Before the Arbiter for Financial Services

Case No. 023/2019

LN (the complainant)

vs

Axeria Insurance Ltd. (C 55905)

(the service provider/the insurance)

Sitting of the 15 September 2020

The Arbiter,

Having seen the complaint whereby the complainant basically states that:

His claim is for £347 for an MRI scan which was declined by the insurance for no good reason. He is also asking the Arbiter to pay him £2,000 for compensation for stress caused by their failure to provide '*Fast Access*' and '*Peace of mind*' as per promotional material; the stress caused by the length of time they took to assess his claim and then the refusal to pay for the operation which he financed himself to make the claim later.

He further states that the service provider refused to pay for anything related to his prostate. He admits that the insurance did finally pay him the expenses incurred by him with the exception of the MRI scan. He also asks for the payment of £2,000 '*for failure to provide ongoing cover at no increase in premium following a claim'.*

The complainant gives a timeline of events as follows:

In May 2018 his GP wanted him to be checked for bladder cancer as he had had some blood in his urine

On 11 May 2018, the complainant contacted April UK and obtained a claim number.

On 12 May 2018, the complainant met Mr Syed at Spire Little Aston where he told the complainant that he was obliged to check his kidneys, prostate as well as bladder as any one of them could be the cause.

Investigations (CT scan, cystoscopy and later an MRI scan) led to his needing surgery to remove his left kidney which had a small tumour. It was tested after being removed and it was confirmed to be cancer.

On 25 May 2018, the complainant received a request from April UK to complete a consent form to allow them access to his medical records. This was dealt with immediately. The hospital advised him that his insurers were not agreeing to cover the costs that were being incurred. He discovered this because they still had to study his medical records.

On 5 April 2018, April UK advised the complainant that they were declining his claim as they considered it to be a pre-existing condition.

The complainant had been passed on to Mr Chandrasekharan at Spire Solihull and had been given the 11 July for his operation. Mr Chandrasekharan had informed him that there was a 2014 scan on his records which showed two healthy kidneys. This encouraged the complainant to go ahead and self-fund the surgery. He had to raise funds to pay the hospital £5,662 upfront, knowing that this was in addition to significant costs that had already been incurred.

On 7 July 2018, the complainant wrote back to April UK with a long and detailed explanation of how this could not have been a pre-existing condition. (He had notified them about the 2014 scan before their decision).

The complainant received a reply telling him that he would hear back from them within 15 working days, after which time they replied admitting their error but adding that nothing relating to his prostate would be covered.

On 30 August 2018, the complainant wrote to April UK contesting their decision to not accept costs relating to his prostate. He listed the items which totalled £1,197. He received neither acknowledgement nor reply.

On 18 September 2018, he wrote again, and he received a reply by return promising to get back to him *'quickly'*.

On 18 October 2018, the complainant wrote again adding a claim for compensation of £2,000 and giving them until 28 October to reply.

On 29 October 2018, the complainant received a reply informing him that they had offered to pay for his biopsy but not for the MRI scan, even though he needed the biopsy because the MRI showed up something that looked suspicious.

Having seen the reply of the service provider which states:

In response to customer's complaint of 22 March 2019, please find below a summary of history of events.

<u>Version of events according to LN</u>

May 2018 – LN stated that he required investigations due to blood in his urine;

11 May 2018 – LN stated that he contacted Axeria Insurance's claims handler and was given a claim number;

25 May 2018 – LN stated that he received a request for consent form from Axeria Insurance's claims handler, that being two weeks after his investigations;

5 July 2018 – LN stated that he was advised that his claim was refused;

11 July 2018 – LN had his cancerous kidney successfully removed;

1 August 2018 – LN received a letter from Axeria Insurance's claims handler informing him that his claim will be partly settled. All invoices in relation to the claims will be settled except for the MRI costs since these related to a pre-existing condition.

<u>Axeria Insurance's version of events</u>

2 May 2018 – GP stated that '*the issue started on this day'* and Axeria Insurance's claims handler authorised an initial consultation only and requested a five-year history of urology issues from GP;

25 May 2018 – LN first made contact with Axeria Insurance's claims handler;

25 May 2018 – Axeria Insurance's claims handler requested GP referral and consent form;

30 May 2018 - Axeria Insurance's claims handler informed LN that Axeria Insurance's claims handler was not in receipt of the GP referral or consent form as yet;

31 May 2018 – LN returned a clinic letter to Axeria Insurance's claims handler which referred to a history of his symptoms;

31 May 2018 - Axeria Insurance's claims handler asked LN again for a consent form;

2 June 2018 - Axeria Insurance's claims handler received the consent form;

7 June 2018 - Axeria Insurance's claims handler requested GP surgery's medical history (given that the claims handler was already in possession of the consent form);

3 July 2018 - Axeria Insurance's claims handler received the GP surgery's medical history;

5 July 2018 - Axeria Insurance's claims handler informed LN of the decision regarding the claim;

1 August 2018 – LN received a letter from Axeria Insurance's claims handler informing him that the claim will be partly settled. All invoices will be settled with the exception of the MRI costs due to a pre-existing condition.

To recapitulate, LN stated that in May 2018, he required investigations due to blood in his urine. Given these symptoms, the consultant checked his kidneys, prostate and bladder.

