DRN-4706644

The complaint

Mrs C complains about how Vitality Health Limited handled a claim against her private medical insurance and its decision to decline her claim.

What happened

The details of this complaint are well known to both parties, so I won't repeat them again here in full. In summary, Mrs C is the beneficiary of private medical insurance. Her cover started on 6 April 2022 and was on a moratorium basis. That means that it didn't cover treatment of any medical condition or related conditions Mrs C received medical treatment for, had symptoms of, asked advice on, or was aware existed in the five years before cover began, until she had been a member for two years in a row and had a period of two years in a row trouble-free from that condition.

In September 2022, Mrs C made a claim against the policy in relation to lower back pain. Vitality authorised an initial course of physiotherapy and I understand that it covered four sessions. In October 2022, Vitality asked for medical information from Mrs C. On 9 November 2022, Vitality declined Mrs C's claim. It said that the claim related to a pre-existing condition. Mrs C didn't think that was fair and pursued her complaint.

Vitality asked for further information from Mrs C's GP and Mrs C provided further information from both her GP and physiotherapist. Vitality didn't change its decision. I understand that Mrs C pursued physiotherapy treatment privately on a self-pay basis.

On 1 August 2023, Mrs C's cover was changed to '*medical history disregard*' , so it's no longer on a moratorium basis.

Mrs C says that her lower back pain was not related to her previous upper back pain. She says that both her GP and her physiotherapist have confirmed that. Mrs C says that Vitality's delay caused deterioration in her health. She wants reimbursement for physiotherapy treatment and compensation for distress and inconvenience.

One of our investigators looked at what had happened. He didn't think that Vitality had treated Mrs C unreasonably in declining the claim. The investigator thought that Vitality had acted within reasonable timeframes.

Mrs C didn't agree with the investigator. She said that the consultation she had with her GP on 31 August 2020 was a telephone consultation, so the GP didn't examine her. Mrs C says that the note her GP made at the time is his interpretation of her description of her symptoms. She says that the first time she experienced any symptoms relating to her coccyx was in September 2022. Mrs C says that her physiotherapist examined her and treated both her upper back pain in August 2020 and her lower back pain in September 2022. So, information from her physiotherapist is more reliable than information from her GP.

Mrs C says that Vitality asked for further information then disregarded it. She says that Vitality delayed dealing with the matter.

There was further correspondence between Mrs C and the investigator. The investigator considered what Mrs C said but didn't change his view. Mrs C asked that an ombudsman consider her complaint, so it was 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.

I've taken into account the law, regulation and good practice. Above all, I've considered what's fair and reasonable. The relevant rules and industry guidance say that Vitality has a responsibility to handle claims promptly and fairly. I don't uphold Mrs C's complaint and I'll explain why:

- Mrs C's cover is on a moratorium basis. That means that it doesn't cover medical conditions or related conditions Mrs C received medical treatment for, had symptoms of, asked advice on or was aware existed in the five years before cover began until she had been a member for two years in a row and had a period of two years in a row trouble-free from that condition.

- I don't think that Vitality acted unfairly or unreasonably in asking for medical information from Mrs C's GP. It's entitled to do that under the terms of the cover.

- The medical information form completed by Mrs C's GP contains the following: '*Please give details and dates of all symptoms, treatment, advice and medication received for this condition between 06/04/2017 and now:*
  31/8/20 1 week low back pain, advice, simple pain relief, consider physio.
  15/9/22 3 weeks mechanical low back pain. Advise physio input.'

- I think that Vitality was entitled to rely on the information provided by Mrs C's GP in the medical information form and conclude that Ms C had low back pain in August 2020, within the moratorium period. That's because the GP was referring to contemporaneous notes he made at the time of the consultation. I've noted what Mrs C says about this consultation - that it was a telephone consultation, so her GP didn't examine her and relied on her description of her symptoms. But I don't think that alters the fact that Vitality is entitled to rely on the information Mrs C's GP provided from his contemporaneous notes.

- Mrs C's GP subsequently provided Vitality with relevant extracts from his clinical notes which include the following:
  '[…]
  31/08/2020 Telephone encounter
  COVID call
  Having problems with her back.
  Past physio for left shoulder symptoms […]. Onset of similar past last (sic) week in left shoulder but then worsening over the course of the week with some severe lower back pain. […]'

- The information in Mrs C's GP's clinical notes supports the information he initially provided in Vitality's medical information form. I think that Vitality acted fairly in maintaining its decision to decline Mrs C's claim because the clinical notes clearly refer to lower back pain in the moratorium period.

- Mrs C's GP said that Mrs C had told him that her pain in August 2020 was in a very different location than her pain in September 2022. I don't think that Vitality is at fault for preferring to rely on Mrs C's GP's contemporaneous notes, rather than his report of his discussions with Mrs C after her claim had been declined.

- Mrs C subsequently provided information from the physiotherapist who treated her in both 2020 and 2022. The physiotherapist said that in 2020 he treated Mrs C for upper back pain and in 2022 he treated her for non-specific low back pain, which was nothing to do with the treatment in 2020.

- Whilst Mrs C's physiotherapist can give details of the treatment he provided in 2020 and 2022, it doesn't alter the fact that Mrs C's GP's contemporaneous notes indicate that she reported lower back pain in 2020. I think that Vitality considered the additional information but was entitled to maintain its decision to decline Mrs C's claim.

- Mrs C invited Vitality to speak with her physiotherapist but I don't think that Vitality was obliged to contact Mrs C's physiotherapist directly for further information as it had what it needed to make a decision.

- Mrs C has asked that this service contact her physiotherapist. This service doesn't manage and assess claims. In this decision, I'm looking at whether Vitality acted fairly and reasonably in its handling of Mrs C's claim. So, I'm looking at what information Vitality gathered and how it was assessed. As the investigator has explained, it's open to Mrs C to provide Vitality with further information from her physiotherapist and ask it to reconsider her claim. If she is not happy with its response, she can complain to this service about that in a separate complaint.

- Mrs C complains that Vitality delayed dealing with the matter. I don't think that there was undue delay in Vitality reaching its initial decision to decline the claim in November 2022. There were subsequent exchanges between Mrs C and Vitality as Mrs C wanted Vitality to change its decision. Vitality gave Mrs C the opportunity to provide further information and asked Mrs C's GP some further questions. Vitality considered the further information. I've looked at the timing of the exchanges and I don't think that there was an unreasonable delay in Vitality dealing with Mrs C's further correspondence. I appreciate that Mrs C remained dissatisfied with Vitality's decision.

- I'm sorry to disappoint Mrs C but, for the reasons I've explained, I don't uphold this complaint.

My final 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 Mrs C to accept or reject my decision before 8 July 2024.

Louise Povey
Ombudsman