the totality of the medical evidence provided by the treating hospitals and Miss D's treating specialists to decide whether I think it was fair for AIG to place more weight on the treating consultant's evidence.

As I explained above, I'm satisfied that the policy terms make it clear that AIG will only pay claims for the specific, listed procedure codes it's set out in the contract.

In this case, AIG was provided with discharge information, completed by Miss D's treating surgeon, which stated that Miss D had undergone 'laparoscopic right salpingo-oophorectomy and omental biopsy and biopsy of other peritoneal cystic nodules in pelvis.' I appreciate that one of the stated benefits of this procedure was that an ovarian cyst would be removed for diagnostic testing. And that there is some cover under the policy for the puncture of an ovarian cyst and the biopsy of it. But based on the discharge information AIG was given, I don't think it acted unfairly when it concluded that Miss D's surgery had been for the wider removal of her right fallopian tube and ovary, along with the removal of an adnexal mass. As such, I don't think it acted unfairly or unreasonably when it decided that Miss D's procedure wasn't covered by the policy terms.

I accept that following AIG's initial decline of the claim, other specialists who'd been involved in Miss D's care stated that in fact, Miss D's surgery did fall within a covered procedure code. But given this information was different to the original information AIG had been given, I still think it was fair and reasonable for AIG to contact Miss D's treating and discharging surgeon to clarify exactly what type of surgery Miss D had undergone. That's because I think they were best placed to comment on the procedure and what had happened. And as I've explained, the treating surgeon reiterated that Miss D's surgery matched the information they'd given on the discharge papers.

As such then, I still don't think it was unfair for AIG to find the evidence of the surgeon who'd carried out Miss D's surgery to be more persuasive than the evidence of the other specialists. And so it follows that I still don't find that AIG acted unfairly or unreasonably when it maintained its decision to turn down Miss D's claim.

Overall then, despite my natural sympathy with Miss D's position, I'm not telling AIG to pay Miss D's claim or to do anything more.

My final decision

For the reasons I've given above and in my provisional decision, my final decision is that I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss D to accept or reject my decision before 9 January 2024.

Lisa Barham
Ombudsman