LN said that on 25 May 2018, he received a request to complete a consent form from Axeria Insurance's claims handler to give them access to his medical records as well as to present GP referral notes. Although LN pointed out in his report that these were completed immediately, this was not the case.

In his report, LN is saying that he was informed by the hospital that the claims handler hadn't yet agreed cover two weeks after his investigations took place. This is phrased in an inaccurate light, because LN actually made first contact with the claims handler on 25 May 2018.

It did not take the claims handler two weeks to take action as this was the first time the claims handler had been made aware of the claim, and LN was told clearly during the telephone call that no cover was confirmed, and that claims handler required medical records prior to taking a decision.

LN advised that it took the claims handler until 5 July 2018 to inform him that his claim was declined. The claims handler had reiterated to LN on 30 May 2018 that it was not in receipt of the GP referral or consent form which the claims handler had requested as soon as LN called on 25 May 2018.

Once again, the claims handler requested to have GP referral and consent form from LN. LN returned a clinic letter to the claims handler on 31 May 2018, mentioning a history of these symptoms. The claims handler again asked LN for his consent form, which was eventually received on 2 June 2018. Within five working days, the claims handler actioned the request for medical history, and it took LN's GP surgery until 3 July 2018 to fulfil the request. LN was then informed of the decision on 5 July 2018, two working days later.

It was not possible for the claims handler to advise LN any sooner than this, and the terms and conditions clearly state the requirement for medical reports. Clearly, any delay on the part of the GP surgery is beyond Axeria Insurance's control.

The decision to decline the claim was based on the presenting symptoms. The policy excludes pre-existing conditions, defining them as conditions for which '*you have experienced symptoms; whether the condition has been diagnosed or not, before the start of your cover*.'

The member's policy started 1 March 2018. The claims handler was aware of LN's medical history, and that LN had experienced blood in his urine on 11 November 2013, 27 November 2013, 7 January 2014, and 13 March 2014. This was a pre-existing condition and, therefore, not covered under the policy. This

was a decision taken on the basis of his presenting symptoms, medical history and policy wording.

LN was unhappy with the decline as he felt the blood in his urine in 2013 and 2014 was related to his benign prostatic hyperplasia and not his bosniak cyst, which was the cancerous bladder lesion picked up during the investigations he was now claiming for. The case was referred to the chief medical officer, who determined that there was no way of knowing whether the blood in his urine was due to the benign prostatic hyperplasia or the bladder cyst. Regardless of this, the chief medical officer agreed that the bladder cyst was newly identified and diagnosed, and therefore eligible for cover.

LN is, however, claiming also for his MRI which, according to him, was specifically related to his prostate. Since his benign prostatic hyperplasia is pre-existing, relating to the episodes of bleeding in 2013 and 2014, it should clearly remain a liability for LN.

LN has had all other invoices settled with regards to this claim. The MRI is the only aspect which Axeria Insurance has declined as this is related to his pre-existing benign prostatic hyperplasia.

Axeria Insurance does not feel that LN is due any compensation for any stress or any other reason he is saying he encountered; this was a complex case with a lot of grey areas, on which Axeria Insurance acted promptly and with the least possible delay as soon as the information the claims handler had requested was received.

Having seen all the records of the case,

Considers

By means of an email dated 10 June 2019, the insurance informed the Office of the Arbiter for Financial Services that:

'***Axeria Insurance agreed to pay for all the medical treatment related to this claim in full, so I trust that the matter is closed.'***

Having seen this email, the Arbiter understands that the issue raised by the complainant that the insurance company had refused to pay him the expenses of his MRI scan is now settled and that the complainant has been paid even for the contested MRI scan.

However, if for any reason, the amount for the MRI scan has not yet been paid, the Arbiter is ordering the insurance company to pay him this amount immediately.

Compensation for '*stress*' and '*for failure to provide ongoing cover*'

The complainant has also asked the Arbiter to order the service provider to pay him for '*the stress caused by the length of time they took to assess his claim'* and for '*failure to provide ongoing cover'*.

Apart from the fact that the Arbiter has conflicting versions on whether the time taken by the service provider to process the claim was justified or not, the Arbiter's powers to award compensation are limited by law.

In fact, Article 26(3)(c)(iv) of Chapter 555 of the Laws of Malta stipulates that:

'*to pay an amount of compensation for any loss of capital or income or damages suffered by the complainant as a result of the conduct complained of, without or with interest, at such reasonable rate and within the parameters established by law as the Arbiter may determine, on the whole or any part of the money, and for the whole or any part of the period between the date on which the conduct complained of had started until the date of payment.'*

Therefore, the Arbiter is not allowed by law to order compensation for stress and for not providing an ongoing cover as requested by the complainant.

For the above-stated reason, the Arbiter cannot uphold the complaint in this regard. However, since the service provider has informed the Arbiter that it had accepted to pay '*for all the medical treatment related to this claim in full,'* if it had not paid the complainant for the MRI scan, the Arbiter is ordering Axeria Insurance Limited to pay such amount to the complainant immediately.

Each party is to bear its costs of these proceedings.

Dr Reno Borg
Arbiter for Financial Services